City of Hamilton

EMERGENCY & COMMUNITY SERVICES COMMITTEE REVISED

Meeting #: 20-004

Date: July 13, 2020

Time: 9:30 a.m.

Location: Due to the COVID-19 and the Closure of City Hall

All electronic meetings can be viewed at:

City's Website:
https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas

City's YouTube Channel:
https://www.youtube.com/user/InsideCityofHamilton or Cable 14

Tamara Bates, Legislative Coordinator (905) 546-2424 ext. 4102

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1. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

2. DECLARATIONS OF INTEREST

3. APPROVAL OF MINUTES OF PREVIOUS MEETING

3.1 June 19, 2020

4. COMMUNICATIONS

5. CONSENT ITEMS

5.1 Ministry of Health Consultation Meetings (HSC20014) (City Wide)

5.2 Paramedic Service Data Sharing and Network Services Agreement with Health Shared Services Ontario (HHSO) (HSC20017) (City Wide)

5.3 Leveraging a Provincial Contract for Digitizing Ontario Works Client Files (HSC20023) (City Wide)

Discussion of Appendix "A" of this report in Closed Session is pursuant to Section 8.1, Sub-sections (b) and (d) of the City's Procedural By-law 18-270, as amended, and Section 239(2), Sub-sections (b) and (d) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees, and labour relations or employee negotiations.

5.4 Child Care Reopening Framework (HSC20027) (City Wide)

6. WRITTEN DELEGATIONS

*6.1 Kevin Gonci, Hamilton Collaborative Partnership Group, respecting Response to City of Hamilton Staff Report HSC20026 (City Wide) dated June 19, 2020

*6.2 Dr. Jill Wiwcharuk and Dr. Tim O'Shea, Hamilton Social Medicine Response Team, respecting the City's strategy about homeless encampments

*6.3 Jody Ans and Lisa Nussey, Keeping Six, respecting request that the City re-evaluate and change its approach to encampments

*6.4 Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, respecting Dismantlement of Homeless Encampments

7. STAFF PRESENTATIONS

7.1 Hamilton Paramedic Service 2019 Annual Report (HSC20021) (City Wide)

8. DISCUSSION ITEMS

8.1 Home for the Holidays Wrap Up (HSC20024) (City Wide)

8.2 Provision of Conditional Grants for the Purposes of Paying Development Charges for Two Non-Profit Affordable Rental Housing Projects (HSC1960(a)) (Ward 3)

*8.3 Adaptation and Transformation of Services for People Experiencing Homelessness Update 1 (HSC20020(a)) (City Wide)

9. MOTIONS

10. NOTICES OF MOTION

*10.1 Signing of the AMO-OFIFC Declaration of Mutual Commitment and Friendship with Local Municipality and Friendship Centre Support

11. GENERAL INFORMATION / OTHER BUSINESS

12. PRIVATE AND CONFIDENTIAL

12.1 Appendix "A" to Report HSC20023, Leveraging a Provincial Contract for Digitizing Ontario Works Client Files (City Wide)

Pursuant to Section 8.1, Sub-sections (b) and (d) of the City's Procedural By-law 18-270, as amended, and Section 239(2), Sub-sections (b) and (d) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees, and labour relations or employee negotiations.

*12.2 Potential Litigation Report (LS20019) (City Wide)

Pursuant to Section 8.1, Sub-sections (e) and (f) of the City's Procedural By-law 18-270, as amended, and Section 239(2), Sub-sections (e) and (f) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to litigation or potential litigation, including matters before administrative tribunals, affecting the City and the receiving of advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

13. ADJOURNMENT

EMERGENCY & COMMUNITY SERVICES COMMITTEE
MINUTES 20-003

9:30 a.m.
Friday, June 19, 2020
Council Chambers
Hamilton City Hall
71 Main Street West

Present: Councillors E. Pauls (Chair), B. Clark, T. Jackson, S. Merulla, and N. Nann

Absent with Regrets: Councillor T. Whitehead – Personal

THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. Canadian Medical Association Foundation COVID-19 Community Response for Vulnerable Populations Fund (HSC20022) (City Wide) (Item 5.2)

(Nann/Jackson)

(a) That the General Manager of Healthy and Safe Communities, or his designate, be authorized and directed to enter into and execute an Agreement with the Canadian Medical Association Foundation to administer the Canadian Medical Association Foundation COVID-19 Community Response for Vulnerable Populations Fund; and

(b) That any agreements with Community Services Provider(s), as well as any ancillary agreements, contracts, extensions and documents required to give effect thereto be in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

2. Self-Contained Breathing Apparatus Parts (SCBA) Parts Shortage (HSC20025) (City Wide) (Added Item 5.3)

(Nann/Clark)
That Report HSC20025, respecting Self-Contained Breathing Apparatus Parts (SCBA) Parts Shortage, be received.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

3. Basic Income Pilot (Added Item 6.1)

(Nann/Pauls)
(a) That the Emergency and Community Services Committee reaffirm Council's position supporting permanent basic income programs and encourage the federal government to pursue a pilot; and

(b) That the Emergency and Community Services Committee reaffirm Council's support to Basic Income Hamilton to continue its voluntary advocacy group.

4. Expanding Housing and Support Services for Women and Transgender Community Sub-Committee Report 20-001 (Item 8.1)

(Nann/Clark)
(a) Appointment of the Chair and Vice-Chair for 2020 (Item 1)

(i) That Councillor Nrinder Nann be appointed Chair of the Expanding Housing and Support Services for Women and Transgender Community Sub-Committee for 2020.

(ii) That Carol Cowan-Morneau be appointed Vice-Chair of the Expanding Housing and Support Services for Women and Transgender Community Sub-Committee for 2020.

(b) Change to the Name of the Sub-Committee (Added Item 13.3)

That the name of the Expanding Housing and Support Services for Women and Transgender Community Sub-Committee be changed to Expanding Housing and Support Services for Women, Non-Binary, and Transgender Community Sub-Committee.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

5. Ontario Works Facilities Update (HSC20015) (City Wide) (Item 8.2)

(Merulla/Clark)
That Report HSC20015, respecting Ontario Works Facilities Update, be received.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

6. Adaptation and Transformation of Services for People Experiencing Homelessness (HSC20020) (City Wide) (Item 8.3)

(Merulla/Jackson)
(a) That the General Manager of Healthy and Safe Communities, or his designate, be authorized to enter into agreements, in a form satisfactory to the City Solicitor, with Living Rock Ministries, Mission Services, Wesley Urban Ministries and the YWCA Hamilton to continue enhanced drop-in services at Living Rock, Willow's Place, Wesley Day Centre and Carole Ann's Place respectively to June 30, 2021 to a maximum of $3.2 M;

(b) That the General Manager of Healthy and Safe Communities, or his designate, be authorized to enter into an agreement, in a form satisfactory to the City Solicitor, with the Salvation Army Booth Centre in the amount of approximately $400 K to fund capital costs to renovate the facility to allow for appropriate physical distancing and create 30 additional single rooms for a total occupancy of 80 single men; and,

(c) That the Mayor formally request additional provincial Community Homelessness Prevention Initiative and federal Reaching Home funding in order to address the shortfall related to COVID-19 spending within Hamilton's homelessness serving population.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

7. Hamilton Collaborative Partnership Group Multi-Sport Facility Proposal (HSC20026) (City Wide) (Outstanding Business List Item) (Added Item 8.4)

(Nann/Clark)
That Report HSC20026, respecting Hamilton Collaborative Partnership Group Multi-Sport Facility Proposal, be received.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

8. Let's Get Growing Seed Share Program (Ward 3) (Item 9.1)

(Nann/Merulla)
WHEREAS, food security has emerged as a critical health equity issue during the COVID-19 pandemic;

WHEREAS, residents are engaging on a hyper-local and neighbourhood level to express and address needs and offer support to each other during these challenging times;

WHEREAS, community members have shown great interest in desire to become more food secure through gardening;

WHEREAS, these efforts increase the community resilience and provide sustainable models to support a more thriving community for years to come;

WHEREAS, Environment Hamilton has developed the Let's Get Growing seed share program to increase food security through education & tools for self-sufficiency and will serve as the primary coordinating body of this effort;

THEREFORE, BE IT RESOLVED:

(a) That $1000 be allocated from the Ward 3 Bell Cell Tower (3301609603) to Environment Hamilton for costs associated with implementing the Let's Get Growing Seed Share Program project through the 2020 growing and harvest season in Ward 3;

(b) That the Mayor and City Clerks be authorized and directed to execute any required agreement(s) and ancillary documents related to the Let's Get Growing Seed Share Program project, with such terms and conditions in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

9. Residential Care Facility (RCF) Complaint Liaison (Added Item 10.2)

(Clark/Jackson)

(a) That a position of Residential Care Facility (RCF) Complaint Liaison be assigned within the Healthy and Safe Communities Department to receive complaints, concerns or questions about the services and care provided to residents in Hamilton's licensed RCFs;

(b) This position will receive complaints, concerns or questions from:

(i) individual residents;

(ii) Anyone acting on behalf of a resident, including, roommates, peers, self-advocates, friends and family members of individual residents;

(iii) Residential home staff, service coordinators, medical providers, hospitals, social service organizations and paraprofessionals regarding a resident(s) issue;

(c) The position will report to the General Manager of the Healthy and Safe Communities Department;

(d) All complaints will be received at no cost;

(e) Complaints will be treated as confidential, unless required otherwise by legislation, including being to be released to the public under MFIPPA, or PHIPPPA or to another agency for investigation;

(f) Generally, the process for addressing a complaint or concern will involve:

(i) A review of the complaint to determine which agency or city department is responsible for investigation;

(ii) If the complaint is determined to be one which can be investigated by the City or another agency, the complaint will be forwarded to the appropriate group for investigation.

(iii) Complaints will be handled as quickly as possible. It is anticipated that some complaints can be resolved within a matter of days. Other complaints may take longer if they are complex;

(g) That Staff be directed to report back on the recommended accountability standards, service levels and process requirements for the various types of complaints that can be addressed by the RCF Liaison position, including details regarding:

(i) How the facility will be told that there is a complaint and given an opportunity to correct the situation.
(ii) If the investigation reveals non-compliance, how the facility will be required to correct the situation and ensure future compliance and how the public will be notified;
(iii) How the Complainant will be provided with follow up information regarding the outcome of the investigation;

(h) The General Manager of the Healthy and Safe Communities Department will report quarterly a summary of the complaints received, and the status of the complaints;

(i) This position will be in place until June 30, 2021 or such time as Council decides on a more permanent structure for this role based on the RCF modernization project and the Outstanding Business List item regarding the RCF tenant advocate role; and,

(j) RCF licensed by the City of Hamilton will be required to post, in a prominent location accessible to residents and their relatives, the contact information for the RCF Complaint Liaison.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

10. Birch Avenue Greenspace (Added Item 10.2)

(Nann/Jackson)
WHEREAS, greenspace in the North end of Ward 3 is deficient;

WHEREAS, pollinator plants are much needed in order to encourage plant propagation across the city;

WHEREAS, a dedicated group of volunteers in the GALA neighbourhood have tended this land successfully for over seven years, adding to the beauty and pride of the neighbourhood;

WHEREAS, this group of community volunteers is willing and interested in further planting of native and pollinator species along the Birch Avenue greenspace;

THEREFORE, BE IT RESOLVED:

(a) $2000 be allocated from the Ward 3 Bell Tower Fund (3301609603) to the GALA Community Planning Team to purchase plants and to cover other costs associated with establishing and expanding a thriving garden;

(b) That the Mayor and City Clerks be authorized and directed to execute any required agreement(s) and ancillary documents, with such terms and conditions in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

FOR INFORMATION:

(a) APPROVAL OF AGENDA (Item 1)

The Committee Clerk advised of the following changes to the agenda:

5. CONSENT ITEMS (Item 5.3)

5.3 Self-Contained Breathing Apparatus Parts (SCBA) Parts Shortage (HSC20025) (City Wide)

6. WRITTEN DELEGATIONS (Item 6.1)

6.1 John Mills, Hamilton Basic Income Group, respecting cancellation of the Basic Income pilot

8. DISCUSSION ITEMS (Item 8.4)

8.4 Hamilton Collaborative Partnership Group Multi-Sport Facility Proposal (HSC20026) (City Wide) (Outstanding Business List Item)

10. NOTICES OF MOTION (Item 10.1)

10.1 Residential Care Facilities (RCF) Complaint Liaison

10.2 Birch Avenue Greenspace

11. GENERAL INFORMATION/OTHER BUSINESS (Items 11.1.a. and 1.1.c.)

11.1.a. Items Requiring a New Due Date (Items 11.1.a.d-e, and 11.1.a.h)

11.1.a.d. Opportunities and Flexibility of Existing Housing Programs – WITHDRAWN
This item is being withdrawn and added under Items to be Removed as Item 11.1.c.a.

11.1.a.e. Hamilton Housing Benefits – WITHDRAWN
This item is being withdrawn and added under Items to be Removed as Item 11.1.c.b.

11.1.a.h. Community Hub Proposal/Multi-Sport Indoor Facility – WITHDRAWN
As this item is being addressed on today's agenda as Item 8.4, it is being withdrawn and added to Items to be Removed as Item 11.1.c.c.

11.1.c. Items to be Removed (Items 11.1.c.a-c.)

11.1.c.a. Opportunities and Flexibility of Existing Housing Programs

11.1.a.e. Hamilton Housing Benefits

11.1.a.h. Community Hub Proposal/Multi-Sport Indoor Facility

(Nann/Clark)
That the agenda for the June 19, 2020 Emergency and Community Services Committee meeting be approved, as amended.

Result: Motion CARRIED by a vote of 4 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 4 Councillor Sam Merulla
YES - Ward 6 Councillor Tom Jackson
YES - Chair - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

(b) DECLARATIONS OF INTEREST (Item 2)

There were no declarations of interest.

(c) APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 3)

(i) February 20, 2020 (Item 3.1)

(Jackson/Nann)
That the Minutes of the February 20, 2020 meeting of the Emergency and Community Services Committee be approved, as presented.

Result: Motion CARRIED by a vote of 4 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

(d) COMMUNICATIONS (Item 4)

(i) Correspondence from Shannon Fuller, Assistant Deputy Minister, Early Years and Child Care Division, Ministry of Education, regarding Child Care and EarlyON Sector Funding - COVID Outbreak (Item 4.1)

(Clark/Nann)
That Correspondence from the Shannon Fuller, Assistant Deputy Minister, Early Years and Child Care Division, Ministry of Education, regarding Child Care and EarlyON Sector Funding - COVID Outbreak, be received.

Result: Motion CARRIED by a vote of 4 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

(e) CONSENT ITEMS (Item 5)

(i) Hamilton Veterans Committee Minutes (Item 5.1)

(Jackson/Clark)
That the following Minutes of the Hamilton Veterans Committee, be received:

(a) September 24, 2019 (Item 5.1 (a))
(b) October 22, 2019 (Item 5.1 (b))
(c) November 26, 2019 (Item 5.1 (c))
(d) February 25, 2020 (Item 5.1 (d))

Result: Motion CARRIED by a vote of 4 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

(f) WRITTEN DELEGATIONS (Item 6)

(i) John Mills, Hamilton Basic Income Group, respecting cancellation of the Basic Income pilot (Added Item 6.1)

(Nann/Clark)
That the Written Delegation, from John Mills, Hamilton Basic Income Group, respecting cancellation of the Basic Income pilot, be received.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

For further disposition of this matter, refer to Item 3.

(g) NOTICES OF MOTION (Item 10)

(i) Residential Care Facilities (RCF) Complaint Liaison (Added Item 10.1)

(Clark/Jackson)
That the Rules of Order be waived to allow for the introduction of a motion respecting Residential Care Facilities (RCF) Complaint Liaison.

Result: Motion CARRIED by a 2/3's vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
YES - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

For further disposition of this matter, refer to Item 9.

(ii) Birch Avenue Greenspace (Added Item 10.2)

(Nann/Jackson)
That the Rules of Order be waived to allow for the introduction of a motion respecting Birch Avenue Greenspace.

Result: Motion CARRIED by a 2/3's vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
YES - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

For further disposition of this matter, refer to Item 10.

(h) GENERAL INFORMATION/OTHER BUSINESS (Item 13)

(i) Amendments to the Outstanding Business List (Item 13.1)

(Merulla/Clark)
That the following amendment to the Emergency and Community Services Outstanding Business List, be approved:

(a) Items Requiring a New Due Date

(i) Poverty Reduction Investment Plan
Item on OBL: 17-B
Current Due Date: June 2020
Proposed New Due Date: September 10, 2020

(ii) Hamilton Youth Engagement Collaboration
Item on OBL: 17-C
Current Due Date: March 26, 2020
Proposed New Due Date: July 9, 2020

(iii) Home for Good
Item on OBL: 17D
Current Due Date: January 16, 2020
Proposed New Due Date: July 9, 2020

(iv) All Seasons Soccer Facility
Item on OBL: 19-B
Current Due Date: January 16, 2020
Proposed New Due Date: October 8, 2020

(v) Expanding Housing and Support Services for Women
Item on OBL: 19-C
Current Due Date: February 6, 2020
Proposed New Due Date: December 10, 2020

(vi) Curling Facilities
Item on OBL: 19-F
Current Due Date: January 16, 2020
Proposed New Due Date: December 10, 2020

(vii) Ministry's continued support for critical housing investments and leveraging federal funding under the National Housing Strategy through new provincial investments and outlining the City's funding for housing and homelessness programs as confirmed through the 2019 Ontario Budget
Item on OBL: 19-H
Current Due Date: January 16, 2020
Proposed New Due Date: December 10, 2020

(viii) Correspondence from Janice Lewis, Board President, Native Women’s Centre, respecting Mountainview Emergency Shelter Operations
Item on OBL: 20-A
Current Due Date: N/A
Proposed New Due Date: July 9, 2020

(b) Items to be Referred

(i) Consumption and Treatment Services and Wesley Day Centre
Item on OBL: 19-K
To be referred to the Board of Health
Rationale: Consumption and Treatment Services falls under Board of Health

(c) Items to be Removed

(i) Opportunities and Flexibility of Existing Housing Programs
Item on OBL: 18-B
Addressed as Item 10.6 at the General Issues Committee, March 20, 2020

(ii) Hamilton Housing Benefits
Item on OBL: 19-A
Addressed as Item 10.6 at the General Issues Committee, March 20, 2020

(iii) Community Hub Proposal/Multi-Sport Indoor Facility Development
Item on OBL: 19-D
Addressed as Item 8.4 on today's agenda

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
YES - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

(i) ADJOURNMENT (Item 13)

(Merulla/Nann)
That there being no further business, the Emergency and Community Services Committee be adjourned at 11:17 a.m.

Result: Motion CARRIED by a vote of 5 to 0, as follows:

YES - Ward 3 Councillor Nrinder Nann
YES - Ward 6 Councillor Tom Jackson
YES - Chair – Ward 7 Councillor Esther Pauls
YES - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 14 Councillor Terry Whitehead
YES - Ward 9 Councillor Brad Clark

Respectfully submitted,

Councillor E. Pauls
Chair, Emergency and Community Services Committee

Tamara Bates
Legislative Coordinator
Office of the City Clerk

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Ministry of Health Consultation Meetings (HSC20014) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Michael Sanderson (905) 546-2424 Ext. 7741
SUBMITTED BY: **SIGNATURE:**	Michael Sanderson Chief, Hamilton Paramedic Service Healthy and Safe Communities Department

COUNCIL DIRECTION

Not applicable

INFORMATION

In November 2019 the Ministry of Health (MOH) announced a series of consultation meetings based on the discussion paper “Emergency Health Services Modernization” (attached as Appendix “A” to Report HSC20014). These meetings were scheduled to occur across the Province, co-chaired by the Advisor on Public Health and Emergency Health Services Consultations (Advisor) and the Associate Deputy Minister (ADM).

The Ontario Association of Paramedic Chiefs (OAPC) engaged the land ambulance leadership group and representatives of the Association of Municipalities of Ontario (AMO) to develop a consolidated position. Several in person and virtual planning meetings were held to create a consensus position. This was followed by a consultation meeting with the Advisor and ADM in Toronto on February 6. Following this consultation meeting a written submission, the “OAPC EHS Modernization Submission” was provided by the OAPC to the MOH (attached as Appendix “B” to Report HSC20014).

A local consultation session was also held in Hamilton by the Advisor and ADM on March 3. The morning session dealt with modernization of Public Health, followed by a lunchtime session with elected officials and senior municipal officials, and then followed by an afternoon session specific to EHS modernization. In addition to a verbal presentation a written submission was provided to the panel on behalf of Hamilton Paramedic Service (attached as Appendix "C" to Report HSC20014). A summary of the submission, and the verbal presentation, is provided below:

1. The foundational principles of seamless, accessible, integrated, accountable, and responsive ambulance service delivery should continue to guide the direction of ambulance system development.

2. Three outstanding consensus recommendations from the Land Ambulance Transition Taskforce (LATT) should be resolved in the modernization process. These include:

    a. Establishment of an operational dispute resolution mechanism;

    b. Establishment of a College of Paramedics; and,

    c. Dispatch reform.

3. Recommendations provided are summarized as follows:

    a. Operational responsibility for land ambulance dispatch should be transitioned to the Land Ambulance Service Provider and core dispatch funding should remain a Ministry responsibility;

    b. Accreditation should be pursued as a replacement for the existing Ambulance Service Review (ASR) process;

    c. Delays in transfer of care on arrival at hospital continue to create systemic pressures as paramedics perform hospital hallway medicine. Cost of this hallway staffing should be reimbursed by the Ministry to the ambulance service provider, removing the additional cost burden from the municipal tax base;

    d. Inter-facility transfers should be the subject of a fully integrated Provincial working group.
        i. Terms of reference from successful implementation in another provincial jurisdiction is provided.
        ii. All inter-facility transfers should be coordinated through the respective

CACC and the process of booking and scheduling should be automated.

iii. Legislation should be considered to provide for the capacity to contract out delivery of low acuity non-urgent patient transfers to an appropriately qualified patient transfer service; and,

iv. The Ministry should fully fund the cost of all inter-facility patient transfer service.

a. Community Paramedic programs should continue to be developed to match specific community needs. These programs should be integrated fully with the respective Ontario Health Teams and funded through the respective Ontario Health regional delivery program.

b. Ministry funding of land ambulance delivery should continue at a minimum level of 50% of the respective council approved operational budget inclusive of municipal overhead costs. The current one-year lag in funding should be eliminated through implementation of one-time funding processes.

c. A College of Paramedicine should be established under the Regulated Health Care Practitioners Act. The scope of paramedic practice, and the performance of delegated medical acts should be revised to reflect a Certification – Registration – Authorization paradigm. Base hospital funding should be redistributed to the respective land ambulance service providers who would then be required to establish appropriate medical oversight for both delegation and quality review.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC20014:	Ministry of Health Emergency Health Services Modernization discussion paper
Appendix “B” to Report HSC20014:	OAPC EHS Modernization Submission
Appendix “C” to Report HSC20014:	Modernization Submission Hamilton Paramedic Service

Ministry of Health

Discussion Paper:

Emergency Health Services Modernization

November 2019

Ontario

Purpose

As the Ministry of Health works with our system partners to end hallway health care, it will be important to involve the organizations that deliver pre-hospital care in meeting that goal. Ontarians require timely access to Emergency Health Services in a system where these services are effective and integrated.

Whether it is a patient waiting on a stretcher to be triaged in the emergency department, a senior waiting for transport to an MRI or an accident victim needing lifesaving emergency services by land or air ambulance, high functioning emergency health services in our communities are vital.

This paper is intended to guide ongoing discussions with our municipal and service partners to develop solutions for well-established issues in both the dispatch and delivery of emergency health services, while at the same time sparking innovative ideas to build an emergency health system for a modern health care system.

In our conversations and upcoming in-person consultations, we are seeking advice and input on how we can improve emergency health services for our communities.

We look forward to hearing from you.

Context

The Ontario government is transforming the whole health care system to improve patient experience and strengthen local services. This means a connected health care system through the establishment of Ontario Health Teams, and a new model to integrate care and funding that will connect health care providers and services focused on patients and families in the community. These changes will strengthen local services, making it easier for patients to navigate the system and transition among providers. Changes will also include the integration of multiple provincial agencies into a single agency – Ontario Health – to provide a central point of accountability and oversight in the health care system.

It is key to the success of the broader health system that emergency health services be strengthened, better coordinated and modernized to respond to the changing needs of Ontario's communities. That is why we are also proceeding with new models of care for

select 911 medical emergency patients, to expand treatment and transport options on scene and ensure Ontarians are receiving the care they need, when and where they need it.

Emergency Health Services in Ontario

Emergency Health Services (EHS) provide life-saving front-line services for Ontarians and support access to, and transportation of, patients within the health care system.

Each year, approximately 1.5 million 911 calls come to our ambulance dispatch centres, and land ambulances are dispatched to respond to both 911 and other calls for service. Over 8,800 paramedics and 1,100 ambulance communications officers work to provide front-line life-saving care to Ontarians. 50 municipal ambulance services, six First Nations ambulance services, 22 ambulance communications centres and Ornge air ambulance deliver these services to Ontarians across the province.

The *Ambulance Act* and its regulations and standards provide the framework for the operation and delivery of pre-hospital care in Ontario, including the certification of ambulance service operators (land and air) and regulation of paramedics. Regional base hospitals provide clinical oversight of the system, ensuring patient safety and service quality.

The Ministry of Health, along with municipal partners, provides funding for land ambulance services through a 50/50 cost sharing arrangement, while the ministry provides 100 per cent of funding for specific emergency health services such as ambulance communications centres, certified First Nations paramedic services and air ambulance services.

The Canadian Triage and Acuity Scale is used to prioritize the urgency of an emergency department patient's required care. In 2018, there were approximately 1.2 million patients transported by land ambulances in Ontario. Of those patients treated and transported by paramedics, approximately one per cent needed resuscitation, 23 per cent needed emergent care, 52 per cent needed urgent care, 12 per cent needed less-urgent care, and three per cent needed non-urgent care. Nine per cent of patients were medically-stable patient transfers.

Key Challenges

The EHS system went through a significant transformation in the late 1990s when municipal land ambulance services were transferred to municipalities. Since that time, additional changes have been made to improve services, and legislative amendments in 2017 provided some needed updates to the *Ambulance Act*. However, some key challenges remain. The Auditor General, the Dispatch Working Group, the Association of Municipalities of Ontario and the Ontario Association of Paramedic Chiefs, among others, have identified challenges that affect delivery of critical EHS services, including:

- Outdated dispatch technologies;
- Lengthy ambulance offload times and delays in transporting medically-stable patients;
- Lack of coordination among EHS system partners;
- Need for innovative models that improve care; and
- Health equity, or access to services across regions and communities.

Outdated Dispatch Technologies

Reports from the Auditor General (2013), the Provincial-Municipal Land Ambulance Dispatch Working Group (2014) and other stakeholders have called for upgrades to the province's Ambulance Communications Centre technologies to support improved responses, resource allocations and patient outcomes. Improvements to dispatch technologies will help ensure the right patients enter the hospital system at the right time.

Ensuring that ambulance services deliver only those who require hospital care to emergency departments is essential to addressing hallway health care.

Questions for Discussion

- Beyond the foundational technologies currently in implementation – Computer-Aided Dispatch, medical triage system, updated phone systems, updated radio network and equipment, and real-time data exchange – are there other technologies or technological

approaches that can help to improve responses to 911 calls and increase the efficient use of resources in the EHS system?
- How can communication between dispatch centres, land ambulance services, and air ambulance be improved?
- Are there local examples of good information sharing between paramedic services, hospitals and/or other health services?

Lengthy Ambulance Offload Times and Delays in Transporting Medically-Stable Patients

When paramedics must wait to transfer patients in emergency departments to the care of the hospital, it contributes to hallway health care. Paramedics and their ambulances waiting to offload patients are then not available to the community for emergency calls, nor are they able to move medically stable patients who need timely access to care, such as dialysis and medical imaging.

Questions for Discussion

- What partnerships or arrangements can improve ambulance offload times?
- What other interventions would be helpful to address ambulance availability?
- How can we best ensure that medically stable patients receive appropriate transportation to get the diagnostics and treatments they need?
- How do we respond to the transport of medically stable patients in a way that is appropriate to local circumstances (e.g., less availability of stretcher transportation services)?
- Should there be changes to oversight for private stretcher transport systems to ensure safety for medically-stable patients?

Lack of Coordination among EHS System Partners

Emergency health services are intended as a quick response to stabilize patients and safely transport them to hospital or help them safely access primary care at great distances. However, jurisdictional issues and communications between and among ambulance communications centres, land ambulance service operations and air ambulance can create challenges to getting appropriate services to patients. This also extends to connections between EHS and other parts of the health care system.

Questions for Discussion

- How can land ambulance and air ambulance systems be better coordinated to address transportation of medically-stable patients, especially in the North?
- How might municipal land ambulance services address "cross-border calls" to ensure that the closest ambulance is sent to provide care of patients?
- How can relationships be improved between dispatch centres and paramedic services?
- How can interactions between EHS and the rest of the health care system be improved (e.g., with primary care, home care, hospitals, etc.)?

Need for Innovations that Improve Care

Innovation at local levels can often be replicated to other regions and care situations. EHS is both a health and social service and can benefit from community integration and alignment. As part of this consultation, we are actively seeking where communities and regions have had success in delivering health related services or found ways to reduce barriers to care.

Questions for Discussion

- What evaluated, innovative models of care can be spread or scaled to other areas, as appropriate?
- Are there new or different approaches to delivery that could be considered as part of a modern EHS system?

- As new models of care for selected 911 patients are piloted, how can we adapt these models to elsewhere in the province, and how can we encourage uptake? What needs to be standardized versus locally-designed?
- How can community paramedicine fill gaps in health care services for Ontarians, and how should this be implemented, scaled, or spread across the province?

Health Equity: Access to Services Across Regions and Communities

The Indigenous population in Ontario is composed of First Nations, Métis and Inuit peoples who may live on and off reserve, in urban, rural and remote areas, each with their own histories, languages, cultures, organizational approaches and jurisdictional realities. All six First Nations paramedic services in Ontario are funded 100 per cent by the ministry. Services provided by municipal land ambulance services to First Nations are also funded at 100 per cent.

Health care access for remote and northern Indigenous communities is an ongoing issue and concern. In the north, land access issues create pressures on both land and air ambulance services where they are primary responders to communities that are difficult to reach by road.

There are new and innovative pilot programs in a number of remote communities that have shown initial promise in lowering call volumes and emergency hospital transport. However, there are ongoing concerns for regions where emergency health services are affected by jurisdictional issues, restrictions and lack of infrastructure.

Changes made to modernizing these services must reflect the needs of Indigenous communities and build partnerships in a meaningful and respectful way.

Under the French Language Services Act (FLSA), services provided in French-designated areas are subject to requirements for the provision of services and communications in French. Services delivered by the ministry, its agencies, or by a 'third-party' on behalf of the government have obligations under the FLSA. In the EHS sector, ambulance communications centres (both those delivered directly and those through transfer payment)

must adhere to these requirements, as well as air ambulance services delivered by Ornge. The FLSA does not address municipally-delivered services.

Questions for Discussion

- What initiatives could improve delivery of emergency health services to Indigenous communities?
- How can EHS services be more sensistive to the unique needs of Indigenous people, including providing culturally safe care?
- How can EHS support First Nations in creating better services for pre-clinic services in far northern communities?
- What improvements to EHS can be made for rural areas?
- Are there opportunities for partnerships to align and improve health and social services in rural and northern areas?
- Are there opportunities to address social determinants of health and health disparities in rural, remote and Northern regions to reduce the need for EHS transport of patients out of these regions?
- What improvements could be made to the provision of services in French to Francophone communities?

Your Feedback

With the release of this paper we are beginning a consultation process to discuss modernizing emergency health services. We hope to receive your input on the questions in this paper. Feedback can be submitted by completing our survey by March 31, 2020.

We will also be conducting in-person consultation sessions where we look forward to continuing the conversation about how we build a modern emergency health service system.

ONTARIO ASSOCIATION
OF PARAMEDIC CHIEFS

EHS MODERNIZATION:
Submission by the Ontario Association of Paramedic Chiefs

March 20, 2020

ONTARIO'S PARAMEDIC SERVICES

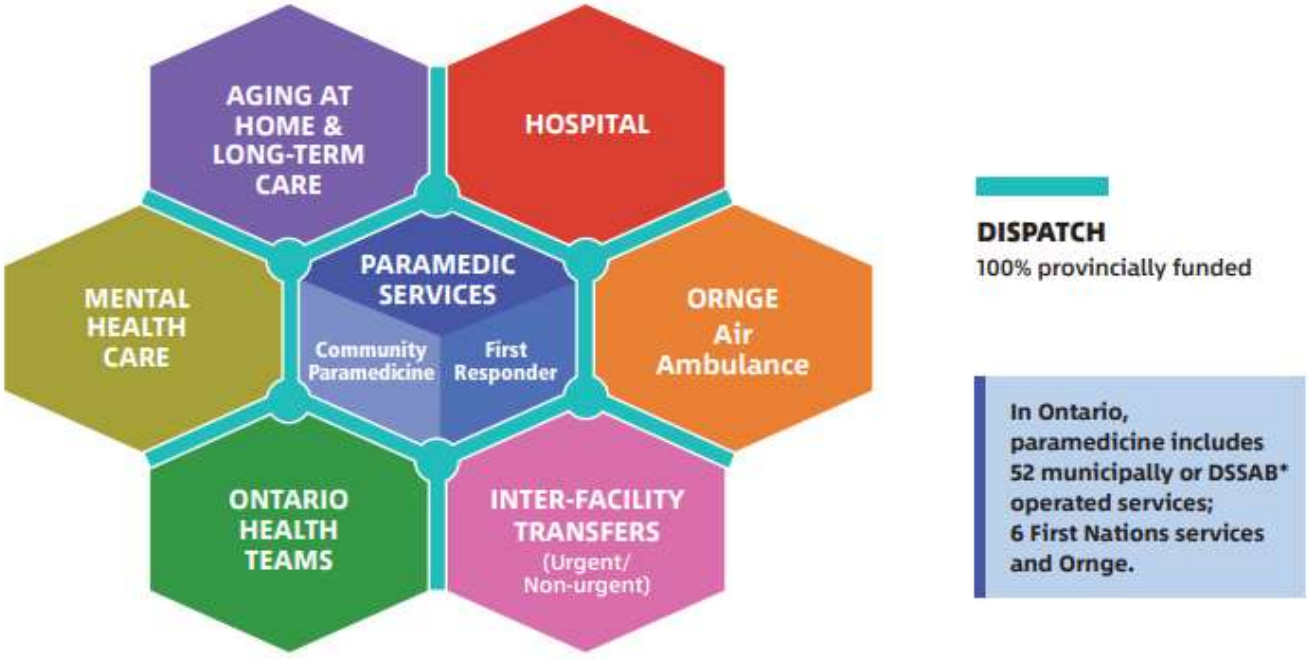
At the centre of health care, public health, public safety and aging.

Introduction

The Ontario Association of Paramedic Chiefs is the voice of paramedic leadership in Ontario. Our members include chiefs from all 52 upper tier or single city municipalities or District Social Services Administration Board (DSSAB) operated services, the six First Nations services and Ornge. We also oversee the work of 8,800 primary, advanced and critical care paramedics.

Ours is a critical voice in the province's efforts to modernize Emergency Health Services, end hallway health care, and transform the healthcare system. We use evidence and best practices to guide our decisions on a daily basis. As such, the Ministry can be confident the recommendations that follow are based on research and successes found in Ontario, Canada and internationally.

Paramedicine is health care, and paramedics are like no other health professional. Paramedics are healthcare professionals. We have a broad scope of skills to deliver quality care at the scene through to the transfer of care. We are on the front lines with patients during their most vulnerable moments. Our services sit at the centre of health care, public health, public safety and aging.



Paramedics are doing our part
It is important to recognize that since 2000, when paramedic services were downloaded, municipalities and District Social Services Administration Boards (DSSABs) have invested significantly to build high performing paramedic services. Each service ensures residents have access to high quality and timely paramedic services that meet local needs.

These investments have been borne by municipal taxpayers. They include, but are not limited to, the following:

- construction of stations and other facilities and associated annual operating costs
- increased staffing
- initiatives to reduce response times and offload delay
- enhancing clinical skills of primary care paramedics and advanced care paramedics to expand their scope of practice in order to improve patient outcomes in the field
- investing in information technology projects, such as automated vehicle locating, on-board network connected computers, electronic patient care reports, scheduling software, inventory software, automated dispensing systems for medical equipment, supplies and medication, and credential management software.
- providing education to upgrade primary care paramedics to advanced care paramedics
- rolling out public access defibrillation and cardiopulmonary resuscitation (CPR) and other public education programs.
- creating and implementing specialized tactical paramedic, marine paramedic and bike paramedic teams
- Community Paramedic programs to support vulnerable residents, including community referrals by EMS, CP@Clinic, CP@home, remote patient monitoring and the provision of influenza vaccines to high risk populations
- clinical research trials
- participation in numerous local community partnerships, most recently the formation of Ontario Health Teams

These efforts and commitments are working. We are making progress. All modernization efforts need to build on these successes and continue the positive movement forward.

Paramedic services have access to a rich system of medical evidence.
Our services are proud to lead and participate in pre-hospital and emergency healthcare-specific research. In the recent past, paramedic services have been a key stakeholder or conducted studies that have resulted in many efficiencies or improvements to patient care. Some highlights include:

- improved resuscitation outcomes
- validation of medications and new clinical guidelines for trauma and cardiac arrest through the Resuscitation Outcomes Consortium and the Canadian Resuscitation Outcomes Consortium
- provincial bypass protocols for STEMI, Stroke and Trauma patients

Bringing paramedic services into the circle of care, expands the data being used to make informed decisions and is another step forward in improving processes and leading to better patient outcomes.

Modernization means legislative and regulatory changes.
It is important to recognize that modernization will require legislative and regulatory changes. Current legislation is outdated and, is, in fact a barrier to needed change. They keep paramedics separate from the rest of the healthcare system and prevent province-wide systems of efficiency. They do not put patients at the centre of health care.

For example, the current response time performance plan requirements contained in legislation focus on response, not patient outcomes. They aren't working and should be removed or modernized.

Changes are needed not only to the *Ambulance Act* and Reg. 257 but other pieces of legislation with accountabilities related to paramedicine, such as revisions to the *Personal Health Information Protection Act.*

As modernization efforts are rolled out, the OAPC calls on the province to take strong leadership in creating new legislation that breaks down silos, improves data sharing, opens the door to accreditation and allows alternate destinations to ensure patients can access the high quality of care they need and expect at each step in their journey. Many of these changes the OAPC has been advocating to previous governments for nearly two decades. We are hopeful, through this review and consultation, this government will take action. This is the time.

The changing landscape
As the Ministry considers its modernization efforts, it must remember that paramedics face greater challenges in the field than ever before. New legislation, protocols and systems need to be nimble and take into account that the landscape has shifted and will continue to shift in the delivery of emergency healthcare. These changes include:

- increased call volumes
- growing mental health needs
- the opioid crisis
- an aging population
- increased traffic congestion
- infrastructure intensification and growth: taller buildings
- direct impacts of emerging infectious diseases on paramedic services

Putting patients first

All of us, paramedic services and the province, want the same thing: coordinated and connected care that puts patients first.

Paramedic services across Ontario have been doing our part. We look forward to continuing to partner and work with the provincial government to see this vision achieved.

Overarching Principles

This submission is organized around key themes identified in the province's EHS Modernization Discussion Paper as well as by Ontario's paramedic chiefs. Recommendations are guided by six key, overarching principles.

- We all serve one patient through one healthcare system. Modernization should make paramedic services an efficient and proactive part of the healthcare system. We can help achieve Ontario's vision for coordinated and connected care.
- Paramedic services are at the centre of health care, public health, and public safety. As both first responders and an integral part of provincial health care, paramedic services must remain municipally or DSSAB operated with appropriate provincial funding that reflects patient needs and respects municipal taxpayers.
- Today, paramedics offer seamless, highly skilled care across Ontario. Modernization should keep what is working well and fix what needs fixing by looking to best practices and proven solutions. There is no need to reinvent the wheel.
- Municipal paramedic services are innovative and have created strong local partnerships. These need to be recognized and protected because they are working well.
- Municipal governments, DSSABs and paramedic leadership are committed to running efficient services and will continue to look for ways to work collaboratively with other services and the province to reduce costs where possible.
- Paramedics have the skills, mobile outreach within the community and a breadth of medical evidence to support health care. Modernization can leverage this unique position to reduce hallway medicine and achieve broader goals, like offsetting the high costs of hospital use.

Improving Dispatch

Modernization starts with a reformed dispatch system. Better systems will reduce hallway medicine and improve patient care by putting the right resources in the right place, at the right time considering local needs.

Improving dispatch is the number one priority. Central Ambulance Communications Centres (CACC) need to be nimble and evolve into a system navigator to ensure that patients get the right care for their needs. Given the municipal and DSSAB role in paramedic services, the province needs to view municipalities and DSSABs as equal partners for dispatch to be effective and to use resources efficiently.

The inability to retain consistent, reliable staffing is a significant concern in CACCs. The province needs to address high attrition rates that are currently being tolerated, but are unacceptable. By working w with municipalities and DSSABs solutions can be found, which may include looking at options to change governance structures locally if appropriate.

Improving dispatch will be achieved in four ways: expediting technology improvements, supporting real-time data sharing, establishing stronger quality assurance and accountability structures, and increasing staffing.

The goals of a modernized dispatch need to be:

- Accessible to cutting edge and connected technology
- A realigned system that acts as a "navigator" for patient's accessing Ontario's health care system
- Resourced through proven technology to reduce in call processing and overall incident response times
- Enhancement to the roles of communications personnel
- Developed through integrated continuous quality improvement mechanisms
- Accountable

Technology

- Implement robust call triaging software that will allow the centre to act as a "System Navigator" ensuring that callers needs are properly assessed, triaged and supported with the appropriate resource.
- Implement predictive analytics and decision support software that better supports staff and enhances system performance, leading to improved efficiency, effectiveness, better use of resources and ensures that the overall system operates as efficiently as possible.
- Expand software to include functionality that alerts paramedics within the first few seconds of a call entering the communication centre, like that used in Niagara Region.
    - Note: The current provincial system mandates a two-minute response time to notify paramedics. Often that standard is closer to three to four minutes. Early alerts/notifications to paramedics would save valuable time, increase performance, and reduce the reliance on manual processes in the communications centre.

- Ensure that in-vehicle computers directly link to the Communication Centre and can receive real time information, mapping and updates. This would also cut down on work load of ambulance communication officers and save radio "air time".
- Deploy bio-surveillance software within the Communications Centre that could detect in real time:
    - Opioid events and clusters
    - Public Health Outbreaks (Influenza/COVID-19/food borne illness)
    - Local events – violent crime clusters, major events
    - Other trackable events
- Implement software that links paramedic services, dispatch and hospitals to a centralized information sharing system to better align all key stakeholders and emergency service partners in real time. A common technology platform would ensure interoperability and provide for better data sharing and improved reporting.
- The province must stay current with the advances in dispatch technology. The Ministry cannot afford to resist change nor allow bureaucratic barriers to slow progress. This information could be linked in real time to the Provincial Emergency Operations Centre, local Public Health Units, Hospitals, other agencies as designated. This would provide the Province with much need live intelligence reporting to deal with many emerging and ongoing issues.
- Fast track technology improvements as a critical investment in improved care and the better use of resources.
- Proven technology to support improved decision-making is readily available and in place in Toronto and Niagara.

Real-time data sharing

- Ensure full paramedic access to a single electronic patient record that is shared across the healthcare sector, so all health professionals work seamlessly towards the continuity of care for patients, while still protecting privacy. This concept of “one patient, one chart” would help ensure the province’s goal of coordinated and connected care.
- Improve the triage system not only with the rollout of MPDS, but also by including a clinician in the dispatch centre. This will reduce risk for patients and paramedics, and use resources more wisely. It would also provide more consistency province-wide in how calls are triaged.
- Dispatch needs to be a system navigator for patients. These improvements will help get us there.

Quality Assurance and Accountability

- Rigorous dispatch quality assurance programs should be in place to measure performance. This greater oversight of dispatch is needed to ensure patient need is more consistently aligned with the response.
- Implement stringent lines of accountability and a reporting framework so municipalities are better engaged and consulted on the governance of Land Ambulance Dispatch Centres that control their day-to-day operations.
- The province should further examine and explore with municipalities and DSSABs whether system efficiencies can be achieved through better consolidation of dispatch centres with improved technologies.
- Explore the most practical governance model for delivery and oversight which could include direct municipal oversight, a municipal partnership model or a provincial model which ensures

local resources are in the right place at the right time responding to the needs of the community.

- Establish a Quality Model to improve communication and accountability between dispatch and operations.
- As the Medical Priority Dispatch System (MPDS) is being deployed, the province should pursue Accredited Center of Excellence status from the National/International Academies of Emergency Dispatch.
- An accreditation model for paramedic services, rather than direct provincial oversight and management, would ensure consistency and unbiased assessment against a set of standards, with regular renewals. The accreditation model is used extensively across the healthcare system in Ontario.
- As MPDS is rolled out, all aspects of the protocol must be deployed by the Ministry, including the MPDS inter-facility transfer protocol.
- Integrate operations with dispatch by including an operations commander at the centre. This will ensure resources are deployed in the most efficient manner. (Good models include Toronto Paramedic Services and the use of Road Sergeants by Ontario Provincial Police in Provincial Communications Centres.)
- Work with us to establish a standardized provincial platform for tiered response agreements and deployment plans. These will relieve pressures on Ambulance Communications Officers, increase efficiencies and improve accountability in dispatch. Standardized plans will reduce layers of bureaucracy by removing the need for multiple individual response plans at each centre. They will also better clarify the role of fire services.
- The dispatch system should use a common provincial infrastructure and be fully funded by the province.

Staffing

- More dispatch staff resources and frontline supervision on the dispatch floor are needed to meet the needs of the public and paramedic services.
- Identify the number of incoming calls a centre can expect to manage efficiently as a critical component to ensuring sufficient staffing levels.
- Supervision needs to be provided 24/7.
- Address the fundamental reasons for high attrition rates and inability to hire appropriate replacement staff in Ministry operated CACCs.

Dispatch model examples include Niagara Region (clinician model), Toronto (MPDS, decision support, call diversion), and Ottawa (dashboard interoperability).

Refer to Appendix 1: *Review of the Ontario Ambulance Communications Delivery Model*: Deloitte, June 2017

Reducing Offload Delays

Paramedic services are needed in the field, not sitting in a hospital. Hospital transfer of care times must be established and measured consistently across the province and hospitals held to account by providing financial incentives when issues are addressed or penalties imposed when not.

- Offload delays are a symptom of a broken system. Proper system navigation is a significant part of the cure. Developing alternatives that would see patients treated by paramedics at the scene and referred for community-based care or transferred to a more appropriate type of healthcare facility would reduce pressures on hospital emergency rooms.
- Financial incentives are an important part of the solution to help address offload delays. Working with paramedic services and hospitals, offload delay time standards should be established. Another solution could be through allocation of municipal capital funding to hospitals granted based on meeting specific performance criteria. These would motivate senior hospital leadership to work with us to improve processes. (York Region is an example)
- Address root causes of hospital capacity and flow to get paramedics back on the road to serve the community sooner. Part of this can include looking at more protocols to expand the decision-making abilities of paramedics to determine to which hospital to send patients. Other enhancements should be made to the Patient Priority System to increase efficiencies and properly address the needs of the patient.
- Dedicated Offload Nurses (DON) play a role in addressing offload delays and was introduced as a stop gap measure in 2007 so that other measures could be put into place. This did not come to fruition. The ability to keep pace with the increase in volume within the ER and from paramedic services has not kept up. Paramedic services are responsible to negotiate wages and conditions for transferring patients directly with the hospitals. Offload delay is a symptom of a broader healthcare issue and a temporary solution does not work. DON funding can be a partner to other strategies that need to be put into place and provided to all paramedic services.
- Set up a consistent reporting mechanism to measure offload delays to ensure consistent data and accuracy across the province. Offload delays must be addressed across the province, not site by site.
- There needs to be local flexibility in how alternative models of care are used, based on what services are available in the community and their capacity to accept patients.
- Look at other strategies to improve initial triage so more options are available and decisions can be made where to best place patients transported by paramedics (examples – move to waiting room, place in Gerry chair, etc.)

Refer to Appendix 2: British Columbia Emergency Health Services *Clinical Response Model* Fact Sheet, July 2018

Managing Interfacility Transfers

Interfacility transfers are a provincial healthcare responsibility and should be treated equitably across the province.

- Hospitals and other healthcare facilities need plans and resources in place to transfer non-urgent patients to other facilities. This is especially needed in remote and northern communities. Cost incentives and penalties would ensure that municipal property taxpayers aren't indirectly funding a provincial healthcare service through the use of ambulances for these services.
- Invest in dedicated Critical Care Land Resources to better support patient movement throughout Ontario's healthcare system. Investment in transport services needs to be considered to relieve the current pressures on ORNGE and municipal systems.
- All non-urgent transfers serviced by paramedic services must be funded 100% by the province.
- Following the Vancouver model, give the CACC responsibility for dispatching private stretcher transfer companies. This ensures the right resource gets assigned to meet the patient's needs and reduces pressure on paramedic services. These private services must also be regulated with provincial oversight, which includes standards that ensure quality patient care and reduce patient risk.
- Provide oversight to ensure that low-acuity patients are not "up coded" to ensure an interfacility transfer. Adopting MPDS Transfer algorithms would also ensure calls are appropriately prioritized in a manner consistent with how 911 calls are prioritized.
- In some cases, hospitals are also calling both private and land ambulance services at the same time for transfers. This duplication cannot be allowed. It puts a burden on the system and on taxpayers.
- As the province finds solutions to manage interfacility transfers, current paramedic resources cannot be negatively impacted.

Improving Coordination, Fostering Innovation and Efficiency

Put patients at the centre of solutions. Open the door to greater data sharing and expanded partnerships and service agreements, so all health professionals work seamlessly to direct patients to the care they need, relieving undue pressure on emergency departments.

New models of care, expanding scope of practice and using enhanced technology will fill gaps in the healthcare system.

Data sharing

- Remove barriers to ensure paramedics are in the circle of care and have full access to real-time data and personal health information that will improve response and patient care. This requires the province to formally provide clear statements and set clear expectations with all partners that data-sharing, including patient outcomes, is allowed and the protection of privacy is inherent and should not be a burden amongst the healthcare partners. It also requires upgraded technology across the system, and legislative/regulatory changes, such as to the Personal Health Information Protection Act (PHIPA). Paramedics must be deemed to be included in the "circle of care".
- Systems are needed to better coordinate information sharing between paramedics, emergency departments, Ontario Health Teams, Primary Care, and other partners, like CritiCall and Ornge.
- Access to patient outcome data would lead to increased understanding of paramedic response success, better decisions and improved processes and protocols. Again, this requires legislative/ regulatory changes to support access to the information.

Partnership and Integration with Ontario Health Teams

- Paramedics belong as part of Ontario Health Teams (OHT). They are uniquely positioned at the centre of health care and public health and safety. Current efforts to collaborate and be innovative can be leveraged to improve efficiency and address healthcare challenges.
- Through a written statement, the Ministry of Health should encourage Ontario Health Teams to engage paramedic services so they can explore opportunities to leverage paramedic clinical expertise as part of the local OHT service delivery mandates. (Note: Some services have already signed on to OHTs. This practice should be expanded to all.)
- Several healthcare providers are at the table to expand service partnerships to allow direct transfer of patients. Fast track these partnership agreements as a win to system modernization, efficiency and improved patient care, system navigation and outcomes.

Community Paramedicine

- Community Paramedicine keeps people out of hospitals and reduces hallway medicine. It allows people to be cared for in their homes and communities, where they should receive care.
- Community paramedicine should be expanded province wide, with flexibility at the local level. It should also be fully funded by the province and not cost-shared, as it is a healthcare service not an emergency response. A modest investment in community paramedics can mitigate growth in 911 calls, reduce readmissions and visits to hospitals, and support patients' navigation through the system.

- The province needs to support community paramedics to be better integrated into the healthcare system, such as working with primary care, Family Health Teams and Ontario Health Teams.
- Community paramedics can be used as mobile healthcare providers seeing patients through both scheduled and unscheduled visits, even supporting transportation when necessary.
- Using community paramedics to provide patient monitoring and assessment, as well as to help people navigate health care and social supports is a cost-efficient way to divert patients from acute care.
    - It can be particularly helpful for those who are frequent users of 911 ambulance services or with mental health issues.
    - It can support more people to live longer independently, reducing pressures in long-term care.
    - It can be used to transition patients requiring alternative levels of care within hospitals back into the community while awaiting a permanent LTC placement/bed. This could be used as an interim option for Ontario as it continues to deal with a shortage in LTC beds in Ontario.

Refer to Appendix 3: *Community Paramedicine,* OAPC

Innovation

- Innovation needs to promote patient dignity and respect, recognizing that an emergency response can at times exacerbate patient issues. Paramedics need more tools beyond hospital triage.
- Leverage evolving technology to improve care in innovative ways. Initiatives such as bringing OTN “virtual care” on scene or into long-term care homes would help deal with low-acuity issues like flu, back pain, gastrointestinal pain, onsite.
- The system should be nimble enough to allow for future innovation and technology when they become available, such as the use of drones and FaceTime to facilitate care and medical advice. This would also include new products or research initiatives.
- Allowing self-regulation for paramedics under the Regulated Health Professionals Act will effectively protect the public interest and break down silos between paramedics and other health professionals.
- Expand paramedic scope of practice by allowing medics to initiate referrals, perform live birth registrations and prescribe some medications as examples. This will further relieve pressure on acute care.
- Work with the Ministry of Labour to support mental health programs to care for those that care for others. Mental wellness is critical for all staff on the frontline of emergency health services, both the municipally employed paramedics and provincially employed dispatch staff. There is a collective responsibility to provide the supports, resources and benefits to maintain their mental health. Recognize that a larger than expected subset of the workforce is off due to post-traumatic stress disorder. This has an impact on the municipal tax base and on resource capacity.
- Support collaboration efforts to partner with universities and other partners to help research and address mental health issues in emergency responders across the board, including fire, police and paramedics.

Efficiency

- Support municipalities and DSSABs with resources and incentives to review internal processes and find efficiencies. Together we can reduce non-frontline costs and look for opportunities to increase collaboration amongst services where possible.
- Look at joint buying powers for paramedic ubiservices to find efficiencies.

Health Equity

All Ontarians deserve access to the health services they need no matter where they live. This can be achieved by involving key stakeholders in decision-making and increasing partnerships, collaboration and training. It can also be achieved by alternative funding models beyond the "50/50" cost share.

Cultural Diversity

Ontario is a multi-cultural province. All diverse communities must be recognized. Resources and training are needed to ensure the needs of all Ontarians are respectfully and effectively met, and cultural barriers are removed.

- Enhance language and cultural training for paramedics based on the communities they serve.
- Use technology to support multi-lingual needs in the field.
- Engage religious and cultural leaders in helping inform how to administer care that is respectful and effective.

First Nations

All First Nations should have equitable access to emergency health services.

Modernization of Emergency Health Services for First Nations communities starts with funding preventive programs that address social determinants of health and provide alternate transportation in the north to access health care. These are direct factors resulting in high First Nations ambulance call volumes in relation to population sizes.

- Provide First Nations services with reliable, timely, and stable funding from the province and multi-year capital plans to operate efficiently and effectively.
- Consult with First Nations to find solutions, such as through a joint task force.
- Engage with and learn from health agencies currently working with First Nations communities.
- Conduct more robust research with First Nations communities to increase data and inform evidence-based decisions that will drive solutions and funding models that better meet the healthcare needs of these communities.
    - Conduct a comprehensive healthcare needs assessment that includes Emergency Health Services, of all First Nations communities in Ontario to better understand gaps in accessing equitable healthcare. Based on findings Increase the number of first response teams where necessary, especially in the North.
    - Evaluate the current paramedic deployment and response rates into First Nations communities when compared to nonindigenous communities.
- Improve cultural understanding and sensitivity through training for paramedics and the engagement of a Community Indigenous Patient Navigator to bridge cultural differences between the healthcare system and First Nations communities.

- Explore developing First Nations paramedic services where there is no road access, only access through Ornge (James Bay vs. Northwest Ontario).
- Develop and appropriately fund primary care programs including, but not limited to, preventative CP programs.

Refer to Additional Documents section: *Truth and Reconciliation Commission of Canada: Calls to Action,* 2015

Francophone

Addressing francophone needs includes increased training and resources.

- Evaluate current resources to better understand language skills and capacity. Support French language learning for existing staff, especially in the French Designated Areas of Ontario, and in paramedic college programs.
- Support expanded francophone services in dispatch, using technology to ensure 24-hour access to meet language needs of francophone communities.

Rural/remote

Rural and remote communities face unique challenges. They do not have capacity to pay for the same level of service as urban areas. Therefore, preventive programs play a more substantive role. These communities also require additional and/or targeted resources.

- Retain the "50/50" cost share model as a minimum in all communities. However, alternative funding models, beyond the "50/50" cost-share must be considered for rural, remote, First Nations and northern communities. The current cost-share program is inadequate for these communities.
- When considering solutions to address healthcare needs in rural and remote communities, it is critical to reemphasize that the province needs to invest in community paramedicine. It is especially important to help fill gaps to improve patient care and outcomes where access to healthcare services is limited. Partnering with Ontario Health Teams would be especially helpful in ensuring community-based care.
- Invest in technology, faster internet access, and special equipment to access patients. This would reduce risk and improve both quality of care and efficiency, resulting in savings down the road.
- Pre-booked flights to transport multiple patients requiring regular treatment would improve access for northern communities and reduce costs.

College of Paramedics

Self-regulation through a Regulatory College facilitates modernization, which will result in improved patient care. It increases public trust, safety, transparency and accountability for paramedic services, as it does for all other healthcare professions.

- Ontario can learn from successful models within Canada, including Alberta, Saskatchewan, Manitoba, New Brunswick and Nova Scotia, as well as other jurisdictions abroad.

- A self-regulating college would put paramedics on par with other healthcare professionals.
- A college could direct needed and comprehensive paramedic service-related research to better inform evidence-based practice that drive improvements in patient outcomes and improve efficiencies.
- Patients across Ontario expect and deserve consistent service. A college would ensure consistent standards for skills and competencies, licensing and registration and conduct. It would ensure portability of credentials across Ontario.
- A college facilitates best practices, which improves patient care and outcomes, e.g. community paramedicine, family health teams, medics in dispatch, healthcare system navigators, and rural/remote specializations.
- A college lends a professional voice to inform policy, practice, and inter-professional practice.
- A college model would allow paramedics to oversee paramedics and increase individual accountability resulting in a higher standard of care. It would also reduce red tape and bureaucratic layers with the Ministry of Health and reduce pressure at base hospitals by replacing a layer of oversight from those physicians.
- A college could be phased in, starting with title protection, registration and conduct/competencies, while working toward full responsibilities over time.
- Development of a college would need to address questions around paramedic fees, labour union impacts and impact on local training budgets.

Refer to Appendices 4 to 6:

- OAPC *Paramedic Self-Regulation:* cover letter and submission to the HPRAC, July 2013
- Glen E Randall paper: *Understanding Professional Self-regulation*, November 2000

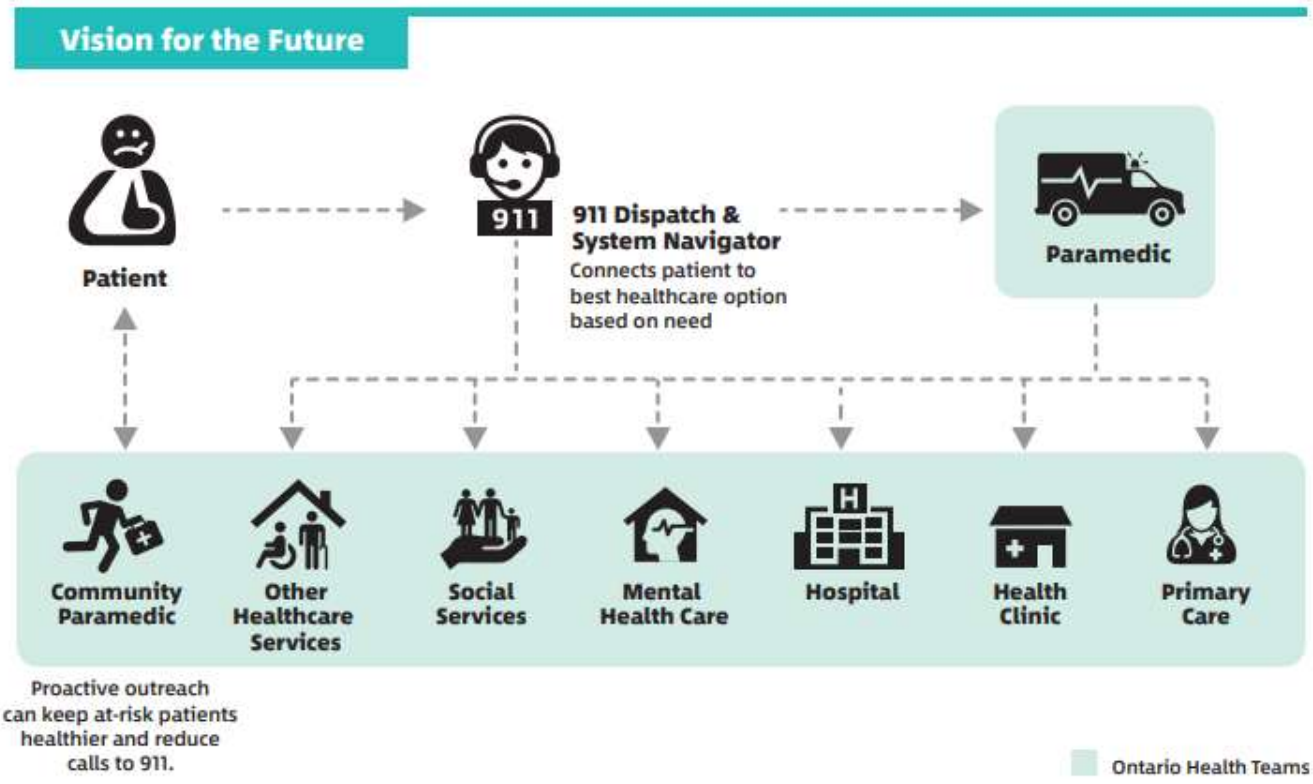
Final Thoughts: Redefining the Patient Journey

Emergency health services modernization should focus on the patient, their journey through the system and their outcome. Paramedicine is part of the care model. It is not a focus on patient transportation.

For many patients, 911 is their access to the healthcare system, and they use it when they are vulnerable and need care. They expect and deserve a system that works and is seamless.

Under the current system, all patients are taken to the hospital emergency department, resulting in backlogs and delays. Patients should be at the centre of solutions. Strengthening dispatch, offering alternative response models and improving coordination across healthcare will better meet patient needs and reduce pressure on the system.

Partnership and collaboration between paramedic services, health agencies and the Ministry of Health will be key. Neither partner can do this alone. Paramedic services need to be aligned as a partner in the health system.



Additional Resources

The recommendations provided in this submission build on previous work by the sector. The following links provide examples of this work and additional resources that may be useful to the consultation. Additional appendices follow, which include further relevant studies and documentation.

- **Recommendations from the Provincial Municipal Land Ambulance Dispatch Working Group**
  Submission to the Minister of Health and Long-Term Care, May 28, 2015

- **Greater Toronto Area Emergency Medical Services Ambulance Communications and Dispatches Services Review, Final Report and Recommendations for the Regional Municipalities of Peel, Durham, Halton, York and the County of Simcoe**
  Prepared by POMAX Public Safety, December 2009

- **Improving Access to Emergency Services: A System Commitment**
  The Report of the Hospital Emergency Department and Ambulance Effectiveness Working Group, Submitted to the Honourable George Smitherman, Minister of Health and Long-Term Care Summer 2005

- **Truth and Reconciliation Commission of Canada: Calls to Action:** specifically refer to pages 2-3 for sections related to health, 2015

Appendix 1
Review of the Ontario Ambulance Communications Delivery Model: Deloitte, June 2017

Appendix 2
Clinical Response Model Fact Sheet, British Columbia Emergency Health Services, July 2018

Appendix 3
Community Paramedicine: Ontario Association of Paramedic Chiefs, February 2020

Appendices 4 and 5
Paramedic Self-Regulation: Ontario Association of Paramedic Chiefs cover letter and submission to Health Professions Regulatory Advisory Council, July 2013

Appendix 6
Understanding Professional Self-regulation: Glen E. Randall BA, MA, MBA, PhD *candidate,* Founding Registrar of the College of Respiratory Therapists of Ontario (CRTO) 1993 - Nov 2000

Deloitte.

Review of the Ontario Ambulance Communications Delivery Model

June 2017

Table of Contents

Background and Context

The Vision for Change

Vision for Change: *Patients First*

The government is committed to providing Ontarians with the right care, at the right time, in the right place, that is fiscally responsible and sustainable

- ***Patients First: Action Plan for Health Care*** was released in 2015 and is focused on the ongoing commitment to put people and patients first by improving the healthcare experience
- The plan highlights four key objectives for the next phase of health care system transformation
    1. **Access:** Improve access - providing faster access to the right care
    2. **Connect:** Connect services – delivering better coordinated and integrated care in the community, closer to home
    3. **Inform:** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health
    4. **Protect:** Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come
- With the government's commitment to provide patients with the right care, at the right time, and in the right place, there is a growing need for Emergency Health Services to evolve and align with the strategic objectives of *Patients First*
- Emergency Health Services (EHS) is considered a key gateway to the broader health care system and system improvements are underway to align with *Patients First and* other health sector reforms including:
    - A multi-year transformation strategy
    - 2017-18 and 2018-19 planned technology system improvements, including: a new triage tool, upgraded CAD, bi-directional information sharing through central integrated platforms
- The transformation continues the progress towards improving the health system; it is acknowledged that EHS continues to make ongoing changes to operations, therefore findings and recommendations are based on a point in time.

Vision for Change: Enhancing Emergency Services in Ontario

In alignment with Patients First, Enhancing Emergency Services in Ontario (EESO) is a multi-year strategic reform of emergency health services

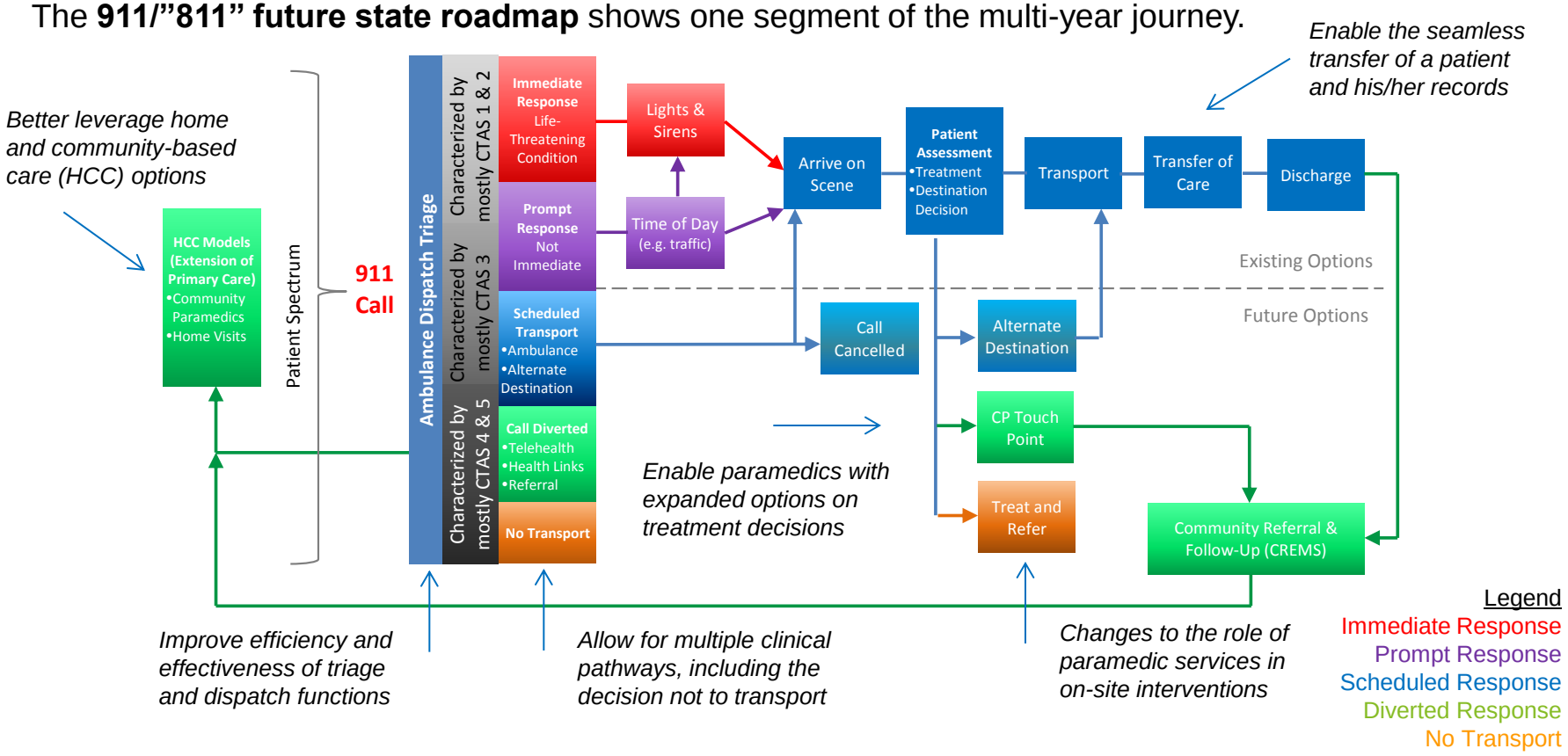
- **Enhancing Emergency Services in Ontario (EESO)** is a multi-year enterprise initiative that supports the strategic objectives of Patients First by proposing to *"improve and sustain quality co-ordinated care across the patient's journey, and implement more effective medical transportation and paramedic services with all health care delivery partners and providers in Ontario".*
- The EHS system in Ontario is intended to provide timely response of pre-hospital and inter-facility care to address the needs of the sickest patients in 400+ municipalities and First Nations communities with 24/7/365 availability.
- EHS partners play a key role in the seamless delivery of land and air ambulance services, and helping improve access to the health care system.
- With this in mind, EESO is coordinating the EHS system transformation with a broad cross-section of service delivery components:
  - EESO vision for change is built on four key pillars of work: change, integrate, build and oversee .

The "911/811" Future State Roadmap of Ambulance Response

The future vision of patient interactions with the EHS/911 system supports a broader range of clinical pathways based on patient needs

- In alignment with Patients First, the future roadmap for EHS will enable access to the right care at the right time and in the right place.

The **911/"811" future state roadmap** shows one segment of the multi-year journey.



Background and context

The Emergency Health Services Branch is committed to improving the patient's journey through the health care system

- "Central Ambulance Communications Centres (CACCs) are often the **initial access point to Ontario's emergency health services** system for many patients who are ill or are injured".*
  - Functions of EHSB include the establishment of province-wide standards, funding and inspection of dispatch services, as well as providing education and training for ambulance communications officers (ACOs).
- The **CACC communication model includes both receiving calls and dispatching the appropriate emergency medical response**
  - Ambulance call takers receive calls from citizens and health service providers, prioritize the urgency of need and provide pre-hospital instructions to the caller
  - Ambulance dispatchers deploy emergency vehicles nearest to the scene to provide pre-hospital care and facilitate transport to the closest, most appropriate health care facility
  - Ambulance Communications Officers (ACOs) coordinate with Ornge Communications Centre (OCC) air and critical care land ambulance transports, which are not accessible through 911
- In 2013 the Auditor General of Ontario made several recommendations regarding ambulance dispatch in Ontario.
- In 2014 the Ontario Association of Paramedic Chiefs approached the Ministry with a range of requests related to changes to the ambulance dispatch model. The Association of Municipalities of Ontario had also requested discussions related to improving ambulance dispatch.
  - In response to these requests, the Minister of Health and Long-Term Care announced that the Ministry would assess improvements to the ambulance dispatch system. The ministry has since began implementing system improvements with three main objectives:
    - Focus on consistency and standardization,
    - Operational improvements focused on efficiency and effectiveness, and
    - Improving quality coordinated care for patients.

*Source: Ministry of Health and Long-term Care website

Background and context

The Emergency Health Services Branch is committed to improving the patient's journey through the health care system

- The **provision of air ambulance and related services** in Ontario is currently through **Ornge, a not-for-profit charitable organization**
  - Ornge Communications Officers, with the assistance of on-call doctors, centrally coordinates patient transports via aircraft or critical care land ambulance throughout the province.
- In March 2012, the Auditor General of Ontario released a special report, which raised issues around inadequate oversight of Ontario's air ambulance and related services
  - The Ministry and Ornge have since made significant strides in moving forward to restore public confidence in Ontario's air ambulance service, including the appointment of a permanent President and CEO as well as a new volunteer Board of Directors
  - Additionally, the ministry amended its performance agreement with Ornge to improve transparency and accountability through an increased emphasis on performance standards for operational and financial costs, increased reporting and disclosure of information
  - In July 2012, the ministry established the Air Ambulance Program Oversight Branch (now Air Ambulance Oversight Unit, within EHSB) to provide dedicated oversight over Ornge and to manage all current and future initiatives relating to the delivery of air ambulance related services in Ontario, including ensuring that terms and conditions of the amended Performance Agreement are successfully implemented.
- In July 2015, amendments to the *Ambulance Act* came into effect, which provide the government with the authority to take a number of actions including the ability to:
  - Appoint special investigators or a supervisor when it is in the public interest to do so, similar to the Ontario public hospitals
  - Appoint members to Ornge's board of directors
  - Prescribe terms in the performance agreement between the government and Ornge by regulation;
  - Provide whistle-blowing protection for staff who disclose information to an inspector, special investigator, supervisor, or the ministry

Purpose and Approach

Purpose of the Provincial Assessment

The purpose of this evaluation was to develop a series of options for the optimal delivery model for land and air ambulance communications in Ontario, which:

- Support a robust and flexible organization and delivery structure
- Improve the patient's journey through the health care system
- Ensure a sustainable health care system province-wide

There is currently work underway to reform the emergency health system. The ministry recognized that there are **opportunities for further growth and enhancement of the current system** to better align with *Patients First* and the EESO Future State Roadmap, and key foundational work has begun including planning for the implementation of a new medical algorithm.

Vision for Transformation of Emergency Health Services

Patients First → **2017-18 Technology System Improvements & EESO Multi-year Transformation** → **911/811 Future State Roadmap of Ambulance Response**

The work undertaken to inform this report will be used to identify the next steps in the transformation of emergency health services in Ontario

Project Objectives and Scope

The project scope includes a variety of strategic and operational elements when considering the future needs of Ontarians

Specific objectives included:

- A review of current Emergency Medical Services (EMS) communication and dispatch models across the province;
- A jurisdictional scan evaluating various service delivery models and best practices for land and air ambulance systems outside of Ontario;
- Identification of opportunities to positively optimize resources and impact financial performance;
- Developing options for the optimal delivery model for land and air ambulance;
- Providing advice to the Director, EHSB, concerning the evolution of the organization including timelines, resource requirements, organization redesign and structure;
- Conducting an analysis of human resources (HR) data to determine the drivers for attrition and attendance issues within the land communications centres and field office support structure, and provide strategy/model options to effectively retain resources and enhance attendance

Project Approach and Activities Completed

A model framework guided the activities to shape the current state of ambulance communications and future state model options

Phase 1: Project Initiation and Current State

Key Activities:

ANALYSIS of CACC performance and HR data for land dispatch including dispatch times, call volumes, overtime, sick time and span of control

INTERVIEWS AND FOCUS GROUPS with key internal and external stakeholders

ONLINE SURVEY with ~550 respondents to understand current state and opportunities for future state

MODEL FRAMEWORK to guide categorization of insights from current state

Current State of Ambulance Communications

Phase 2: Identification of Priorities and Opportunities

Gap Analysis informed by:

EXAMINATION of practices across 6 jurisdictions in Canada, the USA, and the UK

CURRENT STATE AND LANDSCAPE of emergency communications in Ontario

Priorities and Opportunities for Future of Ambulance Communications

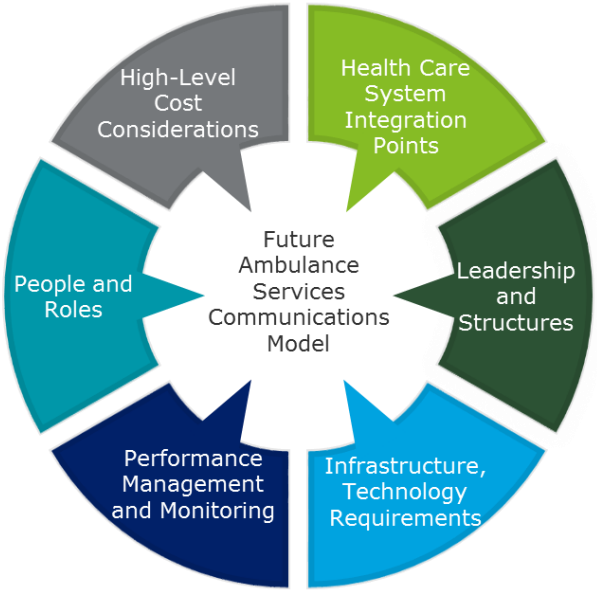
Phase 3: Development of Future State Model Options

GUIDING PRINCIPLES to drive development of model options

Model Framework and Guiding Principles for Decision Making

We have established a framework to inform future potential models and guiding principles that will inform decision making around the future state

Model Framework



Leading Practices

Key Priorities and Business Process Improvements

Guiding Principles

- Greater value for Ontario citizens
  - Improved service quality and outcomes
  - Cost efficiency
- Improved utilization of Paramedic Services resources
- Promotes standardization of processes/practices
- Evidence informed and based on leading practices
- Promotes greater system integration
- Enhances future transformation potential for pre / post call stages of the process
- Ease and timeliness of implementation

Key priorities are driven from the synthesis of insights captured through the framework, jurisdictional practices, and guiding principles, to support an integrated, sustainable health system

Current State

Description of Today's Model

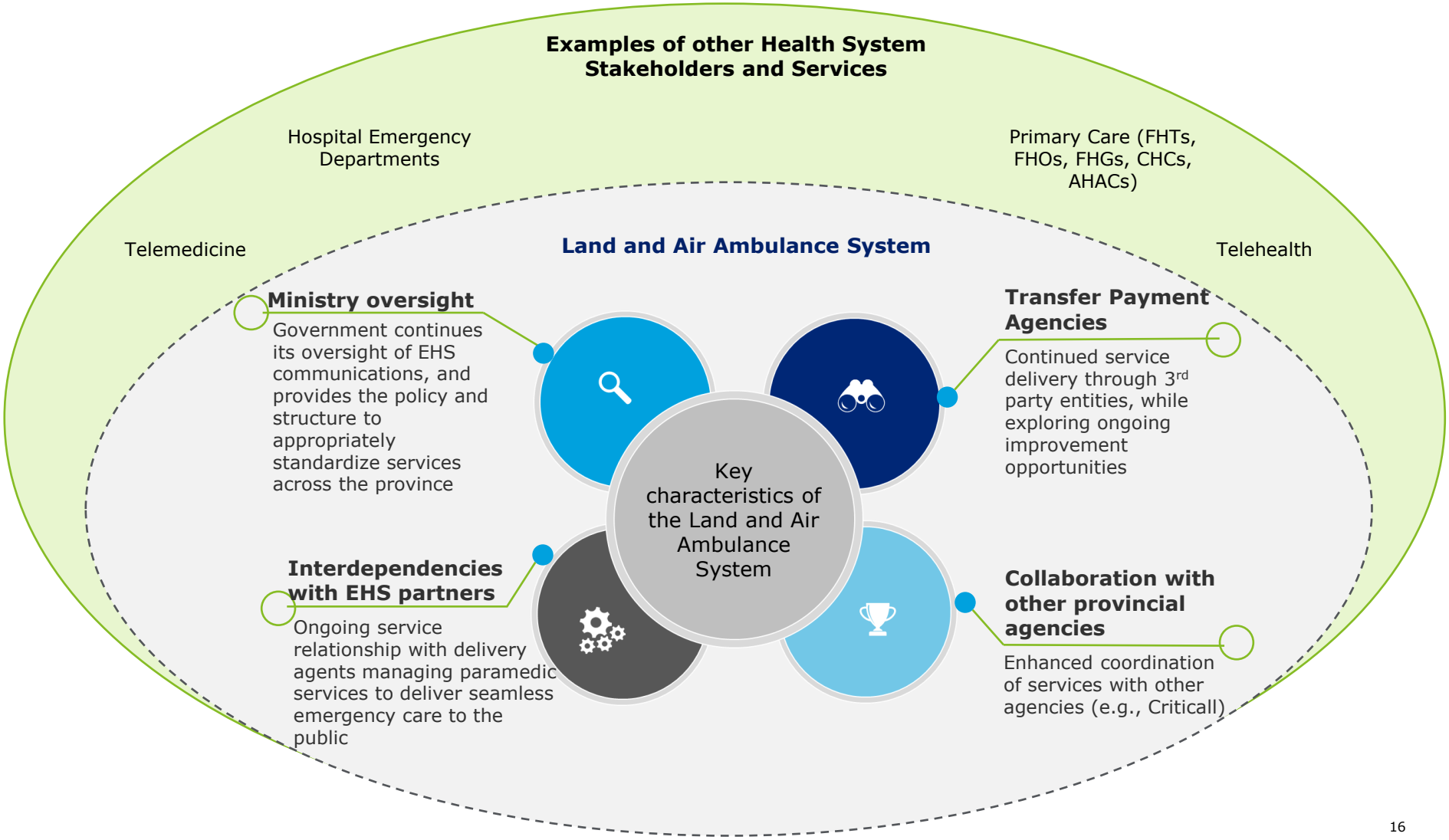
Current Model of Ambulance Communications in Ontario

Our understanding of the current model was informed through analysis of data, interviews with stakeholders, discussions with EHSB leadership and survey responses

Structure	• **22 Central Ambulance Communication Centres** (CACCs) in Ontario, operating in a hybrid model – 11 operated directly by the Ministry – 6 operated by Hospitals – 4 operated by Municipalities – 1 private • CACCs communicate with **56 Paramedic Services (PS)** providers across the province (50 Upper-tier Municipal services + 6 First Nations services) • Ornge Communications Centre - dispatches air ambulance and critical care land ambulance resources.
Funding	• The Ministry currently funds **100% of dispatch centre costs** • Funding for Municipal PS providers is split 50/50 between Ministry and Municipalities • First Nations Paramedic Services are 100% Ministry funded • Ministry funds 100% of air ambulance and critical care land ambulance services (Ornge is provider)
Technology/ Supportive Tools	• **Computer Aided Dispatch (CAD) technology is used at all CACCs and Ornge dispatch centre** to support call taking, triage and dispatch, however varying versions of this technology are in use across CACCs • While Medical Priority Dispatch System (MPDS) is used to triage patients at Niagara and Toronto CACCs and, all other CACCs currently use **Dispatch Priority Card Index (DPCI) II** to inform prioritization of patient needs. • Ornge's Flight Vector triages patients using a **5-point scale** for acuity

Landscape of Ambulance Communications in Ontario

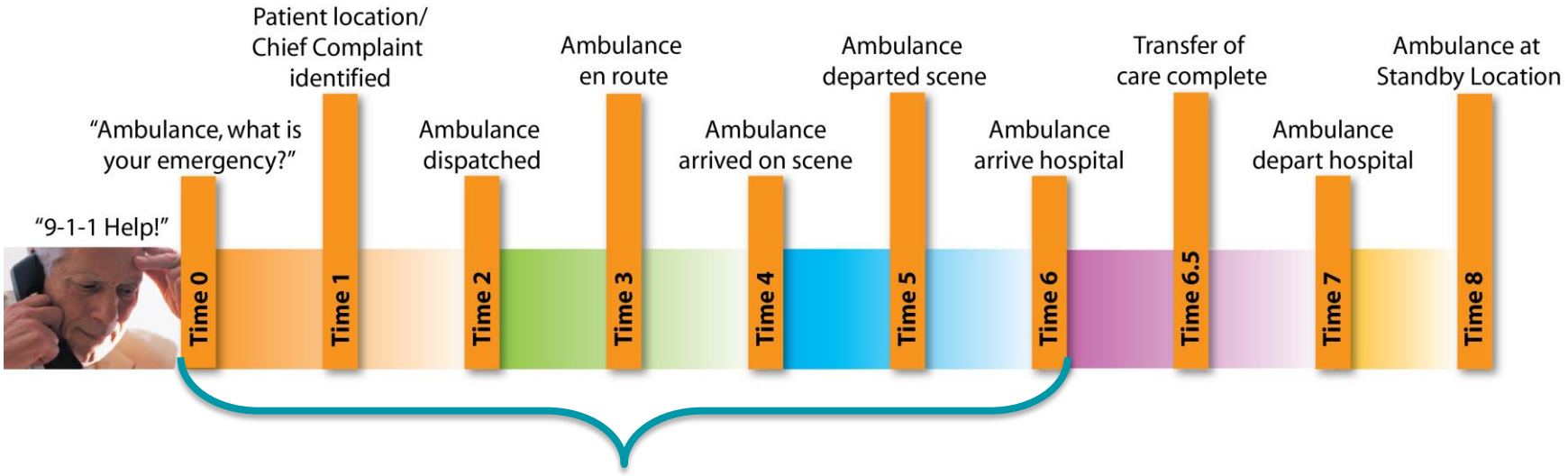
The current environment in which ambulance communications services exists includes direct partners, as well as elements of the broader health care system



Performance Indicators

Description of Land Ambulance Communication Services

Ambulance dispatch is a key part of the emergency response to a 9-1-1 call from the time a call is received by the communications centre, to the delivery of the patient at the appropriate health care facility



The Ambulance Communication Officer triages the call based on answers provided by caller to questions in the medical triage algorithm and remains in contact with the caller providing:

- Pre-arrival first aid and patient comfort instruction
- Reassessment of call priority, determining if further support (including air ambulance) is required
- Patient status updates to paramedics

Upon arrival of Paramedics on scene, the Ambulance Communication Officer may provide:

- Coordinated communication between paramedic and Regional Base Hospital if required
- Notifications to Emergency Department of incoming patient

Dispatch Performance Metrics – Land Ambulance

Dispatch performance is currently monitored through the response time standard data and posted publicly on the Ministry website

Time Intervals:

Time 0 – **Call Received:** time when the ambulance communications officer initially answers the telephone to commence call taking.

Time 2 – Crew Notified: time at which the ambulance communications officer has completed selecting which ambulance resource to assign and provided the ambulance crew with the response code and sufficient call location information (by base page, radio, telephone, belt page, PDA) to begin responding.

Time 4 – Arrived Scene: time at which the ambulance crew advises the ambulance communications officer (by radio or status messaging) that they have arrived at the call's location.

Dispatched Priority Code: 1, 2, 3, and 4

Code 1 – Deferrable Call: A non-emergency call which may be delayed without being physically detrimental to the patient.

Code 2 – Scheduled Call: A non-emergency call which must be done at a specific time due to the limited availability of special treatment or diagnostic/receiving facilities. Such scheduling is not done because of patient preference or convenience.

Code 3 – Prompt Call: An emergency call which may be responded with moderate delay. The patient is stable or under professional care and not in immediate danger.

Code 4 – Urgent Call: An emergency call requiring immediate response. The patient is life, limb or function threatened, in immediate danger and time is crucial.

Canadian Triage Acuity Scale (CTAS) Levels

CTAS Level 1: CTAS level assigned for resuscitation.

CTAS Level 2: CTAS level assigned for emergent.

CTAS Level 3: CTAS level assigned for urgent.

CTAS Level 4: CTAS level assigned for less urgent.

CTAS Level 5: CTAS level assigned for non urgent.

Dispatch Performance Metrics – Air Ambulance

Performance for Ornge is monitored according to dispatch and reaction time targets

Dispatch time targets:

Scene calls: Within 10 minutes of receipt of each call (T0), the caller will be advised on status of Ornge's ability to dispatch an aircraft

Acute care air transfers: Within 20 minutes of receipt (CO-Medical Patient Details Complete (T1)) of each call, the caller will be advised on status of Ornge's ability to dispatch an aircraft

CCLA Transfers: Within 20 minutes of receipt (CO-Medical Patient Details Complete (T1)) of each call, the caller will be advised on status of Ornge's ability to dispatch a CCLA vehicle

Reaction time targets:

Ornge aircraft, emergent and urgent calls: If aircraft is fueled, within 15 minutes of pilot's acceptance of the call, Air Traffic Control (ATC) clearance will be requested. If fuel is required, within 25 minutes of pilot's acceptance of the call, Air Traffic Control (ATC) clearance will be requested

SA carriers, emergent and urgent calls: Within one hour of agreed-upon departure time, ATC clearance will be requested

CCLA: Within 10 minutes of request for CCLA response, the CCLA will be mobile

Ornge Triage Acuity Scale

Ornge Triage Acuity Scale (OTAS) differs from CTAS and has been developed specifically for Ornge's transport environment

- OTAS is a 5-level triage acuity scale established by Ornge's Medical Advisory Committee replacing Ornge's 3-point scale (emergent, urgent and non-urgent) as of April 1, 2017
  - This scale is used in deployment decision-making for air ambulance

OTAS Levels and Best Effort Time to Receiver Facility*:

Level 1 - Resuscitation: 4 hours or less, without delay. OTAS 1 calls are to be dispatched without delay and are automatically approved for shift extension or duty out. The most appropriate Critical Care Land Ambulance (CCLA) will be dispatched or aircraft will be weather checked within 10 minutes of Patient Details Complete

Level 2 – Emergent: 6 hours or less. OTAS 2 calls require TMP approval for shift extension or duty out. The most appropriate CCLA will be dispatch or aircraft will be weather checked within 10 minutes of Patient Details Complete

Level 3 – Urgent: 12 hours or less. OTAS 3 calls are not approved for shift extension or duty out pursuant to the current Collective Agreement provisions

Level 4 – Less Urgent: 24 hours or less. OTAS 4 calls are not approved for shift extension or duty out pursuant to the current Collective Agreement provisions

Level 5 – Non-Urgent: 48 hours or less. OTAS 5 calls are planned using the Long Term Planning tool

*Each call is assessed based on circumstances (e.g., weather, patient needs, etc.) and is assessed against all other pending calls for the same/similar assets. Any one of these numerous factors could impact time to Receiver.

Performance and HR Data Analysis for Land Ambulance Dispatch

Performance and HR Data for Land Ambulance Dispatch

Our understanding of the current state was further informed through analysis of performance data for land ambulance and a review of available CACC HR data

Performance Data Findings

- Review of land ambulance performance data included analysis of call volumes, response times by CACC and Priority Code, and total spend from 2014-2016
- It was noted that call volumes have been steadily increasing by over 3% since 2014, with the distribution of call Priority Code remaining consistent
  - The distribution of call volumes across CACCs in Ontario is variable with several CACCs receiving less than 20,000 calls annually
  - Dispatch times across the province ranged from 2.0-3.3 minutes. Based on the overall data, there does not appear to be a direct correlation of performance relative to geography or call volumes.

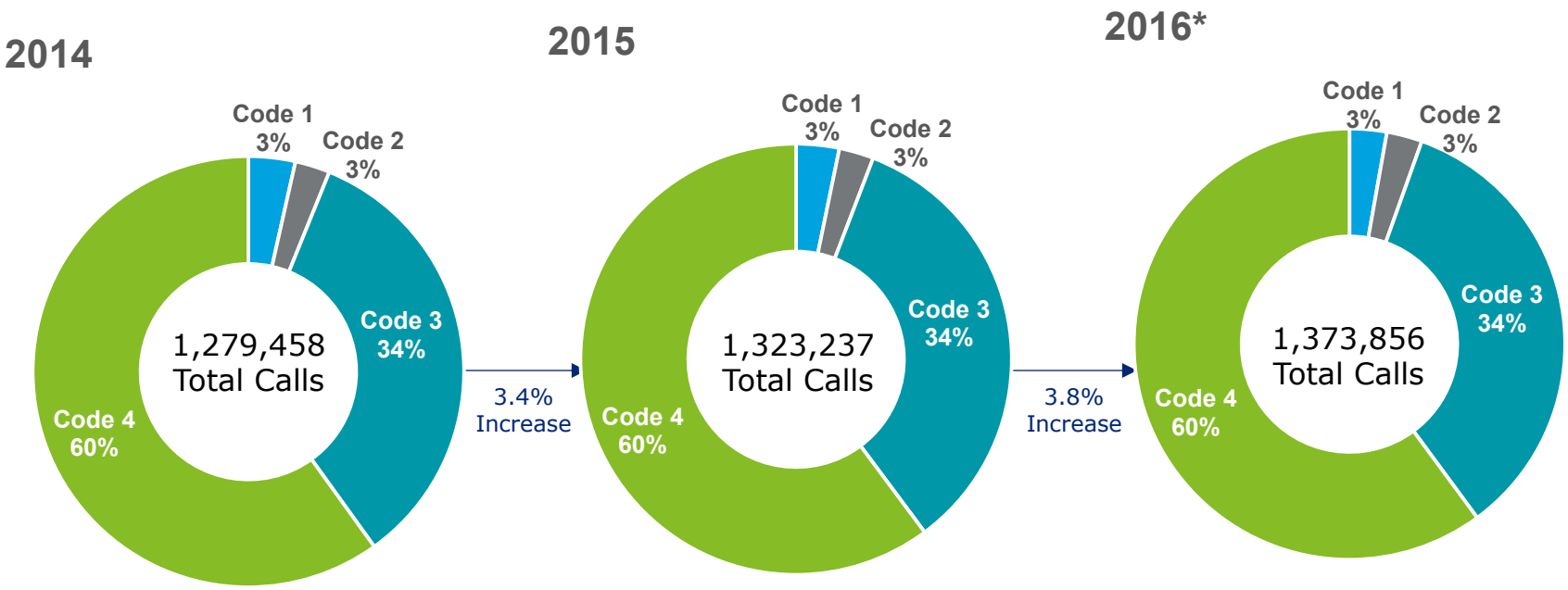
HR Data Findings

- Due to inconsistencies in data collection around attrition, sick time and overtime, we were unable to conduct a detailed analysis of HR data and identify strengths and challenges of the current HR management processes

The following slides provide a detailed view of the performance data analysis as well as a summary of data limitations. Methodology and further analysis can be found in the Appendix.

Ontario Volumes of Calls Received

CACC call volumes have been steadily increasing by over 3% year over year



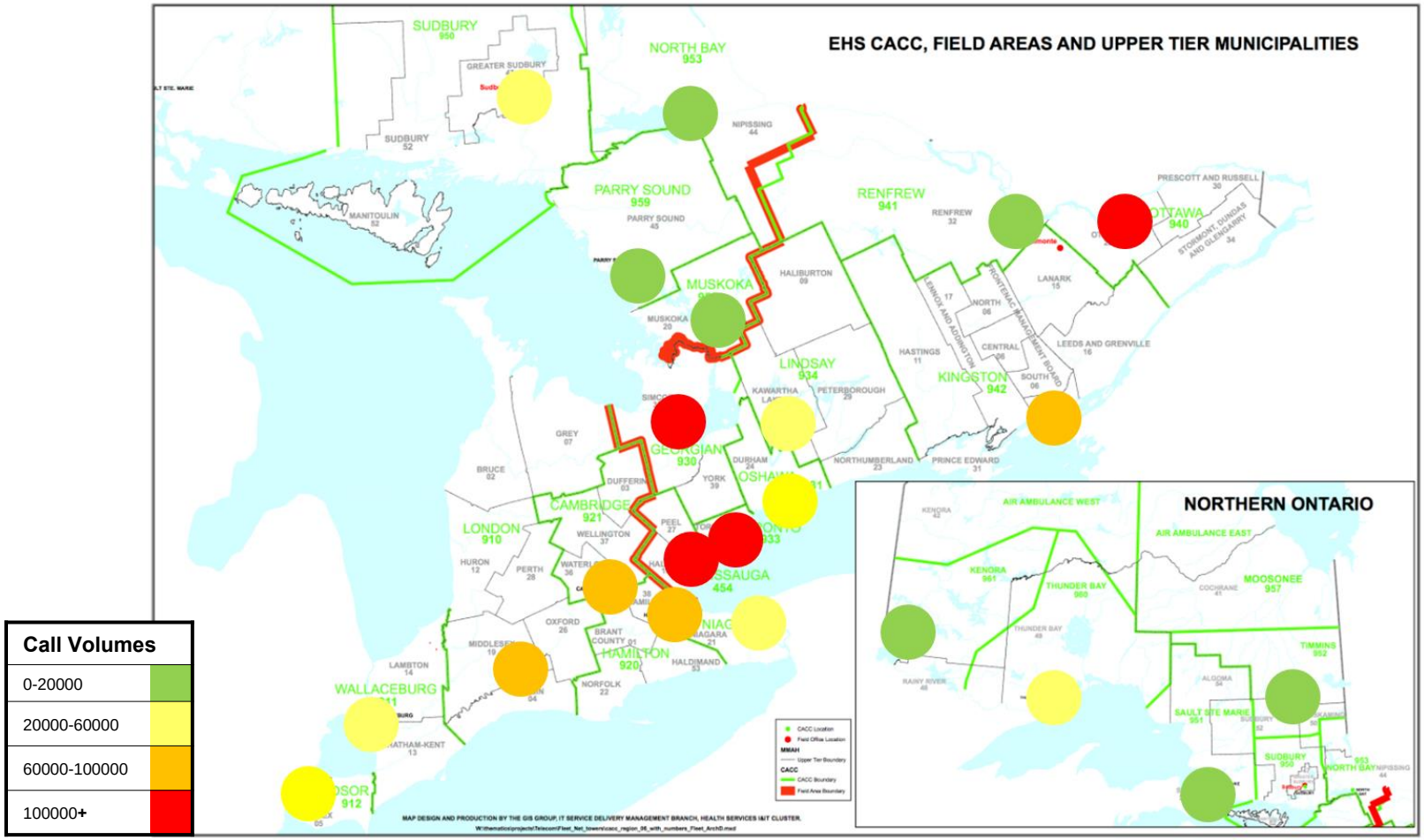
When data from the Toronto CACC is excluded, the proportion of Code 4 calls increases to ~66% for each year

- The proportion of Code 1-4 calls has remained constant year over year from 2014 to 2016
- Majority of calls received are categorized as Code 4
- From 2015 to 2016, Parry Sound saw the largest increase in call volumes (9%) whereas Muskoka saw the largest decrease (8%)
- The Toronto CACC receives the largest number of calls on an annual basis (~273,000 in 2015), accounting for over 20% of total calls received in Ontario

Source: ARIS Reports
*Data from January-September 2016 was used to project the total volume for the year

Volumes of Calls Received by CACC in 2016*

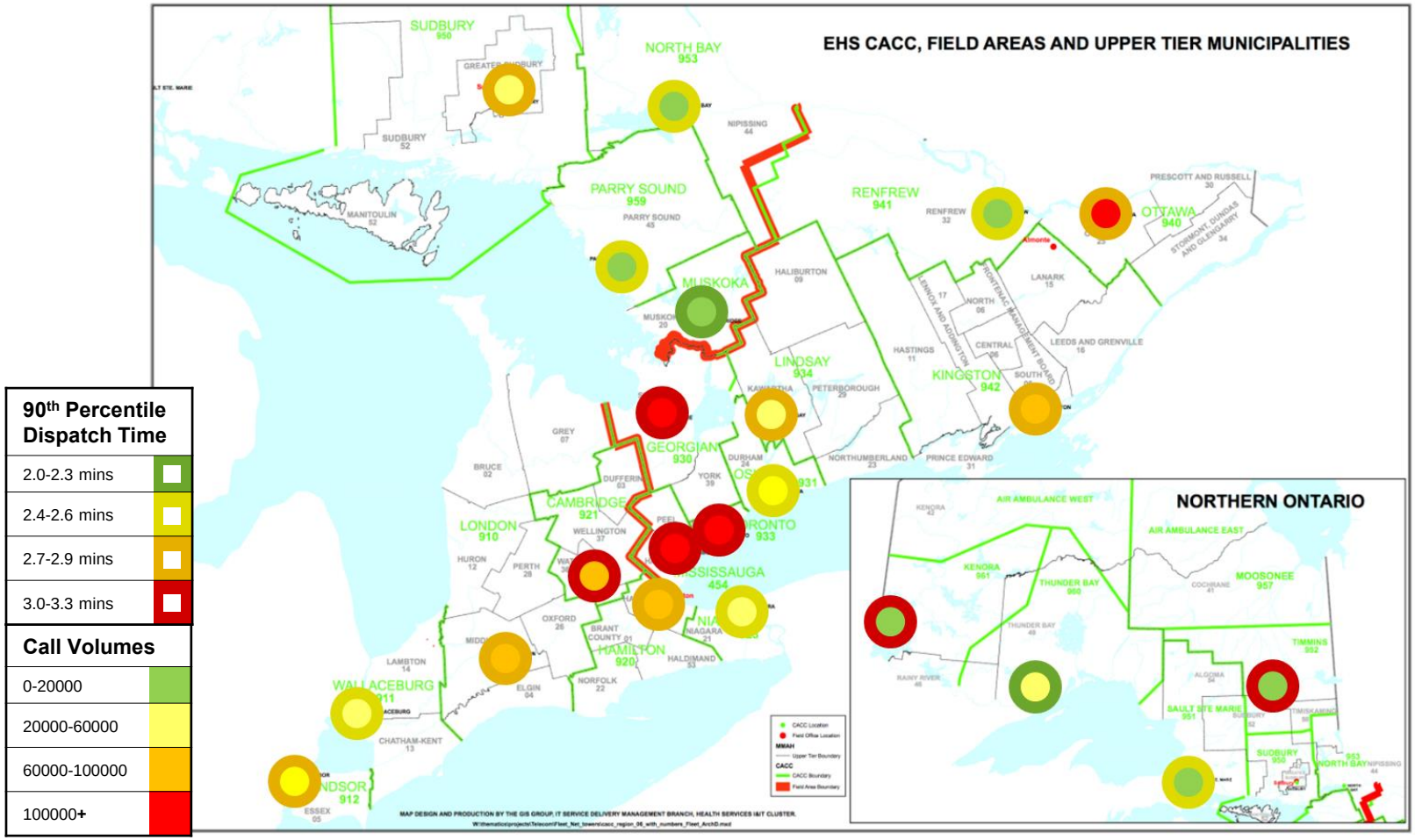
- Volumes of calls received by CACC ranged from 3,400 – 287,000 calls
- The Toronto, Mississauga, Ottawa and Georgian CACCs received the highest volumes of calls in Ontario
- 7/22 CACCs received call volumes <20,000



*Data from January-September 2016 was used to project the total volume for the year, call volumes represent Code 1-4 calls received

Volumes of Calls Received and Corresponding Dispatch Times by CACC in 2016*

- 90th percentile dispatch times across Ontario ranged from 2.0 – 3.3 minutes
- There appears to be no direct relationship between call volumes and dispatch times



*Data from January-September 2016 was used to project the total volume for the year, call volumes represent Code 1-4 calls received, dispatch times are for Code 4 calls

Data Analysis Limitations

A review of performance and HR data revealed a number of challenges, limiting the ability to identify drivers for attrition and attendance issues in CACCs

We sought to review:

- CACC Performance
  - Dispatch and response times across CACCs based on assigned Priority Code
  - Volumes of calls received by CACC
  - Volume of calls dispatched by Priority Code
- CACC Financials
  - Actual expenditures by CACC
- Employee Data
  - Attrition rates across CACCs
  - Attendance issues and associated contributors including:
    - Total sick time per employee
    - Overtime hours worked per employee
    - Span of control

Our findings show:

- Inability to compare calls received to calls dispatched due to variability in capturing data across CACCs
- Inability to track details of spend due to consolidated spend data vs. categorization and tracking of dollars
- Challenges in identification of attrition rates across CACCs due to variation in definitions and tracking
- Differences across CACCs in tracking sick time, overtime, and movement of employees within and outside of CACCs
- Inconsistent tracking of reasons for employees leaving CACCs

Due to the variability and inconsistencies in capturing performance and HR data, this review was unable to identify recommendations to retain resources and enhance attendance

Key Priorities for Transformation

Priorities to Inform the Future Model of Ambulance Communications

The synthesis of the current state findings, jurisdictional practices and future vision led to the creation of key priorities to enhance service delivery

Current State, Landscape of Ambulance Communications in Ontario, Future Vision for Emergency Services

Gap Analysis and Opportunities

Review of Jurisdictional Practices

Using the Model Framework to categorize the priorities and opportunities

Priorities and opportunities to evolve ambulance communications in Ontario

Key Priorities for Transformation

The following key priorities are recommended to transform the existing dispatch model to align with the desired future vision for emergency services

The key priorities provide direction to shape the future of ambulance communications, regardless of the stage of transformation. It is recognized that, with the current technology system improvements and the EESO multi-year transformation strategy, the Emergency Health Services Branch has started the journey towards an evolved future and these priorities will allow EHSB to build upon the progress.

Performance Management and Monitoring	**Comprehensive performance management** Enhance relevant benchmarks for clinical and service performance targets to drive system performance • Implement advanced management reporting systems to enable measurement of tangible KPIs and identification of potential issues, including patient experience indicators • Enhance dedicated support/business analysts to conduct more robust performance analysis and identification of trends to inform future planning decisions
Leadership and Structures	**Clear service expectations and accountability** • Enhance the accountability frameworks by evolving service expectations and performance based contracts to increase accountability for dispatch services • Identify appropriate organizational structure including direct governance, arms-length oversight, and/or contracted service agreements (may include private organizations)

Key Priorities for Transformation continued

The following key priorities are recommended (and in some cases underway) to transform the existing dispatch model to align with the desired future vision for emergency services

Infrastructure, Technology Requirements	**Integrated technology and information management practices** • Integrate technology between dispatch centres, paramedics, and services that arrange air and inter-facility transportation to support seamless ambulance communication • Establish an integrated approach to information management to enable standardized reporting across all centres • Implement provincial standardization of triage methodologies and relevant technology platform to support accurate and consistent prioritization of calls
People and Roles	**Focus on HR management and standardization across sites** • Standardize policies and procedures across CACCs to enable a consistent approach to delivery of ambulance dispatch services • Advance HR management practices with a focus on leadership, succession and retention management • Achieve formal accreditation by a sector recognized entities, such as the International Academies of Emergency Dispatch
Health Care System Integration Points	**Collaboration with partner organizations and existing structures to enhance emergency health services** • Revisit roles for partner organizations regarding inter-facility transfers and other relevant services • Enhance future vision that includes integration with the broader health system to support the patient journey from pre-hospital to acute care

Understanding key priorities and business process improvements

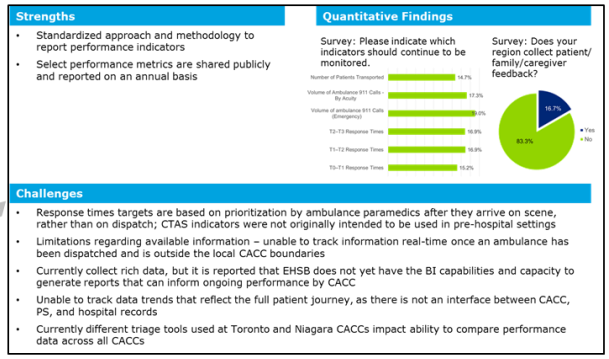
Suggested key priorities and business process improvements were informed by current state findings and jurisdictional practices

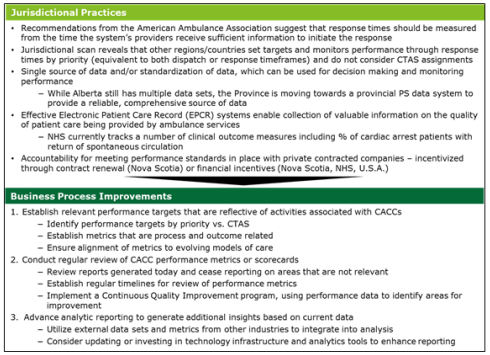
- The model framework guided the collection of current state data and identification of strengths and challenges with the current emergency health services system, which subsequently informed business process improvements
- The visual below illustrates the structure used to present findings and suggested improvements as highlighted on the following slides

Strengths associated with model framework category

Quantitative findings from survey and current state review

Practices from jurisdictions in Canada, USA, and the UK





Challenges associated with model framework category

Proposed business process improvements

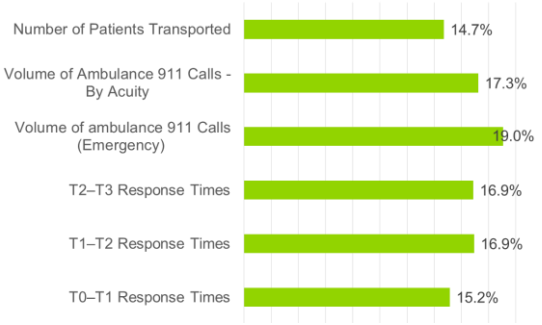
Performance Management and Monitoring

Strengths

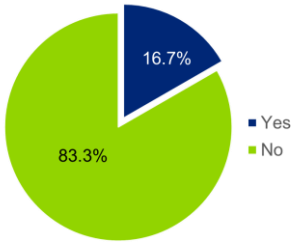
- Standardized approach and methodology to report performance indicators
- Select performance metrics are shared publicly and reported on an annual basis
- Ornge's CAD system enables accurate reporting of key performance indicators as outlined in the Ministry/Ornge performance agreement

Quantitative Findings

Survey: Please indicate which indicators should continue to be monitored.



Survey: Does your region collect patient/ family/caregiver feedback?



Challenges

- CACC response times targets are based on prioritization by ambulance paramedics after they arrive on scene, rather than on dispatch; CTAS indicators were not originally intended to be used in pre-hospital settings
- Limitations regarding available information – unable to track information real-time once an ambulance has been dispatched and is outside the local CACC boundaries
- Lack of comparability between measured targets for land and air
- Currently collect rich data, but it is reported that EHSB does not yet have the advanced business intelligence (BI) capabilities and capacity to generate reports that can inform ongoing performance by CACC
- Unable to track data trends that reflect the full patient journey, as there is not an interface between CACC, Paramedic Services (PS), and hospital records. Although, Ornge has initiated work to track patients journey based on it unique data sets, the interface with land services is not yet captured
- Currently different triage tools used at Toronto and Niagara CACCs impact ability to compare performance data across all CACCs. This issue is mitigated in air ambulance due to a single system coordinated centrally, however it is not comparable to CACC data

Performance Management and Monitoring cont'd

Jurisdictional Practices

- Recommendations from the American Ambulance Association suggest that response times should be measured from the time the system's providers receive sufficient information to initiate the response as the time taken to collect information can be variable depending on circumstances
- Jurisdictional scan reveals that other regions/countries set targets and monitors performance through response times by priority (based on an advanced triage system) and do not consider CTAS assignments as these are assigned retrospectively
- Consistent use of a single source of data and/or standardization of data, which can be used for decision making and monitoring performance, as this allows for valid review of trends
  - While Alberta still has multiple data sets, the Province is moving towards a provincial PS data system to provide a reliable, comprehensive source of data
- Effective Electronic Patient Care Record (EPCR) systems enable collection of valuable information on the quality of patient care being provided by ambulance services
  - National Health Service (NHS) currently tracks a number of clinical outcome measures including % of cardiac arrest patients with return of spontaneous circulation, which is enabled through its EPCR system
- Relationships with privately contracted companies enable accountability through performance-based contracts and independent oversight to monitor performance and compliance – incentivized through contract renewal (Nova Scotia) or financial incentives (Nova Scotia, NHS, U.S.A.)
  - Medavie reports indicators, such as call processing times and overall response times, to oversight body, while further breakdown of indicators is reviewed internally to identify opportunities to improve services

Business Process Improvements

1. Enhance relevant performance targets that are reflective of activities associated with CACCs
   - Ensure alignment of metrics to evolving models of care
2. Enhance CACC and Ornge OCC performance metrics or scorecards
   - Review reports generated today and cease reporting on areas that are not relevant
3. Advance analytic reporting to generate additional insights based on current data
   - Consider updating or investing in technology infrastructure and analytics tools to enhance reporting
4. Improve the Quality Assurance framework/program to drive performance and quality in the service model

Leadership and Structures

Strengths

- Some support by leadership to front line staff in the form of training and mentorship
- For the smaller centres, inter-professional relationships are fostered between staff and management
- Each centre is familiar with the practices of municipality and service providers and can tailor local services to meet the needs of communities
- Ornge and CACCs regularly connect to collaborate on operations

Quantitative Findings

- 22 CACCs, 11 run by Ministry and 11 are non-Ministry CACCs
- Ornge OCC and OCC back-up location
- Municipalities currently fund 50% of ambulance services but not dispatch centres

Challenges

- With each of the interviews and focus groups conducted, **all participants** indicated that there are too many CACCs in the province and there is opportunity to consolidate, while maintaining quality service
- Varied standardization across the province with regards to practice and technology – different interpretations of policies due to large number of CACCs
  - This variation contributes to the inefficiencies when operating EHS systems
- With the current number of CACCs, it can be difficult to provide robust oversight and governance to introduce new programs or initiatives
- Some stakeholders reported the challenge with gaining full transparency provincially in understanding operations and expenditures by CACC, with the different accountability structures
- Within EHSB, it is reported that variation exists between the span of control at the supervisor or manager level, which impacts the ability to provide consistent oversight and performance management
- As some of the CACCs provide dispatch services other than PS (e.g., fire, police), a proportion of stakeholders report this can restrict access to ambulance service, as there are competing priorities
- Currently no established standard for management processes and operational functions, which could be achieved through accreditation

Leadership and Structures cont'd

Jurisdictional Practices

- Consolidation to reduce the overall number of land dispatch centres in various jurisdictions enabling achievement of efficiencies and ease of standardizing practices across centres
  - NHS moved from 31 dispatch centres in 2006 to 14 in 2016, in order to improve strategic capacity and achieve efficiency gains
    - Success of this initiative was largely due to advanced technology, which allowed dispatch centres to manage calls quicker and more efficiently, supported communication between dispatch centres, and enabled seamless transition of calls between dispatch centres; Challenges included concerns from community members that the dispatch centres were not in close proximity to them and fear of dispatch officers lacking local context knowledge
  - Similarly, Alberta attempted to consolidate the PS dispatch system, which was put on hold in March 2010
    - Reported benefits included the standardization of dispatch processes and consistent technology use across the province; Consolidating the PS dispatch system posed funding challenges for centres that previous dispatched multiple services (i.e., PS and fire), as these centres no longer received funding for their PS services
- Contracting private companies to provide ambulance dispatch services, using contracts to ensure accountability for meeting performance standards – e.g., Medavie in Canada
  - The trend for government, including other areas within the healthcare system, is to continue its evolution towards a stewardship model and empower other entities for direct service delivery, while maintaining 'arms-length' oversight; this model enables accountability for service provision and achievement of metrics to be placed on the service provider vs. the oversight body
- Achievement of accreditation by a national/international organization provides assurance that provider is aligned with recognized standards of excellence
- Centralized dispatch of air and land ambulance to enable transparency between providers and more efficient provision of transportation services – e.g., Manitoba, British Columbia, Nova Scotia

Business Process Improvements

1. Investigate opportunities to pursue accreditation for emergency dispatch communication across all CACCs and OCC from a recognized, international organization
2. Review current accountability frameworks and enhance service and performance expectations and monitoring

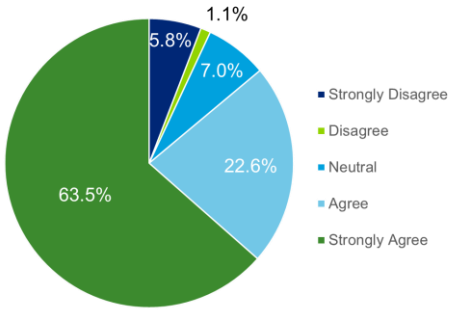
Infrastructure, Technology Requirements

Strengths

- Over the years, EHSB has invested in gradually improving technology to support communications
- MPDS system used in Niagara and Toronto is known to be reliable and accurate due to real time data and allocation of paramedics
- It is reported that a number of CACCs may have the physical infrastructure to take on additional capacity
- A data sharing agreement and technology solution enables information from CritiCall to be pushed to Ornge to help populate the CAD and inform patient transfers

Quantitative Findings

Survey: The current dispatch triage tool could be improved to contribute to an enhanced patient experience during a 911 call



Challenges

- Delays in obtaining important patient information due to incompatibility of patient care record from ambulance to hospitals
- The majority of survey participants who provided additional comments reported that the current triage system is "risk averse" and there are scenarios where the priority response does not fully align with the triage assessment
  - It is perceived that there are too many calls assigned a Priority Code 4
- It is reported variability exists across the province regarding the process to re-route public-safety answering point (PSAP) calls when dispatch does not field calls: mix of automated re-routing through telecommunications company vs. manual calling by PSAP staff. This poses a key risk to timeliness of access to service
- Each CACC has a designated back-up centre, however almost all areas use manual processes (phone, radio, and paper) to manage calls when systems go down, which poses risks during downtime situations
- All CACCs currently use the same CAD platform but not the same instance of it, which impacts the efficiencies where collaboration across CACCs is needed or in shifting to new service models in the future. Further, Ornge's CAD currently does not interface with the CACC CAD preventing integration

Infrastructure, Technology Requirements cont'd

Jurisdictional Practices

- Consistent advanced triage functionality across all dispatch centres enabling standardization of data collected, ease of integration across dispatch centres and comprehensive triage of emergency calls
  - MPDS is used in BC and Manitoba, enabling a standard of care protocol for medical emergency triage as well as pre-arrival instructions to patients/callers
  - MedStar in Forth Worth, Texas, and the Regional Emergency Medical Services Authority (REMSA) in Reno, Nevada are both accredited through the International Academy of Emergency Dispatch (IAED) and use MPDS as their triage tool
- CAD to CAD compatibility enabling communication between dispatch centres and across the continuum of patient care (Dispatch to ambulance to hospital)
  - Integrated CAD systems enable dispatchers to see location of ambulances, send information to mobile data terminals, and ensure that time stamps are accurately captured
- Seamless transfer of calls
  - Telecommunications company in NHS automatically re-routes calls where dispatch is unable to receive calls enabling timely response to emergency calls
  - In BC, peak demand rollover is seamless – unanswered calls go seamlessly to the backup centre

Business Process Improvements

1. Procure a standardized electronic triage system across all CACCs, in alignment with 2017-18 and 2018-19 system improvements
   - Procure a triage system with an advanced algorithm to assign priority status that reflects patient needs
2. Implement technology to allow seamless transition of calls to mitigate system or switch failure across all CACCs and Ornge's OCC
3. Implement advanced dispatch technology functionality that aligns with the future model of services
   - Consider standardizing CAD instance across CACCs to enable effective sharing of information
   - Implement a system to enable two-way communication with PS mobile data terminal and CAD system, thus enabling a combined rich data set of EPCR and CAD data, in alignment with proposed 2017 system improvements

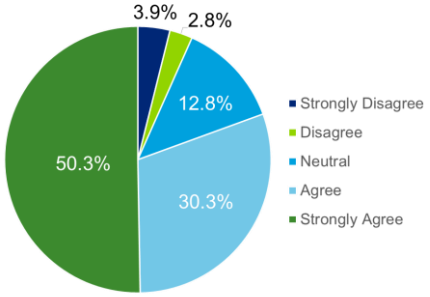
People and Roles

Strengths

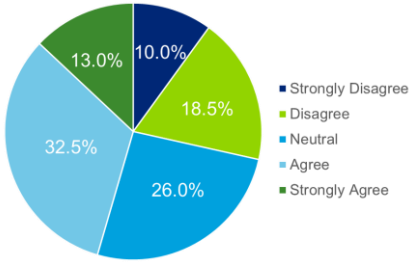
- Regional centres foster strong interpersonal support amongst peers
- While not consistent across all CACCs, it was reported that clear lines of communication exist between field offices and head office, though there is ongoing work required to strengthen these
- Interviews indicate there are knowledgeable front-line staff fielding and managing calls from the public

Quantitative Findings

Survey: There are opportunities to improve the pre-arrival instructions given to patients prior to the paramedics' arrival.



Survey: I believe that the current way dispatch staff are utilized supports timely ambulance responses.



- 34% of survey respondents strongly agree/agree that staff receive enough training to effectively perform their jobs

Challenges

- As managers are not staffed 24/7 across all CACCs, this can be challenging to sustain performance management-related activities, as it is reported that staff may not see their managers for an extended timespan
- Overall, forum for all CACC staff to connect does not exist and currently regularly scheduled staff meetings within CACCs does not occur
- It is perceived that there is variation among CACCs with regards to general HR practices, e.g., hiring, management of staff, operations
- There is variability in capturing HR-related data across CACCs including sick time, overtime, and attrition

People and Roles cont'd

Jurisdictional Practices

- Dedicated resources for 911 dispatch vs inter-facility transport to provide clearer roles and reduce competition for resources – e.g., British Columbia
- Cross-training staff on other roles to provide alternate resources and cost efficiencies – e.g., Manitoba
- Providing access to a supervisor/management 24/7 to provide support to front line staff and ensure consistent local operations – e.g., Manitoba
- Focus on creating a workplace of excellence including providing effective education to ensure quality patient care through ongoing skills and knowledge evaluation – e.g., British Columbia

Business Process Improvements

1. Focus on enhancing an engaged culture within the CACCs
   - E.g., establish annual in-person meetings, webinars, social media sites, SharePoint sites, and/or blogs to support regular engagement, encourage connecting with other regions and sharing lessons learned, formal certification of ACOs through accreditation process, increased support for Supervisors and Managers to improve management skills and abilities
2. Explore models that can support management functions 24/7
   - Consider cross-coverage models across CACCs, and unionized vs. non-unionized environments
3. Examine current education practices to determine changes that may be required to increase adoption of training (e.g., alternate approaches, peer-based learning models)
4. Advance HR management practices
   - Consider implementing an electronic scheduling system to better track staff utilization and inform predictive scheduling
   - Stronger focus on development of leadership, succession and retention management using informal/formal methods
   - Conduct a review of staff utilization – particularly attrition, sick time, and overtime – to better understand drivers; this may include collection of quality data to conduct analytics

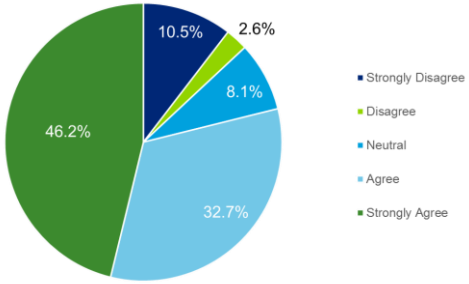
Health Care System Integration Points

Strengths

- Tiered response in place with police, fire, and ambulance to ensure that appropriate resources are dispatched for every call
- CritiCall and the CACCs have a well-established process to communicate and coordinate life and limb transfers
- Strong communication with Ornge, particularly for inter-facility transfers

Quantitative Findings

Survey: I believe there are opportunities to improve the integration between the ambulance dispatch centres and the broader healthcare system.



Challenges

- Currently minimal integration of data between ED, Ambulance, CACCs, and LHINs – majority of survey respondents identified the need for open communication channels between Dispatch Services, paramedics, CACCs and the MOHLTC
- For transport other than life or limb, hospitals do not consistently know who to contact for transport (i.e., air vs. land)
- Lack of integration with parallel call systems such as Telehealth Ontario and 811
- While CritiCall is able to push personal health information to Ornge to populate their Patient Transfer Authorization Centre (PTAC) and CAD, CACCs do not have access to view this information, which increases risk and could impact timeliness of communication
  - It is noted that preliminary integration efforts are underway to integrate Ornge's dispatch system with the CACCs; to date, a technical specifications document has been drafted for this work
- As there is variability among PS regarding their allocation plans, the CACCs must be cognizant of constraints when allocating PS to the airport for transport handoff with Ornge

Health Care System Integration Points cont'd

Jurisdictional Practices

- Emergency Communication Nurse System (ECNS) implemented with MPDS provides an algorithm to triage low-acuity calls and connect them to appropriate community resources or provide self-care instructions
  - This is currently in place Fort Worth, Texas, and Reno, Nevada, as well as in the UK and Australia
  - As there is a shared CAD, the model enables seamless transition to 9-1-1 dispatch to maintain the public safety, rather than repeating information and starting from the beginning
- Multiple centres in the USA and UK have air and land ambulance services dispatched from the same facility enabling a more coordinated dispatch for transports requiring both land and air services
- Within British Columbia, Emergency Health Services is responsible for the Ambulance Service as well as the Patient Transfer Network, which is a 24/7 services that collaborates with health care providers for an integrated approach to safe, efficient transfer of acute and critically ill patients
- Defining the vision for emergency response will support the shaping of the service model for the future
  - E.g., Perspectives on public safety as a priority vs. promoting an integrated health system

Business Process Improvements

1. In alignment with *Patients First* and EESO, establish a future vision of pre-hospital care to inform the roles and responsibilities of CACCs
   - Consider other referral options for the public for low acuity calls
2. Explore model options to strengthen the communication and coordination of critical care transport
3. Identify expanded support or guidance that ACOs can provide to patients and families to improve outcomes, as well as the patient experience

Future State Model Options

Development of Future State Models

The model framework and guiding principles inform the proposed future state models, and a set of operational criteria was developed to support discussions on siting and sizing of the dispatch centres

Guiding Principles

- Greater value for Ontario citizens
  - Improved service quality and outcomes
  - Cost efficiency
- Improved utilization of Paramedic Services resources
- Promotes standardization of processes/practices
- Evidence informed and based on leading practices
- Promotes greater system integration
- Enhances future transformation potential for pre / post call stages of the process
- Ease and timeliness of implementation

Key Priorities for Transformation

- Performance Management and Monitoring
- Leadership and Structures
- Infrastructure and Technology Requirements
- People and Roles
- Health Care System Integration Points

Operational Considerations

1. The volume of calls received and ability of dispatch centres to manage increasing call volumes, particularly if there are fewer centres in operation
2. Consideration of the current size of communication centres and potential for growth to accommodate larger volumes of staff
3. Consideration of Academic Health Science Centres and other provincial transformation priorities to align with referral patterns
4. Availability of workforce to staff centres and consideration of impact on smaller communities
5. Location of back-up centres and distances between back-up centres to enable seamless transitions in the case of system outages

Future Models

Option #1 **Option #2** **Option #3**

Descriptions of Model Options

Overview of potential future state models for ambulance communications

- As described earlier in the report, the implementation activities for the **Key Priorities for Transformation are required in all model options**
- Regardless of the number of CACCs that will be in operation, the future model will be **one, holistic interconnected system** that fosters coordinated collaboration with stakeholders across the emergency health services ecosystem (e.g., one number to call for help, regardless of the severity of the citizen's need)
- In selecting the future state model for ambulance communications, consideration must be given to the **future vision and the capabilities required** to support this vision

Option 1: Existing Dispatch Model Transformation	• Maintenance of 22 land ambulance dispatch centres across Ontario • Current CACC boundaries and relationships with existing paramedic services • Current relationships with air services provider remain in place • Single or hybrid operational model – i.e. direct operation by Ministry, transfer-payment agency, or contractor, or a combination
Option 2: Regional Dispatch Model	• Regional centres for ambulance dispatch that may align with relevant patient flow patterns – Options to inform reduced number of centres include: ○ CACCs that align with three existing Field Offices ○ Alignment with Tertiary Centres in Ontario ○ Consolidation to align with distribution of call volumes • Current relationships with air services provider remains in place • Single or hybrid operational model - i.e. direct operation by Ministry, transfer-payment agency, or contractor, or a combination
Option 3: Centralized Dispatch Model	• Centralized dispatch services for land and air, with back-up site redundancies built-in • Single operational model – i.e., direct operation by Ministry, transfer-payment agency, or contractor

Evaluating Future Model Options

The following pages highlight implications of the three proposed model options relative to the guiding principles, key priorities, and operational considerations

- The visual below illustrates the template used to describe the assessment of the future model options as presented on the following pages
  - Each model option was assessed based on alignment with guiding principles, key priorities, operational considerations and the future vision for emergency health services
  - Although model options may align with specific principles or priorities, the degree of alignment will vary with the number of communication centres

Degree of alignment with Guiding Principles for the proposed model option

Implications related to Guiding Principles

- ✓ **Leading practice**: Existing backup contingency in the case of system failures as a result of multiple centres
- ✓ **Ease of Implementation**: With the focus on transformation within the existing dispatch model, required changes will be easier relative to the other model options
- **Value**: Inability to achieve economies of scale, as the number of centres will remain unchanged. Further, while staffing ratios can be optimized and standardized across sites, minimum staff requirements will limit the extent of efficiencies achieved
- **Utilization of Paramedic Service Resources**: More challenging to employ system status management with many centres vs. fewer
- **Standardization**: While processes and practices can be optimized and standardized across sites, this will require significant effort due to the large number of centres
- **Leading practice**: Other jurisdictions are moving towards consolidation of centres to better optimize resources and standardize processes
- **System integration**: Different dispatch centres for land and air will require increased coordination for complex transports
- **System Integration/Future Transformation**: Due to the limited organizational changes, it may be challenging to seamlessly position for further system integration opportunities

Implications related to Key Priorities for Transformation and Operational Considerations

- Effort and resources will be required to monitor and audit KPIs for 22 communications centres across the province vs. requirements with fewer centres
- Performance based contracts will contribute to increased accountability across centres. However, oversight may be complicated due to the variation across multiple centres
- With the technology improvements underway with the ESSO transformation strategy, triage of calls, bi-directional information sharing, and reporting will be enhanced, with all model options
- The model can achieve a level of standardization, however, the efforts and oversight required to evolve change may be easier to implement with fewer centres
- Local community partnerships can continue to be fostered to strengthen integrated services. However, the model will require regional or provincial entities to collaborate with multiple centres on deployment of future opportunities
- Operational Considerations: as there are no changes to siting or re-organization of dispatch centres, the current workforce, call patterns, and back-up contingency plans continue. Depending on other regional/provincial transformation initiatives underway, EHSB may need to explore impacts to current boundaries to align with integration opportunities

Degree of alignment with Key Priorities and Operational Considerations

Option 1: Transformation of Existing Dispatch Model

Model characteristics relative to the guiding principles, key priorities for transformation, and operational considerations

Implications related to Guiding Principles

- ✓ **Leading practice**: Existing backup contingency in the case of system failures as a result of multiple centres
- ✓ **Ease of Implementation**: With the focus on transformation within the existing dispatch model, required changes will be easier relative to the other model options
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Option 2: Regional Dispatch Model

Model characteristics relative to the guiding principles, key priorities for transformation, and operational considerations

Implications related to Guiding Principles

- ✓ **Value:** Trend towards achieving great economies of scale with fewer centres; efficiencies gained through consolidation of sites as minimum staffing levels are no longer required due to critical mass being achieved
- ✓ **Utilization of Paramedic Service Resources**: Easier to employ system status management with fewer centres
- ✓ **Leading practice**: Existing backup contingency in the case of system failures as a result of multiple centres
- ✓ **Leading practice**: Aligns with the movement in other jurisdiction around consolidation
- ✓ **System Integration/Future Transformation**: With fewer regional centres, the Branch is better positioned for further system integration opportunities
- • **System integration**: Different dispatch centres for land and air will require increased coordination for complex transports
- • **Ease of implementation**: Changes to organizational structures and staffing will require robust planning and efforts

Implications related to Key Priorities for Transformation and Operational Considerations

- ▪ Consolidating communications centres will increase the likelihood of success of standardized performance monitoring due to the reduced number of centres requiring monitoring
- ▪ Performance based contracts will contribute to increased accountability across centres. However, oversight will be less complicated with fewer centres
- ▪ With the technology improvements underway and with the ESSO transformation strategy, triage of calls, bi-directional information sharing, and reporting will be enhanced, with all model options
- ▪ Consolidation of centres will support a structure to better standardize policies and procedures, as well as reinforce HR management practices
- ▪ Although knowledge of local communities may not be as comprehensive due to consolidation of centres, there is still opportunity to tailor centres to meet the needs of the geographical region. The model will require regional or provincial entities to collaborate with multiple centres on deployment of future opportunities, albeit fewer centres
- ▪ Operational Considerations: The EHSB will need to conduct an assessment on the size and physical capacity of the current centres, to support discussions on siting options. The consolidation to fewer centres will have an impact to the workforce in smaller communities, though potential technology supports could allow for virtual workplaces in the future

Option 3: Centralized Dispatch Model

Model characteristics relative to the guiding principles, key priorities for transformation, and operational considerations

Implications related to Guiding Principles

- ✓ **Value:** Model enables achievement of great economies of scale with efficiencies gained through consolidation of sites as minimum staffing levels are no longer required due to critical mass being achieved
- ✓ **Utilization of Paramedic Service Resources**: System status management can be implemented in a seamless way with a centralized model
- ✓ **Leading practice**: Aligns with the movement in other jurisdiction around consolidation
- ✓ **System Integration/Future Transformation**: Implementation of future system integration opportunities may be easier with a common operational leadership to inform and implement transformation changes more broadly
- ✓ **System integration**: Consolidated land and air dispatch will support enhanced coordination for complex transports
- • **Leading practice**: Challenge to ensure sufficient backup contingency with potential system failures and the ability to manage overflow
- • **Ease of implementation**: Changes to organizational structures and staffing will require robust planning and efforts

Implications related to Key Priorities for Transformation and Operational Considerations

- ▪ Consolidating air and land communications centres will increase the likelihood of success of standardized performance monitoring due to the reduced number of centres requiring monitoring. Furthermore, efficiencies may be achieved through consolidated decision support for air and land dispatch.
- ▪ Performance based contracts will contribute to increased accountability across centres. However, oversight can be maintained consistently with a centralized model
- ▪ With the technology improvements underway and with the ESSO transformation strategy, triage of calls, bi-directional information sharing, and reporting will be enhanced, with all model options
- ▪ Consolidation of centres will provide an opportunity to revisit and standardize policies and procedures across all centres and enable a consistent, streamlined approach for air and land dispatch. HR management practices can be reinforced in a standardized way, which can build capacity in the leaders
- ▪ Knowledge of local communities to meet the needs of geographical regions may not be as comprehensive due to consolidation of centres
- ▪ Consolidation of air and land communications centres aligns with the future vision of integration with other services and the broader health system. A centralized approach may accelerate collaboration opportunities in the future with other provincial or regional partners
- ▪ Operational Considerations: The EHSB will need to conduct an assessment on the size and physical capacity of the current centres, to support discussions on siting options. The consolidation to fewer centres will have an impact to the workforce in smaller communities, though potential technology supports could allow for virtual workplaces in the future

A Future Landscape for Land Ambulance Communications

Provincial initiatives, including *Patients First* and EESO, will evolve the health system, allowing for new service models for communications

Innovation in Care Delivery Models

Future models will transform care delivery to participate in community prevention interventions such as home visits and wellness clinics, in alignment with the objectives of *Patients First*. The future state roadmap of ambulance response is for communications centres to play a role in triaging callers and initiating an integrated response including connecting them with **existing community services** that are **closer to home,** such as Telehealth and Health Links, thereby minimizing the use of acute care resources.

Disruptive Enabling Technologies

Evolving technology will play a role in ambulance communications through increased automation of communications, use of artificial intelligence and machine learning, advanced capabilities through telemedicine technology, and virtualized technology to transform service delivery and enable innovative workforce models. The planned 2017-18 and 2018-19 system improvements will focus on technology enabled bi-directional data sharing between dispatchers and paramedics and a comprehensive pre-hospital patient record.

Insights to Manage Performance and Inform Progressive Transformation

Use of analytics will help inform decision-making to improve services offered, patient outcomes and achieve an end-to-end perspective on the patient journey through pre-hospital care. As part of EESO, an accountability structure will be established for emergency health services and benchmarks to measure system performance will be identified. The use of analytics will inform predictive modeling and enable faster and improved access to care for patient and better resource planning.

Appendix

Summary of Survey, Focus Group, and Interview Participants

Stakeholder engagement informed our understanding of the current state of emergency communications in Ontario

Survey	• 558 survey responses were received from the following organizations: – MOHLTC – LHIN – CCSO – Criticall – Municipal Organizations – Ornge – Paramedic Services – CACC / ACC / OCC / ACS
Focus Groups	• 4 focus groups were conducted as follows: – OAPC – ED LHIN Leads – Ornge – EHSB SMT
Interviews	• 7 interviews were conducted, with individuals representing the following organizations: – Rama First Nation Paramedic Services – MOHLTC, Direct Services Division – James Bay Ambulance Services – MOHLTC, Health Services I&IT Cluster – Association of Municipalities Ontario – Criticall – MOHLTC, Emergency Health Services Branch Leadership

Performance and HR Data Methodology

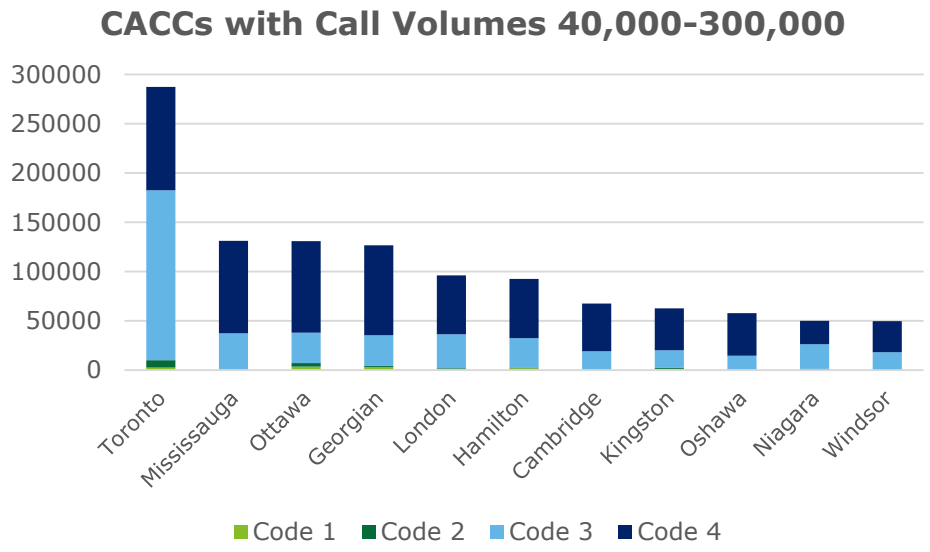
The following methodology was used to analyze performance and HR data for CACCs as demonstrated on the following slides

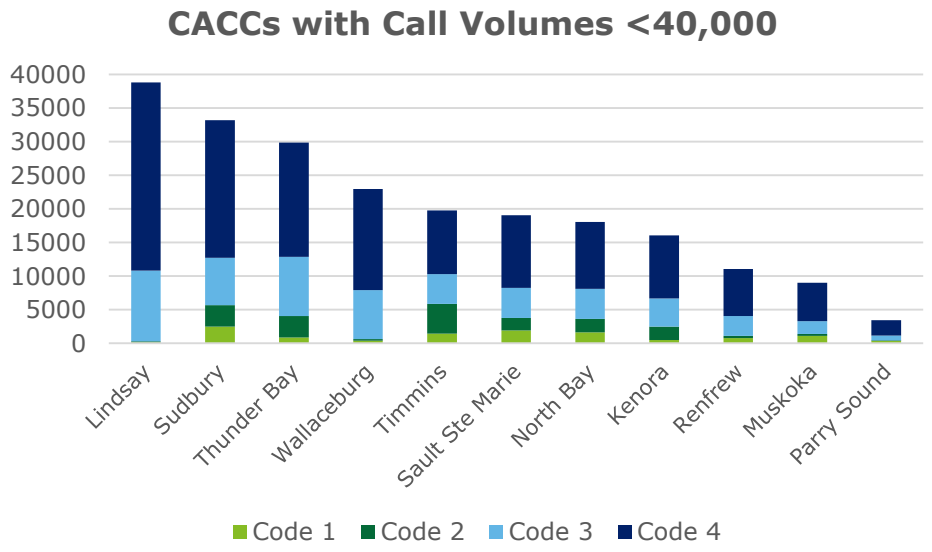
Call Volumes Received	• Data pulled from ARIS Report by Ministry • Includes Code 1-4 calls • Date range: Jan 1, 2014 – Sept 30, 2016
90th Percentile Dispatch Times	• Data pulled from ARIS Report by Ministry • Includes Code 4 calls • Calls with T0-T2 > 1800 seconds excluded • Calls share, double dispatch and unit transfer calls excluded
Actual Spend per CACC	• Data provided by Ministry for FY 14/15 and FY 15/16 • Includes CACC costs only, not costs associated with Paramedic Services
Sick Days	• Number of sick days provided by Ministry for Ministry-run CACCs and by individual CACCs for non-Ministry centres • Sick-time for part time employees was not included • Where sick-time was provided in hours, assumption was 8-hour shifts to convert to days • Date range: Apr 1, 2015 – Mar 31, 2016
Span of Control	• Employee data provided by Ministry for Ministry-run CACCs and by individual CACCs for non-Ministry centres • Date range: Apr 1, 2015 – Mar 31, 2016 • Number of employees determined based on data sent over • Span of control calculation as follows: ◦ (# of full-time + part-time employees) / # of Operations Managers
Call Volumes/ Dispatcher	• Calculation as follows: ◦ *Call volumes received* / (# of full-time employees + sum of FTE of part-time employees)

Performance Data Analysis – Land Ambulance

Volumes of Calls Received by Code (2016)

The majority of calls received were categorized as Code 4, with the exception of Toronto Niagara, and Timmins CACCs



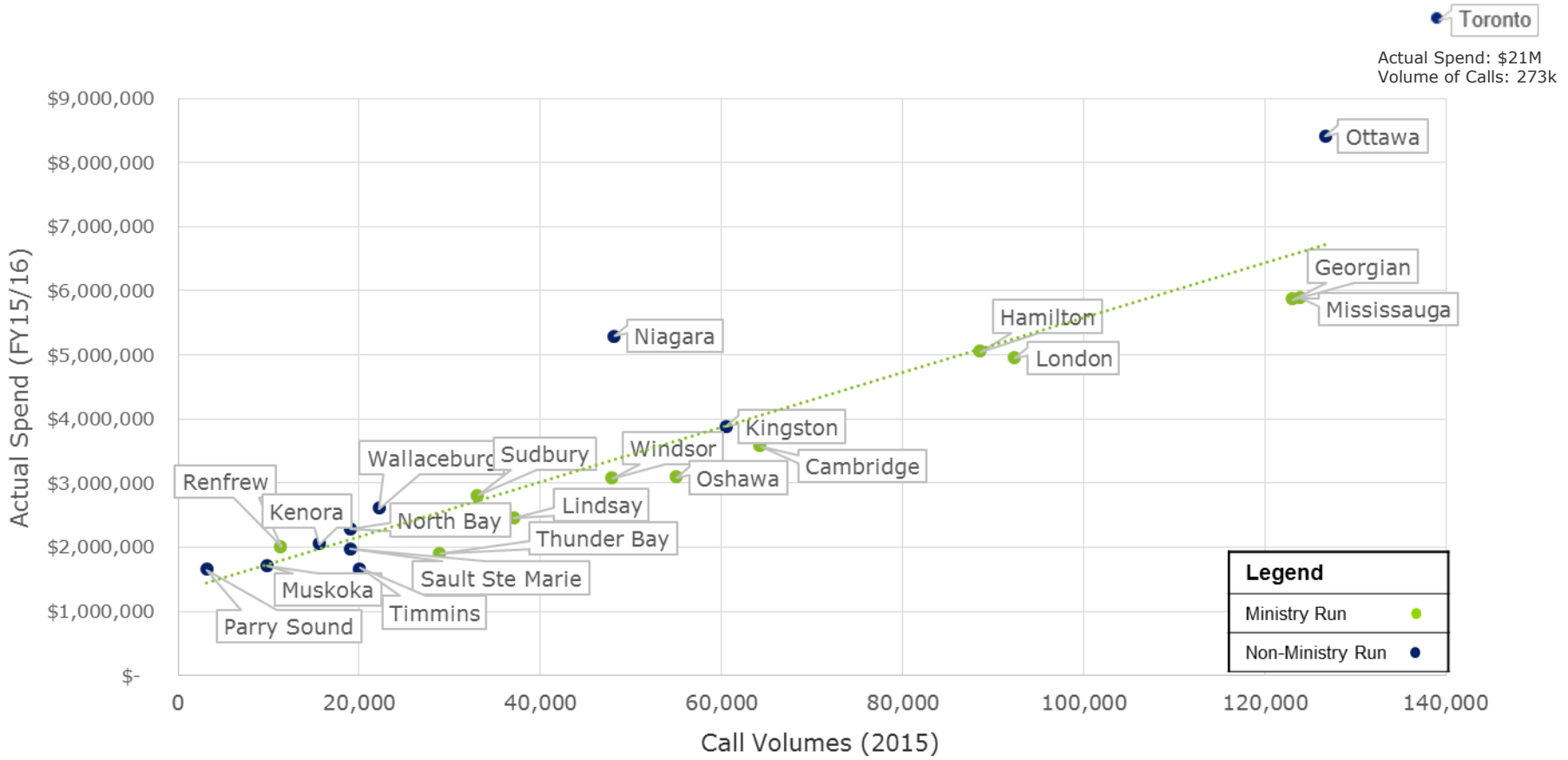


- The graphics illustrate the proportion of priority Code calls by CACC
- The majority of sites categorized the highest proportion of calls as Code 4 calls
- Toronto, Niagara, and Timmins were the only sites that categorized <50% of calls as Code 4
- Timmins had the greatest proportion of Code 2 calls (20% for 2016)

Source: ARIS Reports
*Data from January-September 2016 was used to project the total volume for the year

Actual Spend Per CACC and Corresponding Call Volumes*

Spend varied from $1.7M to $21M relative to the number of calls received



- Toronto CACC had the highest actual spend and highest call volumes in FY15/16, while Parry Sound had the lowest actual spend and call volume

Source: ARIS Reports

*Call volumes represent Code 1-4 calls received

HR Data Analysis – Land Ambulance

HR Data Limitations

Analysis of HR data is limited by availability and quality of information across CACCs

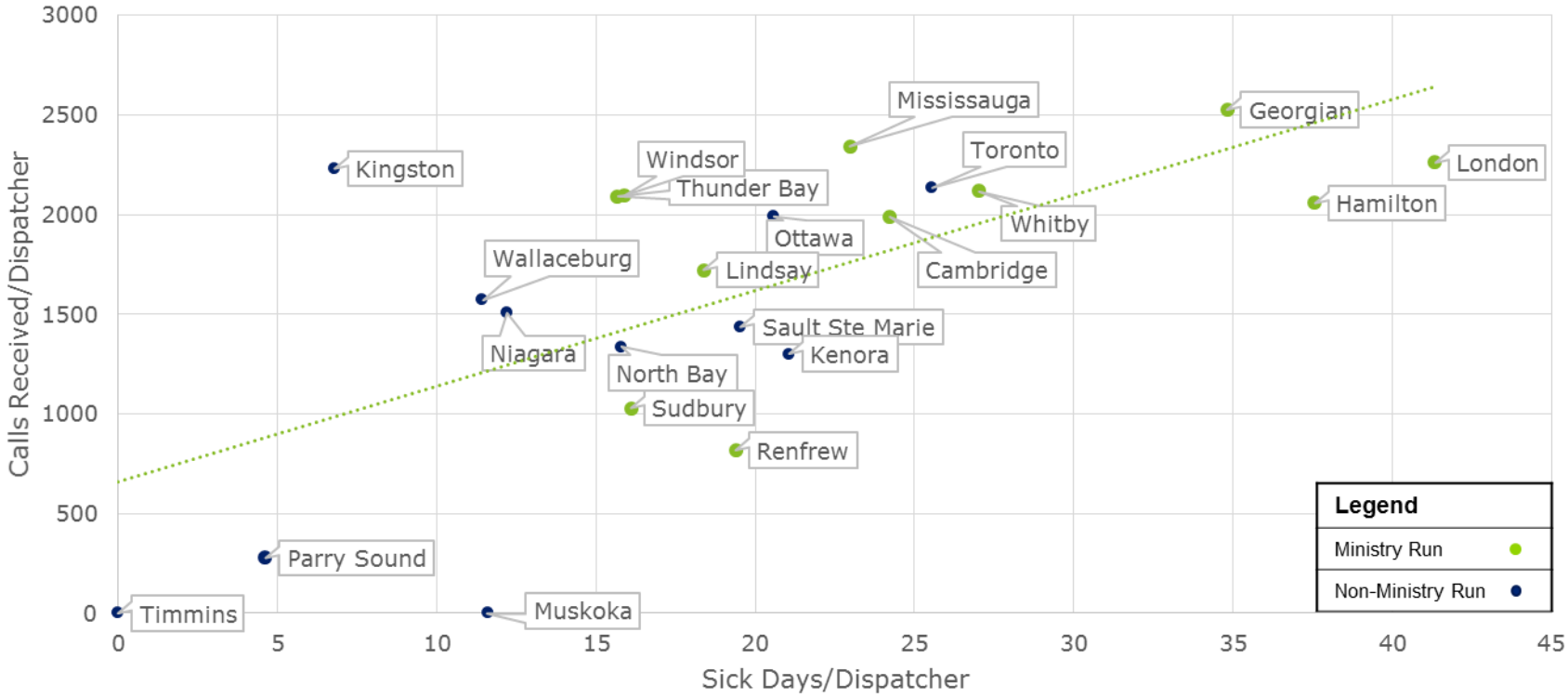
- As part of the current state analysis, our team reviewed HR-related data to gain insights into the operational practices and outcomes to determine impacts to trends, such as attrition, sick time, and overtime use.
- While the data request distributed to the CACCs included standardized HR data points, a number of issues emerged in the process to inform comparisons across regions.

Limited standardization	Variation in methodology to capture data, including role categories, which poses challenges in comparing span of control and responsibilities
Data quality	Limited availability to extract typical HR data easily (e.g., number of FTEs by role, overtime usage, turnover by employee vs. at an aggregate level, etc.), thus manual calculations required to generate data • Unable to extract overtime data for MOH-operated CACCs

With the limitations to the available HR data, only targeted analyses can be conducted and comparisons of CACC performance should be considered directional in nature

Call Volumes and Corresponding Average Sick Days per Dispatcher by CACC*

Trend shows a correlation between increased sick time volume of calls per dispatcher



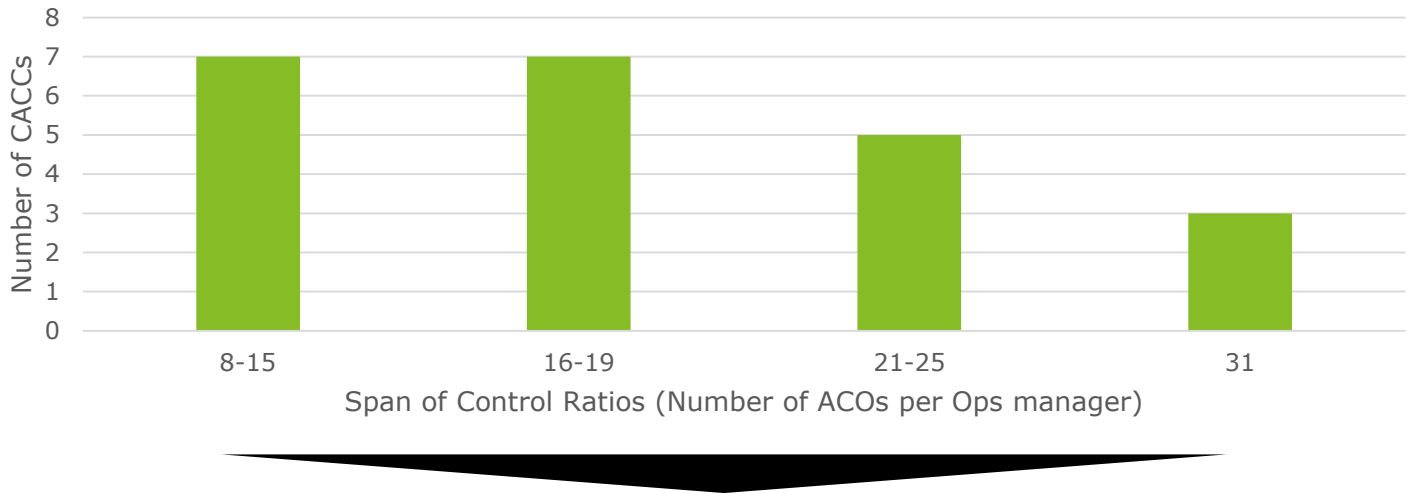
Note that on-call FTE information was not available for the Timmins and Muskoka CACCs, and number of sick days was not available for the Timmins CACC

*Call volumes represent Code 1-4 calls received

Span of Control in CACCs

Ratios of Operational Managers to Dispatch Officers is variable across CACCs

- The number of Operations Managers in CACCs ranges from 1-6, and is proportional to call volumes and number of employees
- Regardless of CACC size, at least one Operations Manager is required on staff
- Span of control for Operations Managers ranged from a ratio of 1 Operations Manager:13 ACOs to 1 Operations Manager:31 ACOs, averaging ~19 ACOs per Operations Manager



Further investigation is required into an optimal ratio for span of control, however opportunities for efficiencies of scale with regards to staffing exist in larger CACCs

Jurisdictional Review

Summary of Review of Jurisdictional Practices

Key highlights from the review of ambulance communication models in different regions provide opportunities to consider for the future state

- All jurisdictions reviewed had a **single governance entity** for oversight of ambulance dispatch
  - Current dispatch models establish **government as the overall oversight body** with only municipalities, hospitals, or private companies operating as direct service providers
  - For jurisdictions with contracted out services (i.e., USA and Nova Scotia), **performance based contracts** with penalties and incentives are used to ensure accountability
    - Regular **review** of performance and a combination of **process and outcome measures** allow for evidence-based decision making and evaluation of service providers
- Use of a **standardized triage system** across all dispatch centres is common in most jurisdictions
- Jurisdictions with **CAD to CAD compatibility** have 'borderless' dispatch allowing dispatch of resources from neighbouring communities and seamless back-up in the event of a system failure
  - Advanced telecommunication systems automatically re-route calls when dispatch centres are not able to receive calls
- Many jurisdictions have moved to an **expanded role of ambulance dispatch centres** where low acuity calls are referred to existing community resources
  - Built-in referral criteria during triage for low acuity calls can optimize use of existing healthcare resources
- Clear criteria and roles for use of air ambulance and inter-facility transfers to streamline processes and ensure clear accountability in emergency health services system
  - Use of **integrated communication systems between service providers** to enable prompt and clear sharing of relevant patient information and performance data
- Advanced **management reporting systems** enable centralized capture of employee data and shift reports, with real-time updates to managers on performance at multiple levels

Jurisdictional Overview – Nova Scotia

	Highlights
Overview	• Provision of emergency services governed by Nova Scotia EHS through a privately owned company – Emergency Medical Care (EMC) • One Medical Communications Centre (MCC) dispatches 160 ambulances from 60 ambulance bases
Performance Management and Monitoring	• EMC is obligated by a performance-based contract with the province • Performance targets include response times and qualifications for paramedics
Leadership and Structures	• The MCC, land ambulances, and air medical transport operation are all operated by EMC
Infrastructure, Technology Requirements	• Standardized communication through Computer Aided Dispatch (CAD) with mapping capability and automatic vehicle location (AVL) through GPS • Mobile terminals in trucks are able to communicate with CADs through specialized software
People and Roles	• All EHS Paramedics and dispatchers are employed by EMC and are unionized
Health Care System Integration Points	• Telecare – the government now contracts EMC to manage a standardized phone number where registered nurses provide advice to callers for their non-emergency scenarios – While most RNs work out of their homes, EMC provides space for a contact centre that can house up to 5 nurses at any time

Sources: Ross Patient Journey through Emergency Care in Nova Scotia (2010), Nova Scotia EHS website, Emergency Medical Care Inc., Auditor General Report

Jurisdictional Overview – British Columbia

	Highlights
Overview	• British Columbia Ambulance Service (BCAS) is the sole ambulance service provider and is managed by BC Emergency Health Services • Three dispatch centres in operation (Vancouver, Kamloops, and Vancouver Island), which dispatch both land and air ambulance • In total, the three dispatch operations centres receive ~1900 requests for emergency response per day
Performance Management and Monitoring	• Measures response times according to dispatch priority with a goal of achieving 9 minutes or less 75% of the time for "highest acuity" patients and 15 minutes or less 75% of the time for medium acuity
Leadership and Structures	• Local presence of front line leadership to ensure dispatchers have immediate access to on site supervisors for assistance
Infrastructure, Technology Requirements	• MPDS in place to triage calls at all BC dispatch centres • Standardized CAD technology connects all dispatch centres, while mobile CAD technology connects ambulances with dispatch centres • GPS/AVL in place in all ambulances
Health Care System Integration Points	• Dispatch Operations Centre operates the provincial Patient Transfer Coordination Centre (PTCC) which is the Central coordination hub for all inter-facility transfers across the province – Coordinates air and ground critical care transports primarily within BC, but will coordinate for international transfers if needed

Sources: BCEHS Strategic Plan 2015-2018, BCAS Communications Services – Fitch and Associates (2005), BCEHS Resource Allocation Plan 2013, BC EHS Process Review – Nickerson (2014)

Jurisdictional Overview – Alberta

	Highlights
Overview	• AHS is responsible for PS services across the province • Three dispatch centres – 2 operated by AHS and one by the City of Calgary • Three satellite centres – 1 operated by AHS, one by City of Red Deer, and one by City of Lethbridge
Performance Management and Monitoring	• Currently two different provincial PS data sets – challenges in using this data for comprehensive performance, quality and safety management • PS dispatch software in place to measure response times for a specific period of time, service, or geographical area
Leadership and Structures	• While AHS is responsible for PS services in Alberta, there have been challenges with consolidation of dispatch, leading to a mixed governance structure where some dispatch centres are operated by AHS and others are under contract
Infrastructure, Technology Requirements	• All dispatch centres currently use the same CAD platform but not the same instance of it, resulting in challenges with communication between centres • Majority of ambulances have on-board computers that communicate with the dispatch centre's CAD system, however there are still areas of the province that do not have this technology in place
People and Roles	• Transition of PS system to AHS has resulted in more standardized staff training, however challenges included a loss of local community knowledge and challenges for staff adjusting to a new organizational culture
Health Care System Integration Points	• Community Health and Pre-Hospital Support Program (CHAPS) allows Paramedics to refer patients to Home Care and other community services to reduce PS transport to emergency departments

Sources: Health Quality Council of Alberta (2013 report), Alberta Health Services website, 2009 Alberta EMS Dispatch Centre Site Evaluation

Jurisdictional Overview – Manitoba

	Highlights
Overview	• Regional Health Authorities (RHAs) are responsible for land ambulance service delivery – services are delivered directly by RHA or through contracts with affiliate agencies • Two dispatch centres with different models – one solely for PS dispatch in northern and rural Manitoba and inter-facility transfers (Manitoba Medical Transport Coordination Centre - MTCC), the other for fire and PS calls originating in Winnipeg (Winnipeg Fire Paramedics Service - WFPS)
Performance Management and Monitoring	• Current structure does not look at patient outcomes • No accountability or performance requirements in place by oversight body, no apparent reporting in place
Leadership and Structures	• Fire and ambulance service integration was supported by the City of Winnipeg and the Winnipeg Regional Health Authority (WRHA) • Regional management of ambulance service dispatch
Infrastructure, Technology Requirements	• AVL used to track location of all fire and PS vehicles, and the system dispatched to Electronic Patient Care Reports (EPCR) to all PS and supervisor vehicles • CAD system not consistent between the two communication centres
People and Roles	• Fire and PS dispatchers work under different collective agreements with a formal work sharing agreement
Health Care System Integration Points	• MTCC is the dedicated dispatch centre for PS services as well as all inter-facility ambulance transfers for the province • WFPS is responsible for dispatching all emergency and non-emergency calls for service for PS and fire originating in Winnipeg

Sources: Manitoba EMS System Review (2013), Regional Health Authorities of Manitoba website, Medical Transportation Coordination Centre website, Winnipeg Fire Paramedic Service website

Jurisdictional Overview – United States of America (select cities)

	Highlights
Overview	• Ambulance dispatch in the United States is variable with some cities using "low-tech" approaches to dispatch, while others have very advanced technology in place • Systems range from publicly operated PS structures to private/for profit PS, depending on the needs of the population
Performance Management and Monitoring	• Both MedStar and RAA have set performance standards of responding to the highest priority calls within 9 minutes, 90 percent of the time • Recommendations by the American Ambulance Association include having performance based contracts in place that measure clinical excellence, response-time reliability, economic efficiency, and customer satisfaction
Leadership and Structures	• American Ambulance Association recommends arms length oversight for contracted emergency services to monitor performance against other high-performance systems, and ensuring established service requirements are met
Infrastructure, Technology Requirements	• MedStar and RAA both have System Status Management (SSM) tools in place, which use predictive modeling to determine the best placement of available vehicles • All systems utilize MPDS for ambulance dispatch triage levels – REMSA and RAA both use ProQA, which is the software version of MPDS
People and Roles	• REMSA has monthly continuing education in place as well as online training modules to educate staff
Health System Integration Points	• REMSA and MedStar: Low or no acuity 911 calls are transferred to a specially trained RN in the communications centre, who evaluates needs and connects patients to the best/most appropriate resource • REMSA: Integrated land and air ambulance dispatch centres – simultaneous dispatch while providing care instructions to callers

Sources: Fort Worth, Texas (MedStar), Reno, Nevada (REMSA), and Richmond, Virginia (RAA) websites, American Ambulance Association website,

Jurisdictional Overview – United Kingdom

	Highlights
Overview	• NHS provides funding to Clinical Commissioning Groups, which come together to purchase ambulance services through NHS Trusts • 13 ambulance services trusts throughout the UK, operated by different organizations
Performance Management and Monitoring	• Performance of every NHS ambulance provider is measure and benchmarked by the government • Numerous benchmarked targets including time to answer calls, time until treatment by an ambulance, call abandonment rate, as well as outcome measures for stroke and cardiac arrest
Leadership and Structures	• Department of Health governs legislation on Ambulance Trusts • Clinical Commissioning Groups funded by NHS to purchase ambulance services for their regions
Infrastructure, Technology Requirements	• Standardized communication through Computer Aided Dispatch (CAD), Mobile Data Terminals • AMPDS in place for identifying dispatch priority as well as NHS Pathways in some dispatch centres • 999 calls are passed to British Telecom and then to designated emergency services – calls will be passed on to another ambulance dispatch centre if the initial centre does not respond – PSAP is operated by British Telecom
People and Roles	• Volunteer community first responders (CFRs) in place – members of the public who have received training to answer ambulance 999 calls and respond immediately within their local area, during their own time

Sources: Ambulance Care in Europe (2010), Transforming NHS Ambulance Services (2011), NHS website, Association of Ambulance Chief Executives website

Jurisdictional Overview – Medavie

	Highlights
Overview	• Medavie is a health company, consisting of Medavie Health Services and Medavie Blue Cross • Medavie Health Services manages a number of subsidiary companies in emergency medical services (EMS), mobile integrated health, telehealth, medical communications, public safety delivery and clinical training • Medavie Health Services currently provides EMS services in six Canadian provinces and in Massachusetts in a number of different services models including end-to-end services in Nova Scotia; land and air ambulance services in New Brunswick; 911 call-taking services, pre-hospital emergency care and non-emergency transfers in Prince Edward Island; community paramedicine and call processing in Saskatoon; and ground ambulance services in a number of areas across Canada
Performance Management and Monitoring	• In Nova Scotia, Medavie operates under a performance based contract with annual performance reviews – while high level reporting is provided to the government (e.g., overall response times), this data is broken down and reviewed internally to identify limitations and mitigation strategies
Infrastructure, Technology Requirements	• Dispatch centres in Nova Scotia, New Brunswick and Saskatoon use MPDS to triage calls and have all achieved accreditation through the International Academies of Emergency Dispatch • Communication centres can coordinate sending patient information to receiving hospital facilities, often through fax; currently exploring virtual whiteboard technology for better integration of services with hospitals
People and Roles	• Contracts often have an Accreditation requirement to drive quality and safety in the system – focus of Accreditation is on ensuring that appropriate advice is provided to callers and sufficient information is obtained to dispatch resources

Sources: Interview with Medavie Senior Leadership, Medavie website

Jurisdictional Overview – Medavie

	Highlights

People and Roles cont'd	• Medavie has a number of subsidiaries that have achieved accreditation including
	  • Prairie EMS – the first private Ambulance operator in Alberta to receive Qmentum accreditation
	  • EHS in Nova Scotia – accredited by the Commission on Accreditation of Ambulance Services (CAAS), National Academies of Emergency Dispatch (NAED), and Commission on Accreditation of Medical Transport Systems (CAMTS)

Health Care System Integration Points	• Have experience integrating EMS system with 811 in Nova Scotia, which is a provincial health care service offering 24/7 telecare service through a registered nurse (RN)
	  • Medical dispatch centres are used as a hub for appropriately triaging and coordinating incoming calls in order to optimize coordination and improve the accessibility and delivery of primary health care
	  • It is reported that this has reduced ambulance dispatch volumes by appropriately redirecting low priority calls

Lessons Learned	• Important to identify a vision for service provision (i.e., public safety vs. alignment with health system transformation) and ensure that structure of emergency services aligns with vision • Achieving true integration of a system requires uniformity and alignment across service providers; this will contribute to efficiencies in the system and allow for effective allocation of resources

Sources: Interview with Medavie Senior Leadership, Medavie website

BCEHS | BC Emergency Health Services

Appendix 2

FACT SHEET

June 2018

Clinical Response Model

- As of May 30, 2018 BC Emergency Health Services (BCEHS) has updated the system for how it assigns paramedics, ambulances and other resources to 9-1-1 calls.
- The new Clinical Response Model (CRM) is aimed at more accurately matching resources to the needs of the patient.
- It is one of the many changes being made as part of the three-year BCEHS Action Plan to improve patient care.
- The focus of the CRM is to get paramedics to the most critically ill and injured patients as quickly as possible, and to improve the health-care experience for all patients.
- The CRM replaced the Resource Allocation Plan (RAP), which assumes ambulance transport for every patient.
- As with the previous system, the condition of the patient is categorized by dispatch staff using the Medical Priority Dispatch System (MPDS). Once the condition is categorized, resource assignment is determined using the Clinical Response Model.
- The CRM uses a colour-coding system with some similarities to the colour system used in hospitals (see chart below).
- The CRM provides for six categories (vs. RAP's three) for assignment of resources for both emergency and non-emergency calls.
    - The RAP responses were: BLS 2 (Basic Life Support ambulance going non lights and sirens); BLS 3 (Basic Life Support ambulance going lights and sirens) or HL3 (Highest level paramedics and ambulances available going lights and sirens).
    - CRM responses include six colour codes. The colour indicates the resource and response type for an event and it also indicates the relative priority of the call, with Purple being the highest priority.
        - Calls that are assigned the colour Blue will not be immediately dispatched. Blue calls will be flagged for a patient callback and further clinical assessment by a nurse to determine if their need can be met without transportation.
        - At this time, no 9-1-1 calls will be categorized as Green. Including Green within the current Clinical Response Model allows for the future introduction of on-scene assessment and treatment protocols ("Treat and Release").
- BCEHS receives approximately 140,000 calls per year that are non-urgent. BCEHS estimates that slightly more than half of these calls could be resolved without ambulance transport.
    - About 3,500 of these calls are already transferred to nurses at HealthLinkBC.
- In 2017, the Emergency Health Services Act was updated to allow BCEHS to provide alternative clinical responses to patients calling 9-1-1.
- The BCEHS CRM has been implemented in other major jurisdictions resulting in improvements in the patient experience and clinical outcomes. Examples of the CRM system can be found in Scotland, Wales and Victoria, Australia.

BCEHS | BC Emergency Health Services

FACT SHEET

Patient Condition	Colour
Immediately life threatening (Eg. Cardiac Arrest)	**Purple**
Immediately life threatening or time critical (Eg. Chest Pain)	**Red**
Urgent / Potentially serious, but not immediately life threatening (Eg. Abdominal Pain)	**Orange**
Non-urgent (not serious or life threatening) (Eg. Sprained Ankle)	**Yellow**
Non-urgent (not serious or life threatening). Possibly suitable for treatment at scene **** NOT Being implemented immediately**	**Green**
Non-urgent (not serious or life threatening) Further clinical telephone triage and advice Referrals to HealthLink BC (8-1-1 calls)	**Blue**

Contact: BCEHS Communications
media@bcehs.ca

Media Line: 778-867-7472

Appendix 3: Community Paramedicine

Appendix 3

Community paramedicine programs currently running throughout the province vary in scope depending on the needs in the community (1). Some offer more in-depth or wider ranging services than others. The Ontario Association of Paramedic Chiefs recommends expanding community paramedicine throughout the province retaining flexibility at the local level.

It is important to note that partnership with other healthcare professionals and alignment with Ontario Health Teams, primary care and Family Health teams are keys to the success of community paramedicine programs. Through collaboration and integration with healthcare teams, community paramedics can play a pivotal role in achieving positive patient and system efficiency outcomes.

Positive findings to date

For 9-1-1 callers, community paramedicine programs can provide timely and appropriately resourced navigation to specialized services. They can also help reduce hallway healthcare with effective management of short to mid-term episodic care.

As part of a healthcare team, community paramedicine programs have been shown to:

- reduce costs (2-5) **Example**: Mean reduction in health utilization costs of 56% for enrolled patients (5)
- improve efficiency (4, 6, 7) **Example**: Mean reduction in case management time of greater than two hours per patient, with greater efficiency realized over longer enrollment periods (4)
- reduce hallway healthcare by:
    - shortening length of stay via early detection of deterioration using paramedic-led remote patient monitoring (4) **Example**: Mean reduction in hospital length of stay of 7.1 days for enrolled patients (4)
    - reducing readmissions by connecting 9-1-1 callers to preventative community-based services (4, 8-12) **Example**: 78% of enrolled patients were evaluated, treated, and remained at home (8)
    - reducing emergency department visits by reducing avoidable emergency department visits) (4, 7, 9, 13) **Example**: Less than 6% of enrolled patients required treatment in the ED within 48h of calling 9-1-1 (9)
    - helping patients navigate the system (14-20) **Example**: Treatment and transport options were identified as contributing factors of improved health outcomes (17)

Community Paramedicine…

- **…is a mobilized service able to respond in real time to unexpected events.** Leveraging existing expertise community paramedicine is able to respond to 911 callers and clients in a highly agile manner that cannot be duplicated by other “mobile” health teams, which often require pre-planned scheduled visits. Community paramedics, as mobile healthcare providers, are able to see patients through both scheduled and unscheduled visits, supporting patients with care “in-place,” and assisting with transportation when necessary.

- **… is an adaptable element of patient-centered, integrated care.** Community paramedicine

programs work with multiple stakeholders across multiple disciplines and specialties to support, develop and implement care plans aimed at keeping people safe at home. Community paramedicine programs can include screening, assessment, and navigation to appropriate services for all major populations – chronic conditions, frequent fallers, frail elderly, palliative care at home patients, high risk emergency department discharges, and mental health & addictions.

- **… contributes to safe care transitions and supports other healthcare team members in ensuring a successful return to community settings.** Community paramedicine programs have been designed to include linkages with primary care providers, real-time notification processes, medication reviews, health promotion, patient and caregiver support and education, and integration and coordination with hospital discharge planners and/or home care coordinators.

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ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

1 Yonge Street, Suite 1801, Toronto, ON M5E 1W7
www.emsontario.ca

July 3, 2013

Health Professions Regulatory Advisory Council
56 Wellesley St W., 12th Floor
Toronto, Ontario, Canada M5S 2S3

Re: Paramedic Self-Regulation

The Ontario Association of Paramedic Chiefs (OAPC) submits this letter to the Health Professions Regulatory Advisory Council (HPRAC) to provide input as to whether paramedics should become a self-regulated profession. To this end, the OAPC seeks a meeting with the HPRAC to provide its perspective on the merits of paramedic self-regulation and the potential establishment of a college of paramedics.

The OAPC was chartered as the Association of Municipal Emergency Medical Services of Ontario (AMEMSO). Rebranded in 2012, it represents all fifty-two (52) Ontario EMS designated delivery agents (municipalities), some first nations EMS, and Ornge. The OAPC's members represent Ontario's EMS leadership: chiefs, deputy chiefs, and other leadership personnel. Through its body of work, it is now recognized as an authority on matters relating to the delivery of paramedic emergency medical service to the residents of Ontario.

The mission of the OAPC is: *"Promoting a culture of change surrounding paramedicine that is guided by evidence based decision-making and seeks best practices in the provision of service".* In its pursuit of a world-class EMS system for Ontario, the OAPC has the following goals:

1. To be recognized as the leading authority for developing evidence based expertise in system design and delivery;
2. To be recognized as a trusted advocate for patients as an advisor towards the development of responsible public policy; and
3. To recognize performance excellence and provide "best practice" management tools and resources to its members.

Attached, we offer a summary of our key points in this regard, and we request further discussion on these points.

Sincerely,

Norm Gale
President

Copy: OAPC Membership

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Appendix 5

ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

PARAMEDIC SELF-REGULATION

Being recognized as the leading authority for developing evidence-based expertise in system design and delivery, the OAPC believes:

- The central issue related to paramedic self-regulation is that of improving patient safety
- That by establishing appropriate, evidence-based care guidelines, patients will receive equal access to the highest quality of paramedic care
- That a paramedic regulatory college would allow paramedics to deliver alternative models of paramedic care and that alternative care models will further enhance the lives, health and well-being of Ontarians
- That establishing a paramedic regulatory college would create system efficiencies and provide an opportunity to increase the efficiency of health care delivery and give the health care system greater flexibility and capacity
- That establishing a paramedic regulatory college will clearly define the lines of transfer of patient care between providers and that this definition will result in much improved, safer patient experience in their journey through the health care system

Being recognized as a trusted advocate for patients and as an advisor towards the development of responsible public policy, the OAPC believes:

- That clear definitions of responsibility for care improves patient safety
- The regulatory college of paramedics would provide for increased transparency in that there would be less political influence, processes would be streamlined and paramedic certification would have less influence on the funding provided to current base hospital programmes
- A centralised regulatory body would provide consistent over-sight to ensure that all paramedics across Ontario receive the same continuing medical education quality, quantity and requirements as well as a consistent approach to licensure - adding to the safety of the care provided by paramedics
- That establishing a paramedic regulatory college that replaces other regulatory agencies is most appropriate as a peer-based professional authority is best positioned to streamline existing processes and practices enhancing patient safety and continually improving paramedic patient care
- That paramedics in Ontario are currently heavily regulated by multiple agencies and that by managing the bureaucracy efficiencies will be found easily and naturally
- A clear definition of the profession would emerge from the formation of a regulatory college for paramedics

ONTARIO ASSOCIATION OF PARAMEDIC CHIEFS

PARAMEDIC SELF-REGULATION

Recognising performance excellence and provide "best practice" management tools and resources to its members, the OAPC believes:

- That a paramedic regulatory college would be a responsive and agile system whereby current best practices could be implemented – ensuring care is up-to-date and most appropriate
- A centralised college of paramedics would ensure adequate over-sight of the profession ensuring all providers are engaged in the implementation of paramedic care best practices
- Peer review of any instances of complaints relating to paramedic care is a professional, appropriate and powerful tool to enhance and ensure patient safety
- A paramedic peer review structure within a regulatory college will bring forward clear research opportunities further bringing system efficiencies to the profession

Appendix 6

Understanding Professional Self-Regulation

Glen E. Randall BA, MA, MBA, PhD candidate, *Founding Registrar of the College of Respiratory Therapists of Ontario (CRTO) 1993 - Nov 2000*

In the course of daily life, people routinely come together to make business transactions in which they buy and sell products and services ranging from groceries to dental care. When making these transactions, some people may be disadvantaged as compared to others, due an imbalance of information and knowledge. While the average person will be able to determine when a piece of fruit has spoiled, they may have greater difficulty knowing if their car engine is beyond repair, or if they really require a root canal on a tooth. To address this problem, governments regulate a great deal of commercial activity within society, in order to create a more level playing field between experts and the general public.

Government has a wide range of mechanisms at its disposal to influence or control business transactions. When it comes to regulating transactions between the public and professionals, governments are expected to make sure that the public has some form of protection. For instance, government rules help to ensure that our legal system is fair, teachers are knowledgeable, accountants behave in an ethical manner, and physicians are competent. Examples of government regulation range from rules requiring informed consent when a member of the public has a medical procedure performed, to rules about insider trading for buying and selling stocks. Overall, it is believed that such rules create a fairer system. One of the most common approaches used by government to regulate the practice of professionals is through a system of professional self-regulation.

What is Professional Self-Regulation?

Professional self-regulation is a regulatory model which enables government to have some control over the practice of a profession and the services provided by its members. Self-regulation is based on the concept of an occupational group entering into an agreement with government to formally regulate the activities of its members[1]. The agreement typically takes the form of the government granting self-regulatory status. This is done through a piece of legislation which provides a framework for the regulation of a specified profession, and identifies the extent of the legal authority that has been delegated to the profession's regulatory body.

The specific legal authority transferred from government to the profession's regulatory body varies with different regulatory models. In exchange for the benefits of professional status, the regulatory body of a profession is expected to develop, implement, and enforce various rules. These rules are designed to protect the public by ensuring that services from members of the profession are provided in a competent and ethical manner. This legal authority often includes: the right to set standards for who may enter the profession; the right to set standards of practice for those working in the profession; and the right to create rules for when and how members may be removed from the profession[2].

The self-regulatory model also generally requires that a regulatory body put in place a complaints and discipline system. Such a system permits members of the public to raise concerns about services a professional provides to them, as well as provides a process to investigate and, if necessary, discipline any member of a profession who fails to meet professional standards of practice. It is expected that all of a regulatory body's decisions and activities will be done in the "public interest." In other words, the primary purpose behind all regulatory body decisions is to protect the public from incompetent or unethical practitioners.

Approaches to professional self-regulation range from minimal to extensive control over a profession. Governments select from among different regulatory approaches, based on the nature of the activities performed by a profession's members, and the extent to which the public might be harmed if an incompetent member of a profession provided services. Professional self-regulation may take the form of licensure, certification or registration. While the process of *registration* can be as simple as a requirement to ensure that one's name is recorded on some official record, the processes of licensure and certification have more onerous requirements.

Licensure is one of the most restrictive forms of professional regulation. Specifically, licensure provides an occupational group with monopoly control over who can practice a profession. Only those individuals who have met specific requirements to enter a profession are issued a "license" to practice the profession. Entry requirements are generally quite detailed and often include attaining specified educational requirements and completion of some form of licensing examination.

Certification is essentially the stamp of approval given to an individual for meeting predetermined requirements. Certification is often associated with monopoly use of a specific title or professional designation. This model protects the public by providing information about qualifications so that the public can make an informed decision about who they want to receive services from.

In recent years, in order to improve their accountability to the public and limit the monopoly control that some professions had attained, many regulatory models around the world have undergone reform. These reforms have attempted to provide the public with access to a more transparent regulatory system, as well as greater choice in who can provide various services. As a result of this desire for transparency and choice, more sophisticated forms of regulation have evolved, which might be described as hybrid models - combining different features of licensure, certification and registration.

Ontario's health professions, for example, are regulated under the *Regulated Health Professions Act, 1991*[3] . This piece of legislation has created a new and innovative model for professional self-regulation which no longer gives professions an exclusive scope of practice. Rather, the legislation provides for overlapping scopes of practice, whereby different professionals may carry out the same activities. This overlap offers the public maximum flexibility to determine which professional he or she wants to provide a service.

At the same time, the regulatory model provides title protection for each of the professions, which allows the public the ability to identify which individuals possess which skills.

Jurisdictions around the world have been interested in this new hybrid model for professional self-regulation. This is especially true of other Canadian jurisdictions. This interest suggests that any new occupation, to receive professional self-regulation, can expect to have aspects of a hybrid model incorporated into its regulatory framework.

Why Have Self-Regulation?

In Ontario, professional self-regulation has been used as a means of controlling the practice of some professions for more than 200 years. Government authority delegated to these professions has provided them with a great deal of autonomy and authority in determining both how many, and who, would be allowed to enter each profession. This control has also allowed the professions to limit the supply of professionals, which has ultimately translated into higher incomes for individual members[456].

Today in Ontario, there are more than three-dozen self-regulating professions, ranging from physicians and lawyers to architects and veterinarians. The majority of these self-regulating professions are health professions. This high percentage makes sense since incompetent or unethical health professionals run a high risk of causing harm to the public. Nonetheless, practitioners of other occupations can also cause harm to the public. For example, incompetent engineers can cause buildings to collapse and unethical accountants could embezzle your life savings.

In the later half of the Twentieth century, criticism of the self-regulating professions became wide-spread. The public came to see the monopoly control these professions had as simply a means of increasing the personal wealth of their members, rather than as a way to protect the public from incompetent or unethical practitioners. During this time, formal models of self-regulation have undergone fairly dramatic transformations. The emphasis of self-regulation has shifted from a focus on protection of the profession, to a focus on protection of the public.

Despite this greater emphasis on making the self-regulating professions more responsive and accountable to the public, numerous occupational groups continue to seek government support to become self-regulated professions. This raises the questions: why is self-regulatory status so desirable and what exactly does a profession gain from this exercise? The reality is that when an occupational group is granted the privilege of self-regulation, it gains a great deal. This includes greater autonomy and control, professional prestige and, in many cases, financial rewards.

Greater autonomy and control translates into independence of individual members of a profession to carry out activities with less or no supervision. It also means more autonomy and control for the profession as a whole. Under professional self-regulation, the regulatory body for a profession is able to set entry requirements and standards for practicing the profession, rather than having government, or another profession, impose requirements on the profession. In addition, the regulatory body provides the profession with a means of gaining access to government, which allows it to express its point of view and even negotiate for additional authority.

Prestige comes from attaining “professional” status and all of the benefits that go along with that status. Financial rewards resulting from self-regulation are difficult to quantify and they generally take several years to accrue. The financial benefits to professionals stem, in part, from the increase in demand for the services of a profession due to the public’s greater assurance that these professionals meet high standards.

Governments can also gain a great deal from allowing an occupational group to self-regulate. This form of regulation allows government to demonstrate that they have taken action to protect the public, but in a way that minimizes the government's role. Regulating through a regulatory body also allows for greater flexibility in the regulatory process as rules can often be developed more quickly. The government saves the expense of hiring experts to assist with creating unique rules and standards for the profession. The self-regulatory model also transfers the cost of regulating from government to the profession itself. Most importantly, the self-regulatory model helps to insulate government from the actions of individual members of a profession or the rules put in place by its regulatory body.

One of the most persuasive arguments in favour of self-regulation is that an occupational group has evolved over time and developed a specialized body of knowledge which makes members of the group experts. Because the knowledge these members have is so specialized, it would be difficult and expensive, for the government to determine and monitor standards of practice for the profession. It is therefore thought that members of a profession are in the best position to set standards and to evaluate whether they have been met.

The regulatory body of a profession has significant autonomy from government in regulating its profession. Nonetheless, since a regulatory body's legal authority is delegated from government, there needs to be some mechanism to ensure public accountability. This accountability of a profession is often facilitated through a reporting requirement to the government, usually through the Minister from the department which sponsored the legislation giving the group self-regulatory status. While the government generally has an arms-length relationship with the self-regulating profession -that is, it is not expected to interfere directly with the regulatory bodies decision making process - it often retains some ability to direct the regulatory body to do as it wishes under threat of removal of the profession's self-regulatory status.

Another common method of holding a regulatory body accountable to the public is through the appointment of members of the public to its governing Board. Some organizations may have only one token public member, while others can have a majority of the Board appointed by government. In Ontario, self-regulatory legislation for the health professions mandates that just under half of each Board is composed of public appointees. Some would argue that such a large proportion of Board members need to be public members in order to ensure that there is effective public participation and that the organization makes its decisions in the public interest, as well as remains accountable to the public. Others would argue that having such a large proportion of public representatives on a regulatory body's Board runs contrary to the principle of self-regulation. They would argue that only members of the profession, with specialized knowledge of the profession, are able to make decisions about the practice of the profession.

Qualifying for Self-Regulation

The move towards self-regulation is typically a long journey. In order to qualify for self-regulation, governments tend to consider several factors. First, government considers whether there is a risk of harm to the public from members of the occupational group. The basic philosophy of the self-regulatory model is that if there is no risk of harm to the public, there is no need for any form of government intervention, including self-regulation, which might limit who can provide a service. Under this circumstance, the greater choice of service provider the public has the better.

Second, the occupational group needs to be large enough to have adequate resources to implement a self-regulatory model. The resources required for self-regulation is quite significant. This means having adequate financial resources, as well as the commitment of enough members of the profession to assist with creating the standards and rules that will be necessary for the self-regulatory process to be implemented. Almost all self-regulating professions are expected to finance these activities through fees paid by members, who are required to maintain their memberships in order to practice the profession. As a result, it is uncommon for governments to allow smaller occupational groups to become self-regulated.

Lastly, the occupational group needs to have a defined body of knowledge that may be attained through specified education and does not overlap significantly with another occupational group. If the body of knowledge is too esoteric, or is already possessed by other occupational groups, it becomes impractical to set standards of practice for the profession.

What Does a Regulatory Body Do?

Regulatory bodies are expected to act in the public interest and not in the interest of the profession they regulate. In many situations, the public interest and the profession interest may be the same. In situations where they are not the same, it is the role of the professional association to represent the interests of the profession, while the regulatory body considers the public. Because of the conflict between making decisions in the interest of the public versus that of the profession, governments often requires a separation between regulatory body and professional association[7]. Despite this potential conflict, in some circumstances, such as the profession is newly regulated, fairly small, or the risk of harm to the public is relatively low, government may allow both the professional association and regulatory body to co-exist as one organization. Nonetheless, the public interest is expected to take precedence in making decisions related to regulatory functions. Failure to do so leaves the profession open to losing its self-regulatory status and potentially being regulated directed by government.

The main functions of a regulatory body include: (1) setting requirements for individuals to enter the profession; (2) setting requirements for the practice of the profession; (3) setting up a disciplinary process; and (4) setting up a process to evaluate the on-going competence of members. For most occupational groups that are seeking professional self-regulation, they have already determined entry requirements and have developed standards of practice. In most cases, these requirements will have evolved over time and become informally adopted within the profession, despite lacking the same legal authority they will have under a regulatory body. Likewise, more advanced occupational groups will also already have a process in place for removing undesirable members. However, under a self-regulatory model, this process will probably have to become more formal and transparent.

Finally, a new regulatory body will need to implement some mechanism to assess the on-going competence of members. Again, more advanced occupational groups may have some form of quality assurance already in place. Determining a method for evaluating continuing competence is often the most controversial activity performed by a regulatory body. There is controversy because quality assurance has such a dramatic impact on the individual members of a profession, due to the stress associated with complying with any requirements. Should a member fail to comply with the quality assurance process, or fail to meet current competency standards, the member might be compelled to undergo additional training or run the risk of being removed from the profession.

Quality assurance programs can also be controversial due to their high costs. One of the most common approaches to quality assurance has been to require a minimum number of education credits. This approach is the easiest to implement and is therefore often a starting point for new professions. Professions which use this approach are numerous and include health professions, lawyers, and real estate agents, to name a few. However, research questioning the value of this education credit approach is gaining support. While proponents see the education credit system as a good way of ensuring that professionals continue to expose themselves to ongoing education, critics argue that these system are too focused on the process of education without having any knowledge of whether professional actually learn anything when they attend educational events.

One of the most popular methods of overcoming the deficit of credit systems has been to require professionals to maintain a professional portfolio. This portfolio not only documents a professional's attendance at educational events, but also includes documentation of how those educational events relate to his or her specific educational needs as well as how what he or she learned is translated into the daily practice. While this professional portfolio approach to continuing competence is more proactive than the educational credit approach, it has been argued that it fails to adequately protect the public from members of the profession who are good at maintaining a professional portfolio but actually have not maintained their competence.

To address this dilemma, in some professions, where the potential risk of harm to the public is relatively high, the competence of professionals may be re-assessed on an ongoing basis. This may be done through a peer assessment process, where a professional is observed in his or her normal work environment, or a more formal assessment process, which re-evaluates competence in simulated environments. Examples of professions which undergo this more intensive assessment of their continuing competence include physicians, pharmacists and airline pilots. Where the potential risk of harm to the public is not as high, more cost effective and less stressful approaches to assessing continuing competence may be more appropriate.

Conclusion

Attaining self-regulated status not only sends a message to society about the expertise and professionalism of an occupational group, but also provides members of the profession a priceless opportunity to gain control over their future and that of the entire profession. In the absence of self-regulation, at best, occupational groups can expect to be relegated to the status of second class citizens in a world which has come to highly value professionals. Making the move towards professional self-regulation is one which each occupational group will have to make after thoughtful deliberation. Ultimately, self-regulation has tremendous benefits – but with those benefits come costs and responsibilities.

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Submission to the EMS Consultation Process
March 3, 2020
Hamilton, Ontario

Michael Sanderson,
Chief, Hamilton Paramedic Service

Thank you for the opportunity to provide feedback and submission to the consultation process regarding modernization of land ambulance service delivery. This submission is provided to support the consultation process that has been initiated by the Ministry of Health regarding modernization of Land Ambulance Service in the Province of Ontario. Except where there are differences identified within this document support is expressed for the submissions of the Ontario Association of Paramedic Chiefs (OAPC) and the Association of Municipalities of Ontario (AMO) who have considered, and received input from our municipality, on many of these same issues. There are however some issues, and some approaches that are unique to the City of Hamilton, and some perspectives that have been gained from many years of leadership activity in EMS across both Ontario and Canada.

Summary

1. The foundational principles of seamless, accessible, integrated, accountable, and responsive ambulance service delivery should continue to guide the direction of ambulance system development.

2. Three outstanding consensus recommendations from the Land Ambulance Transition Taskforce (LATT) should be resolved in the modernization process. These include:

    a. Establishment of an operational dispute resolution mechanism;

    b. Establishment of a College of Paramedics; and

    c. Dispatch reform

3. Recommendations are provided in various sections of this submission on the following subject areas, summarized as follows:

    a. Dispatch services, including recommendations that operational responsibility for dispatch be transitioned to the Land Ambulance Service Provider and that core dispatch funding remain a Ministry responsibility;

    b. Accreditation should be pursued as a replacement for the existing Ambulance Service Review (ASR) process;

    c. Delays in transfer of care on arrival at hospital continue to create systemic pressures as paramedics perform hospital hallway medicine. Cost of this hallway staffing should be reimbursed by the Ministry to the ambulance service provider, removing the additional cost burden from the municipal tax base;

    d. Inter-facility transfers should be the subject of a fully integrated Provincial working group.

i. Terms of reference from successful implementation in another provincial jurisdiction are provided.
ii. All inter-facility transfers should be coordinated through the respective CACC and the process of booking and scheduling should be automated
iii. Legislation should be considered to provide for the capacity to contract out delivery of low acuity non-urgent patient transfers to an appropriately qualified patient transfer service; and
iv. The Ministry should fully fund the cost of all inter-facility patient transfer service.

e. Community Paramedic programs should continue to be developed to match specific community needs. These programs should be integrated fully with the respective Ontario Health Teams and funded through the respective Ontario Health regional delivery program;

f. Ministry funding of land ambulance delivery should continue at a minimum level of 50% of the respective council approved operational budget inclusive of municipal overhead costs. The current one year lag in funding should be eliminated through implementation of one time funding processes.

g. A College of Paramedicine should be established under the Regulated Health Care Practitioners Act. The scope of paramedic practice, and the performance of delegated medical acts should be revised to reflect a Certification – Registration – Authorization paradigm. Base hospital funding should be redistributed to the respective land ambulance service providers who would then be required to establish appropriate medical oversight for both delegation and quality review.

The details and background to these summarized recommendations are provided below.

Prior Reports

Before addressing the questions from this current consultation session on modernization it is important to recognize that some of the issues being addressed now have previously been addressed, and that joint consensus recommendations from prior consultation on these issues remain outstanding.

In March 1998 the Ministry of Health and the Red Tape Commission created the Land Ambulance Transition Taskforce (LATT) to address changes contemplated with the revisions to the Ambulance Act which were to take effect in the year 2000. The LATT mandate was:

1. review and analyze outstanding issues relating to the transition of land ambulance services and provide advice on resolving each such issue (e.g. criteria for licensing operator, criteria for Upper-tier Municipalities to assume full responsibility, etc.),

2. provide advice on proposed land ambulance service performance, patient care and delivery standards,
3. review and analyze the appropriateness and content of proposed implementation plans,

4. provide advice to the Ministry of Health on principles and practices for transferring financial and operational responsibility to municipalities for land ambulance services,

5. provide advice to the Ministry of Health on policies and practices relating to the recovery of funds from municipalities and the municipal role in information and decision-making during the transition period.

Representation on LATT was broad including Ministry of Health staff, ambulance service interest groups, central ambulance communications centres, Ontario Hospital Association, Association of Municipalities of Ontario, municipal staff representatives, and the Provincial Base Hospital Advisory Group.

By consensus, the LATT adopted the following principles which were used to develop its recommendations for a patient-focused ambulance system:

· **Seamless**: The closest available and appropriate ambulance will respond to a patient, at any time, or in any jurisdiction, regardless of the political, administrative or other artificially imposed boundaries.

· **Accessible**: Municipalities have a responsibility to ensure reasonable access to ambulance services. Municipalities have an obligation to ensure that ambulance services respond regardless of the location of the request.

· **Accountable**: Municipalities have an obligation to ensure that ambulance services be provided according to the legislation and regulations. The level and quality of care that is provided to patients by municipalities will be monitored by a designated base hospital program.

· **Integrated**: Municipalities are required to ensure that land ambulance service be an integral part of the health care system of the province. The province is required to ensure the transport of patients by ambulance between health care facilities for medically essential services.

· **Responsive**: Municipalities will be responsive to the fluctuating health care, demographic, socio-economic and medical demands of the constantly changing environment.

While many aspects of the LATT, and of the subsequent Land Ambulance Implementation Steering Committee (LAISC), have been addressed there remain three major outstanding consensus recommendations from the final LATT 1998 report:

1. **Operational Dispute Resolution**: The establishment in Regulation or legislation of a dispute resolution mechanism to resolve disagreements on non-medical operational issues arising between the MOH, designated Base Hospital programs, and the Designated Delivery Agents / Upper Tier Municipalities;

2. **College of Paramedics**: The establishment of a self-regulatory college for paramedics under the Regulated Health Professions Act at the earliest possible date;

3. **Ambulance Dispatch Reform**: That government undertake an immediate review of ambulance dispatch in consultation with stakeholders to determine the most appropriate option for providing this service, taking into consideration the interests of the patient, the fundamental principles of an ambulance system, and considering all governance, financial, operational, administrative and ownership issues.

These issues will arise again in response to the specific questions being raised within the consultation request.

Dispatch

While the questions within the consultation paper revolve around technology and communications processes with the dispatch system the largest challenges are operational and functional in nature. While technology is important you have to have the right level of staffing approved, in place, and trained appropriately in order to make technology function. Technology is not a panacea.

From the operational perspective while the dispatch system is not totally broken elements of it appear to be. The LATT process identified the need to align the operation of the dispatch with the municipal service delivery. The 2001 IBI Report identified numerous challenges within the Hamilton CACC. These challenges remain across the Ministry operated CACC's despite efforts to address them:

- Serious shortage of personnel at all levels
- Inability to sustain minimum coverage
- Absence of experience at Communicator level due to high staff turnover
- Rapid turnover in staff attributed to high workload, stress and relatively low wages
- Present communicator staffing falling short of the calculated model requirement
- CACC staffing model underestimates the true staffing requirements
- CACC would benefit from a well defined and active quality assurance program
- Management presence needs to be strengthened
- Communications protocols between fleet and CACC should be reviewed.

The IBI report, while dated, outlined the differences between “level of effort” land ambulance provision as opposed to “performance based” land ambulance service. In this distinction the report nicely identified the need for accountability of the ambulance dispatch operations to municipal officials responsible to monitor the quality of their ambulance operation performance while attempting to control costs. A performance based system is only made possible where the operation of the dispatch centre which controls both the assessment and prioritization of calls and the movement and activities of the ambulance resources is wholly aligned and responsive to the actual ambulance service operations.

The proof of this approach was demonstrated by Toronto well before downloading. Toronto is an internationally recognized model for best practices in ambulance service delivery. The principles were reinforced with the evaluation completed following the Niagara ACS five year trial initiated in 2005. During that trial off the shelf technology (COTS) of several types supporting communicator decision making and operational performance were implemented successfully in combination with the MOH CAD. Epidemiological screening in support of public health was implemented. MPDS, along with the ProQ&A system, was put into place, integrated with the MOH CAD, and operationally accredited, in record time. Successfully integrated technology included MARVLIS, CADPortal, Headstart, smartphone digital paging, and of course MPDS.

Progress by Niagara, similar to that experienced in Toronto and more recently Ottawa, compares favourably to the current MOH implementation of MPDS. Following the Ministers commitment to change all CACC’s over to MPDS province wide the Ministry has now taken twice as long as Niagara to implement the system – and to date not a single dispatch centre has been converted.

Where the operation of the dispatch has been aligned wholly with the operational performance of ambulance service delivery maintaining the core principles established by LATT, as in Toronto, Niagara, and Ottawa, there has been successful MOH certification achieved at every review.

The reality from a service provider perspective is that fully integrating and aligning the CACC operations with the service provider requirements provides for innovation and improved service to the public. With a 90th percentile emergency dispatch call handling time of more than three (3) minutes the dispatch operations continue to consume a large portion of the response time envelope, service providers are unable to effectively influence the operations of the CACC, and barriers to good practice take time.

While understanding that there is the desire on the part of some to “consolidate” dispatch centres into smaller numbers of bigger centres provincially there has been absolutely no evidence put forward, and no business plan subjected to industry scrutiny, that would support such a model being either an improvement in service delivery or a reduction in cost. Most often the premise put forward in support of the concept is the OPP model of centralized dispatching which incorporates centralized concepts with an

entirely different dispatching model. OPP dispatching is not in the least comparable to the business design for paramedic services.

Shared infrastructure where appropriate, mutual back up capacity, and centralized core training all make some sense. However the solution to dispatch is to allow the services impacted by the dispatch to develop the solutions to the current challenges. Turn the operations over to the paramedic services.

Recommendations:

1. Dispatch operational responsibility should be transferred to the respective land ambulance services currently dispatched by the respective CACC. Where designated delivery agents enter into agreement to consolidate or group dispatch functions they should be allowed to do so;

2. The Ministry should continue to provide shared communications infrastructure to ensure provision of service in a seamless and accountable manner; and

3. Core funding of dispatch operations and regulatory oversight of the dispatch operation in accordance with established standards should remain a Ministry responsibility. Core funding should include, at a minimum, 100% of the cost of providing operational and technical functions at a level equivalent to the staffing ratios and technology innovations currently in place in Toronto, Niagara, and Ottawa.

Innovation, aligned with local operation, would include improvements in hospital offload performance through integrated oversight and responsiveness. Innovation could include secondary clinical advice, screening, and call diversion as was experienced in Vancouver during the 2010 Olympics to better triage calls. Innovation could include senior advanced care paramedic advice on aspects such as CBRN or other technical operational process as has been implemented in other centers. And innovation could include on line booking of inter-facility transfers, pre-populating and targeting the details of a transfer request, thereby minimizing the call taking detail processes that currently exist.

Accreditation:

The current Ambulance Service Review process is a quasi-regulatory compliance activity performed by peers with minimal training and experience. The process has moved from the original concept of establishing a unique Ontario accreditation program to a pedantic rules based compliance process.

I strongly recommend a shift from the “Ambulance Service Review” process to an accreditation process, preferably under the jurisdiction of Accreditation Canada (https://accreditation.ca/). This agency performs health care accreditation across numerous agencies including hospitals, long term care, community services, and

others. The driver in the accreditation process continues to be improvement in quality of service delivery.

Preliminary work has already been completed in the development of ambulance service accreditation. In Ontario some land ambulances are investigating pursuit of accreditation through this body and Ornge has already completed the accreditation process. In the Vancouver Island Region of BC accreditation was achieved in 2010 during the early trials of the program and in other provinces, such as New Brunswick, the ambulance service provider has also been accredited.

Savings from the current operation of the ASR team would be extensive as the Province currently expends at least 150 to 200 days of direct activity for a team of 10 to 15 people, plus travel, accommodation, oversight, and management costs for little operational benefit.

Offload Delays:

Ambulance offload time at hospitals continue to be a significant challenge in many jurisdictions. While the standard of transfer of care occurring within 30 minutes of arrival was established in the 2005 report (Improving Access to Emergency Services : A Systems Commitment) the reality is that the problem continues to hinder the performance of land ambulance services. Municipalities are forced through MOH Standards to require paramedics to wait with patients in the most basic forms of hallway medicine until transfer of care is achieved. In Hamilton the lost ambulance capacity resultant from this was more than 30,000 hours last year, and more importantly thousands of patients waited on ambulance stretchers for in excess of two hours.

While Dedicated Offload Nurse Program (DONP) funding helps to alleviate the pressures there is simply not enough capacity. Limited space within ED's prevents effective use of the DONP, there are fewer hospital beds per 1,000 population within the Hamilton area than in many other jurisdictions, there are inadequate community resources including Long Term Care beds and home care to fulfil the needs, and as result patient flow through hospitals is challenged. The DONP is a stop gap measure, it is helpful, but it is not resolving or addressing the root cause of delays in transfer of care. In the interim the municipal taxpayers of Hamilton are paying the cost of hallway medicine.

The MOH has the capacity to track and to mandate system performance and, to date, has declined to do so. Hospital ED staffing is being funded at peak times by municipally funded paramedics and it is doubtful that resolution to this will be speedy or easy. In the interim my recommendations are:

1. Hospitals and paramedic services be mandated to utilize consistent transfer of care software and reporting, including dual transfer of care swipe documentation, to accurately report the involved times; and

2. That the MOH fund 100% of the unit hour cost for the time period beyond the first 30 minutes after arrival. Assuming a current 50-50 funding match this would be an increase of 50% from the present funding. This payment to the designated delivery agent for the provision of hospital hallway medicine would provide the capacity for municipalities to replace lost unit hour response capacity.

Inter-facility Transfers:

One of the agreed upon principles from the LATT Consensus process was that municipalities needed to ensure their land ambulance service was an integral part of the provincial health care system. The province was to be required to ensure the transport of patients by ambulance between health care facilities for medically essential services, a presumption that included funding the cost of such patient transport..

The Ontario Hospital Association put forward a December 1999 position paper (Land Ambulance Issues for Ontario Hospitals) outlining the challenges that would be presented with the pending implementation of provincial downloading, and making recommendations for resolution. A further paper was put forward by the OHA in September 2004 (Non-Emergency Ambulance Transfer Issues for Ontario Hospitals) outlining concerns with the impact on patient care and timely service delivery that had developed since the 1999 report as well as the ongoing progression and cost shifting that was occurring.

The issues raised by the OHA in 1999 and 2004 have changed little. Non-Urgent Patient Transfer (NUPT) providers continue to provide service moving patients between hospitals in a totally unregulated manner, with oversight limited to RFP contractual compliance matters. Hospitals are funding these patient movements through increasing diversion of fiscal resources from global funding capacity as resource specialization increases. There is inequity in capacity between Northern and Southern geographic areas based on the speculative profit motives of the NUPT providers. Simply put, profitable transfer patterns and times are serviced, those that are not profitable are not. Unfortunately the land ambulance service providers have no choice – the MOH CACC will not refuse to service any call, and the land ambulance service provider must perform all calls assigned by the CACC. The predicted cream skimming continues to occur, with inter-facility patient transfer movement on less profitable routes being performed by the land ambulance service at no expense to the hospital or the patient, and instead by subsidy of the municipal taxpayer.

I recommend development of an Inter-facility Transfer (IFT) working group with terms of reference including the following objectives:

1. To define, in detail, the current state of inter-facility transfer operations between facilities within each Ontario Health (OH) geographic area, between facilities across OH boundaries, and between facilities across provincial or national boundaries. This definition shall include establishing who is responsible for the various types of patient transfers and identifying the resources required to conduct them.

2. To identify the desired state of inter-facility transfer operations between facilities within each OH area, between facilities across OH boundaries, and between facilities across provincial or national boundaries.

3. To identify gaps between the current state and desired state of inter-facility transfer operations and develop plans to implement changes that will increase operational efficiency and improve the transfer experience for patients.

4. To develop recommendations for an inter-facility transfer service delivery and funding model that is effective, efficient, and sustainable.

5. To establish a clear line of accountability for the practices and funding necessary to properly conduct inter-facility transfers, so that sufficient resources are available to match patient need.

6. To share information between Land Ambulance providers, OH Regions, Criticall, Ornge, and the Ministry of Health (MOH), and to accept submissions from other stakeholders that impact upon the provision of inter-facility transfer service

7. To build a body of data and knowledge on inter-facility transfers in Ontario.

Further, I recommend that:

8. Funding of medically necessary inter-facility patient transfer, whether by air ambulance, land ambulance, or by Non-Urgent Patient Transfer providers, be 100% covered by the Province of Ontario; and

9. That all patient transfer requests be channelled through the respective Central Ambulance Communications Centres (CACC); and

10. That the CACC be authorized to assign inter-facility patient transfer to air ambulance, land ambulance, or NUPT provider, as is appropriate for either operational or patient condition requirements; and

11. That the Ministry of Labour enact regulation specifying that the assignment of patient transportation to a NUPT as appropriate in the circumstances not be considered to be “contracting out” of service or any equivalent with respect to Collective Agreement interpretations; and

12. That all NUPT providers within a Land Ambulance Service provider jurisdiction be required to meet the standards of service and standards of care as set out by the Land Ambulance Service provider; and

13. That each CACC implement an on-line IFT booking process to facilitate the management and delivery of IFT activities.

Community Paramedic:

Community Paramedicine (CP), or Mobilized Health Care (MHC) as put forward in the EMS Chiefs of Canada White Paper (The Future of EMS in Canada : Defining the Road Ahead), means many things to many people. At its heart are the principles of:

- Providing health care in a timely, and appropriate manner taking into consideration the local operational priorities and the integration of care within the broader health care system; and

- Mitigation of both ambulance response and facilities based emergency health care provision where clinically appropriate.

CP is not intended, nor should it be put forth, as a method to supplant home care provision by an existing provider. It is an outreach mechanism where paramedic services can fill a health care gap existing within a particular community thereby improving the continuum of care for the patient. Taking many forms we have been using the principles for clinic management, remote patient monitoring, targeted complex care visits in support of hospital discharge, and management of high demands for patients also engaged in aspects of the judicial system.

We support the ongoing development of CP or MHC as a value that can be added by paramedic services to any Ontario Health Team (OHT) Integration process. The major financial benefits from CP program delivery are with the broader health care system, recognizing decreased hospital utilization and extended time periods without hospital admission. As such the costs of CP programs should be borne fully by the main recipients. In the past this was LHIN based and I believe in the future should be OHT based.

Extension of the program should consider palliative care patient support as well as the existing complex continuing care patient profiles.

Funding Formula:

Recognizing that some areas of the Province have unique needs the minimal MOH funding should be maintained at 50%, and that for some areas, particularly in unorganized areas in the North, up to 100% funding may be appropriate. Further, as previously noted the MOH should be funding 100% of inter-facility transfer costs and 100% of extended transfer of care time based on average unit hour cost.

Resolution to the current funding lag problem must be found. The current process provides for submission of current year council approved budget in early fall, with the MOH funding for the following year typically being based on that financial submission.

This creates an essential full year lag in Ministry 50-50 funding for any municipal staffing enhancements. For Hamilton over the past 7 years where the City fulfilled it's obligation to determine the appropriate level of service as outlined in the Ambulance Act the funding lag has forced a municipal taxpayer subsidy of the MOH 50-50 portion in the amount of approximately $5.8M.

Funding during the first year of operation of staffing enhancement can be managed effectively through utilization of one time funding letters, a process that was utilized extensively and effectively by the Province prior to the 2000 downloading of land ambulance services.

College of Paramedicine:

In 1999 there was a consensus across all members of the LATT Committee that a College of Paramedics should be created under the Regulated Health Professions Act framework. This recommendation remains outstanding despite the submission some four years ago for creation of a college to match developments and initiatives in other provinces.

Base Hospital programs were initially developed in the 1980's under the guidance of Dr. Dennis Psutka as a mechanism to facilitate the implementation, and the legalization, of advanced life support procedure performance by ambulance personnel. Legends like Dr. Ronald Stewart helped drive the programs forward, creating some of the first ACP programs in the Province of Ontario, albeit a bit later than developed in other jurisdictions such as BC or Alberta. The original intent was to have the BHP's closely integrated with the ambulance service delivery, providing the needed services of training, quality improvement, and medical control under the guidance of the involved ambulance services. There was a distinctly local flavour, significant local involvement in the direction of the BHP, and at the same time a level of consistency across programs established through the provincial advisory group which included service providers, base hospital physicians, and Ministry staff all of whom had an equal say in the general direction of the programs.

This has unfortunately morphed as result of financial considerations into a smaller number of Base Hospital programs striving to exert control over direct service delivery and training, and disconnected from the feedback and guidance of those land ambulance services for which they were created.

The practice of paramedicine should properly be segregated into three fundamental principles:

1. **Certification**: The successful completion of the levelling examination process which ensures a standard base of knowledge across all educational programs aligned with the National Occupation Competency Profiles (NOCP) as periodically adjusted. Certification examinations are currently performed by the MOH and can continue to be done in that manner or that role can be handed over to the College which would

charge a fee for completion, much the same as currently exists for the College of Nurses;

2. **Registration**: This is the process by which paramedics, irrespective of employer, become registered with, and accountable to, the Paramedic College for their practice in paramedicine. Standards are established and maintained by the College;

3. **Authorization**: While a paramedic may have the training and certification to perform a procedure they still require authorization to perform particular medical acts and/or procedures. Such authorization must come from both their employer and from a physician who has particular knowledge and awareness of the normal standards, the individual specific training, and of specific skill competency. Just as with a Nurse who has a particular skill within their scope of practice a paramedic college does not supplant the requirement for actual authorization to perform to that specific scope.

I recommend:

1. That a College of Paramedics be established to fulfil the role of regulating the practice of paramedicine, across the entire spectrum of paramedic service providers, and to ensure the safety of the public when receiving paramedic care; and

2. That the current funding for provision of Base Hospital medical oversight and delegation activities be transferred proportionally, based on either a population or paramedic staffing ratio, to the respective Land Ambulance Service providers; and

3. That the Land Ambulance Service providers be required to contract appropriate qualified physicians to evaluate paramedic skills in the performance of delegated medical acts, to authorize the performance of delegated medical acts, and to oversee the provision of quality assurance and quality improvement in the provision of delegated medical acts.

These recommendations do not preclude the existing Base Hospital programs or staff from continuing activities as many services may opt to contract the required services from partners they currently work with. Instead the recommendations align the function of medical oversight, delegation, and quality review with the operation and provision of ambulance services in a new paradigm of authorization and delegation under a mutual performance agreement with the medical professional of choice.

CITY OF HAMILTON
HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Hamilton Paramedic Service

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Paramedic Service Data Sharing and Network Services Agreement with Health Shared Services Ontario (HHSO) (HSC20017) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Brent McLeod (905) 973-4640
SUBMITTED BY: **SIGNATURE:**	Michael Sanderson Chief, Hamilton Paramedic Service Healthy and Safe Communities Department

RECOMMENDATION

That the Chief, Hamilton Paramedic Service be authorized to enter into and execute the agreement for participation in the Paramedic Bi-directional eNotification web-service interface with Interdev Technologies, Shared Services Ontario, and Ontario Health – West.

EXECUTIVE SUMMARY

The Paramedic Bi-directional eNotification supports seniors and adults with complex needs by increasing and improving the communication with regards to the patient's current status as well as prompting the need for a patient care plan adjustment where applicable.

The proposed Paramedic Bi-directional eNotification process is a web-service interface that sends an auto-generated electronic notification of the patient's status after a paramedic interaction to the patient's care coordinator at Home and Community Care (HCC). The Paramedic Service also receives an HCC services status update from HCC, which will help direct the paramedic's action in terms of referral pathways and increasing supports in the patient's home.

Furthermore, the Paramedic Bi-directional eNotification will also allow the Paramedic Service to send alerts to the Hamilton Public Health Unit of opioid events and COVID-19 screening results information in near real-time.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: None

Staffing: None

Legal: The eNotification Data Sharing Agreement and Network Sharing Agreement will be reviewed for content by Legal Services.

HISTORICAL BACKGROUND

There are currently 130 hospitals integrated with the Client Health Related Information System (CHRIS). Building on this integration, Hospital Bi-directional eNotifications have been utilized throughout the Province for approximately five years. eNotification functionality allows hospital emergency departments (ED) across the Province to know in real-time if a patient presenting is a LHIN patient, and if they have a Coordinated Care Plan (CCP) in CHRIS. The eNotifications alert LHIN Home and Community Care (HCC) coordinators when a patient presents at an emergency department and is admitted to hospital or discharged.

Building on Hospital Bi-directional eNotifications functionality, the Paramedic Bi-directional eNotifications can be leveraged to alert LHIN care coordinators if a LHIN patient has an interaction with paramedic services. The eNotification will include the following information to the LHIN HCC care coordinator:

1. Patient transported to ED
2. Patient assessed but not transported
3. Patient deceased in the community

The Paramedic Bi-directional eNotification allows CHRIS to return a verification to the paramedic service identifying the patient as a LHIN patient and if they have a Coordinated Care Plan in place or not. With the implementation of Bill 160, which now allows paramedics to transport patients to locations other than hospitals, Paramedic eNotifications (of transport vs. non-transport) complement the current Hospital Bi-directional eNotifications in tracking patients.

In response to the Opioid Crisis in the Province, within the HNHB LHIN, an opioid event code was added to the eNotification alert in July 2019. The opioid event code is triggered when a paramedic visit is determined to be due to an opioid event, and the administration of naloxone by paramedics has taken place. The eNotification email does not contain any Personal Health Information.

The notification to Public Health in near real-time allows for early alerting, which may save lives and limit further health system usage.

Similarly, in response to the current global pandemic, a COVID-19 screener was added to the eNotification process on March 16, 2020. Similar to the opioid notification email, Hamilton Public Health will receive a notification via email that a patient has screened positive for COVID-19.

Furthermore, the Paramedic Bi-directional eNotifications are also made available in primary-care electronic medical records via Ontario MD's Hospital Report Manager (HRM). These eNotifications alert physicians when a patient of theirs (using CPSO# or CNO#) has entered the hospital or called 911.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

None

RELEVANT CONSULTATION

The Hamilton Paramedic Service, Ontario Health-West, and the HNHB Community Paramedic Strategic Lead provided input to this report.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Participating in the eNotification process will improve the continuity of care for the residents of the City of Hamilton, specifically seniors and adults with complex needs. The Paramedic Bi-directional eNotifications improves communications and care coordination between paramedic services, HCC care coordinators, hospitals and family physicians, enabling faster and safer follow-up treatment, and potentially reducing hospital readmissions.

ALTERNATIVES FOR CONSIDERATION

None

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities

Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

APPENDICES AND SCHEDULES ATTACHED

None

CITY OF HAMILTON
HEALTHY & SAFE COMMUNITIES
Ontario Works

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Leveraging a Provincial Contract for Digitizing Ontario Works Client Files (HSC20023) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Terry Quinn (905) 546-2424 Ext. 3080
SUBMITTED BY: **SIGNATURE:**	Bonnie Elder Director, Ontario Works Division Healthy and Safe Communities Department

RECOMMENDATION

(a) That Council approve the single source procurement, pursuant to Procurement Policy #11 – Non-competitive Procurements with Nimble Information Strategies Inc., at an estimated cost of $580,839, for the digitization of Ontario Works active case files and that the General Manager, Healthy and Safe Communities Department or designate be authorized to negotiate, enter into and execute a Contract and any ancillary documents required to give effect thereto, in a form satisfactory to the City Solicitor; and,

(b) That Appendix “A” of Report HSC20023 remain confidential and not be released as a public document.

EXECUTIVE SUMMARY

Report HSC20023 requests authority for Healthy and Safe Communities to enter into a non-competitive contract with Nimble Information Strategies Inc. for the digitization of the paper files of Ontario Works’ (OW) clients in the City of Hamilton (City). Digitizing client files is a key part of the Province’s social assistance modernization strategy.

The Province of Ontario has implemented electronic document management in their Ontario Disability Support Program (ODSP) offices. Nimble Information Strategies Inc.

(Nimble) was the successful proponent of the provincial RFP for the digitization of ODSP client files. Utilizing Nimble provides the opportunity for the City to leverage the provincial infrastructure created to modernize the delivery of social assistance and realize administrative efficiencies and future savings estimated at $151,000 (gross) ($75,500 net levy) per year.

With this project, Ontario Works would pay for costs to scan and index Hamilton's active case files. The contract will leverage the Province's negotiated pricing with Nimble which is based on a much larger volume than Hamilton would have on its own. The City of Toronto chose to leverage the Province's contract with Nimble and several other Ontario municipalities are considering similar decisions.

As the Ontario Works division is in the process of consolidating office locations, an additional benefit of digitizing Ontario Works file rooms is it will eliminate the need for large dedicated file rooms and significantly reduce our office footprint.

Alternatives for Consideration – See Page 6

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial:
The estimated cost to digitize the City's Ontario Works active client files is estimated to be $580,839. These costs will be shared with the Province on a 50/50 cost share basis. The City's $290,419 net levy portion will be funded from within the existing Ontario Works 2020 Operating Budget. No additional funds are being requested in Report HSC20023. This one-time cost, as well as costs for ongoing digitization of new documents, will result in service improvements and annual savings estimated at $151,000 gross/$75,500 net levy.

Staffing:
Confidential staffing implications attached as Appendix "A" to Report HSC20023.

Legal:
Legal Services staff will assist with contract preparation and execution in a form acceptable to the City Solicitor.

HISTORICAL BACKGROUND

Ontario Works provides financial assistance to over 11,400 individuals/families using the Social Assistance Management System (SAMS). Provincial regulations require that case related documents be maintained for all cases. In Hamilton, active case files are estimated to include over 1,708,000 pages. These active case files, as well as files from inactive cases, are stored in paper form in each Ontario Works office.

Hamilton's Ontario Works offices receive and handle over 20,000 additional paper documents each month with many of these added to the active case files. Significant effort is required to file these documents and maintain the case files.

In 2016, the Province of Ontario began implementing electronic document management in their Ontario Disability Support Program (ODSP) offices. Nimble was the successful proponent of the provincial RFP for the digitization of ODSP client files *and* all new documents received monthly. Together with the Province, Nimble developed a process to scan, index and upload images of all documents related to case management to a secure server managed by the Province. The process and technology developed meets provincial privacy and security standards and is currently in use in most ODSP offices. ODSP workers are able to access images of all required documents through the same SAMS system used by Ontario Works.

In 2018, Ministry of Children, Community and Social Services (MCCSS) made electronic document management part of their modernization plan for Ontario Works. In response, Hamilton's Ontario Works Division put electronic document management on their multi-year workplan for 2020. Discussions were underway with Procurement to establish a contract with Nimble that would result in the City's Ontario Works files being digitized later this year.

In 2019, the City of Toronto's Ontario Works offices leveraged the Provinces Nimble contract to scan all active case files and all paper documents received monthly. Currently, several of Toronto's offices have fully converted to using electronic documents for all Ontario Works case management activities and no longer rely on paper files. Ontario Works staff are able to access images of all required documents through SAMS.

As a result of COVID-19 office closures in March, Hamilton Ontario Works staff were unable to manage incoming documents mailed or dropped off at Ontario Works offices. A significant backlog of documents resulted, and the temporary process that was developed was not sustainable. Officials at MCCSS suggested that Hamilton advance our efforts for digitizing incoming documents and consider using Nimble, leveraging the tools and processes already demonstrated in ODSP and OW Toronto.

Purchasing approval was received for Ontario Works to work with Nimble to digitize new incoming documents. That project has been successfully completed. However, no commitment was made to Nimble to undertake the work of scanning our existing active case files. This work remains on our multi-year business plan.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

None

RELEVANT CONSULTATION

MCCSS: Ministry officials have digitization of Ontario Works documents as a key element in their modernization plan for social assistance. In discussions with them regarding revised business processes during COVID-19, they suggested leveraging their provincial solution and track record with Nimble to fast-track Hamilton's digitization efforts for new incoming documents. Ministry staff have confirmed all privacy and data security requirements were met with the Nimble solution.

City of Toronto Employment and Social Services (TESS): TESS has confirmed their successful use of Nimble for digitization of Ontario Works existing active case files as well as all incoming documents. Ontario Works staff can manage their caseload and meet all provincial requirements using the digital documents. TESS has accelerated digitization of their remaining offices as a result of COVID-19.

City Information Technology Division: City IT staff have reviewed the completed project to digitize incoming Ontario Works documents. The project successfully met requirements from the security, privacy, business applications and infrastructure/architecture sections of Information Technology and was approved to proceed. There is no additional risk with digitization of the existing active case files as they will be treated identically to incoming Ontario Works documents.

Office of the City Clerk: Corporate Records were consulted on retention guidelines. This plan meets all document retention requirements.

Procurement: The Manager of Procurement was consulted on Procurement Policy #11 – Non-competitive Procurements.

Finance and Administration: Finance and Administration were consulted regarding the net levy impact and ongoing annual savings associated with Report HSC20023.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

The Province made document digitization a key element in their modernization strategy for social assistance. Replacing paper documents with images provides opportunities to improve client service, realize administrative efficiencies and save file management and storage costs.

The Province completed a competitive RFP that resulted in Nimble being the vendor. The system developed by Nimble in collaboration with the Province eliminates paper files (active case files) and digitizes all incoming documents used in social assistance case management. This system is fully integrated with the SAMS system used by both Ontario Works and the provincially managed Ontario Disability Support Program

(ODSP). It has been used extensively in ODSP for over a year and was to be rolled out to Ontario Works locations over the next two years.

Benefits of leveraging the Province's contract with Nimble to digitize Hamilton's active case files include:

- The approach uses the same proven tools and procedures used to digitize ODSP office across the province and currently in use in TESS;

- The approach leverages functionality available within SAMS that has been in use in ODSP offices and Toronto's Ontario Works;

- The recently completed COVID-19 project in Hamilton to digitize new incoming documents tested all of the technology required to digitize existing active case files. Digitizing existing active case files does not require hardware, software or resources from the City's IT department;

- With the proposed approach, Hamilton has no hardware or software costs. Efforts to recreate a digitization process (in-house or with another vendor) would significantly increase costs, time and effort;

- MCCSS has prioritized working with municipalities that agree to follow their developed procedures that work with Nimble. This allows them to better leverage Ministry technical staff required to support each municipality sending documents to the Province's secure server;

- Ministry and City IT staff have confirmed that the proposed approach meets all data security and information privacy requirements. Significant work would be required to ensure this level of security could be met with another vendor; and,

- Hamilton is currently in the process of renewing office leases. Elimination of the file rooms will support a considerable reduction in the required office space. To impact the office space decision, active case files must be digitized in Q3, 2020.

Contracting with a vendor other than Nimble would result in the City incurring significant costs to recreate the required infrastructure, processes and security reviews for digitized documents to communicate with the Province's network and interface with the Province's secure electronic document repository. In addition to added costs, savings that result from file digitization would be delayed. If we choose to utilize Nimble, there is no cost to the City for this design, infrastructure, or security/privacy work.

ALTERNATIVES FOR CONSIDERATION

Hamilton could choose to pursue document digitization with another vendor selected through the City's RFP process. There are no known benefits of pursing this alternative. The risks of pursing this alternative include:

- Significant time required (12-month estimate) for a new vendor to develop the processes and tools that meet the Province's technical, security and privacy specifications. This would forgo annual savings estimated at $151,000 gross/ $75,500 net levy;

- Effort and time for the City's IT resources to complete the full infrastructure risk assessment and privacy assessment that would be required of any new vendor managing confidential client documents;

- Cost for the City to purchase and manage a secure FTP server for receiving document images from the new vendor (if not Nimble) and forwarding them to the Province. (The Province has indicated that they will only receive images from Nimble or an approved municipality);

- Availability of Provincial resources to test and approve the new processes. MCCSS has indicated that their IT resources will prioritize onboarding municipalities that use the already developed Nimble process;

- The costs to develop the processes and tools by the successful vendor will be paid by Hamilton on the 50/50 cost share basis with the Province, either in direct project costs or higher page cost to scan and digitize. With the Nimble process, the development costs were paid fully by the Province;

- Ongoing costs with Nimble were negotiated by the Province based on the much larger monthly volume of all ODSP offices in Ontario plus an estimated number of Ontario Works offices.

For these reasons, the alternative of not directly entering a contract with Nimble that leverages the Province's vendor and technical solution is not recommended by staff.

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities

Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

Our People and Performance
Hamiltonians have a high level of trust and confidence in their City government.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC20023: Confidential Staffing Implications

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Child Care Reopening Framework (HSC20027) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Jessica Chase (905) 546-2424 Ext. 3590
SUBMITTED BY: **SIGNATURE:**	Grace Mater Director, Children's Services and Neighbourhood Development Division Healthy and Safe Communities Department

COUNCIL DIRECTION

Not Applicable

INFORMATION

Closure of the Licensed Child Care System

On March 17, 2020, the Province of Ontario declared a state of emergency and issued an order for all licensed child care centres to close in response to the COVID-19 coronavirus, with the exception of licensed home child care.

During this closure period, the City has worked closely with child care operators and the Ministry of Education to sustain the existing child care system. Funding has been provided within the existing budget to support lost parental revenues, fixed costs such as rent and utilities, and staff salary top-ups. The funding model throughout this closure period has evolved in order to maximize all available federal and provincial supports. Since the closure period, approximately $8.8 M has been issued to child care operators to support the sustainability of the system.

Emergency Child Care for Healthcare and Other Frontline Workers

On March 19, 2020, Children's Services and Neighbourhood Development staff partnered with licensed home child care agencies to offer licensed home child care to essential City staff at a nominal fee. This included staff in Fire, Paramedics, HSR, Long Term Care and Public Health.

On March 22, 2020, the Ministry of Education announced plans to exempt some child care centres from the emergency closure order to provide emergency child care to healthcare and other essential frontline workers, free of charge. In Hamilton, emergency child care continued to be provided through three licensed home child care agencies. Home child care was selected due to the smaller group sizes to mitigate potential risk to children and providers.

Children's Services and Neighbourhood Development staff worked closely with Public Health staff and the three licensed home child care agencies to ensure that additional health and safety measures were put in place. This included enhanced cleaning, screening procedures and ensuring pandemic plans were in place.

Since March 22, 2020, approximately 272 children have been in receipt of emergency child care free of charge. The list of eligible positions for emergency child care has expanded during this closure period based on additional provincial announcements.

The Ministry of Education has now announced that emergency child care will end effective June 26, 2020. All families have been notified. Families have the option of returning to their original child care arrangements or remaining with their current home provider provided that a space is available. Families that choose to remain in child care after June 26, 2020 will be responsible for child care costs or will be returned to fee subsidy if eligible.

Reopening the Child Care System

On June 9, 2020, the Province of Ontario announced that licensed child care centres may begin to reopen as early as June 12, 2020. All centres are required to meet additional requirements to safely reopen including enhanced cleaning, mandatory screening of staff and children, limitations on non-essential visitors and ensuring there is a COVID-19 response plan in place. Restrictions on the size of groups are limited to 10 individuals per room, including both staff and children.

Based on the direction of the local Medical Officer of Health, the decision was made to require that all centres complete and pass an in-person Public Health inspection prior to reopening. All staff are also required to complete mandatory training.

Children's Services and Neighbourhood Development staff have worked closely with Public Health to provide several tools and resources to child care operators to support their plans to reopen. Examples of tools include checklists, policy documents, posters and signage, screening tools and community learning sessions. City staff have also arranged for the professional resource centre in Hamilton to supply Personal Protection Equipment (PPE) to child care centres to support their initial reopening.

Based on the group size limitations, the capacity of the child care system will be significantly reduced during this initial reopening phase. Child care operators are in the process of contacting families to assess their current child care needs and determine their capacity to meet these needs. Initial estimates have indicated that approximately 55% of families that were previously in receipt of child care have indicated they will require child care during this initial reopening phase.

Families that choose not to return to child care at this time will not be charged fees and their child care spaces will be held. Child care operators are also required to maintain child care fees at pre-COVID-19 levels until August 31, 2020. The City will also be extending the affordability grant which reduces the cost of child care by $10/day for families until August 31, 2020 to align with provincial timelines.

Given the smaller group sizes, PPE requirements, and additional staffing needed for screening and enhanced cleaning, the cost to operate child care will be significantly higher during this time. City staff will be working closely with the Ministry of Education and child care operators to maximize all provincial and federal supports and sustain the system to the best of our ability. The total investment to child care centres during this time is not yet known and will be monitored closely. If funding projections exceed the budget, staff will need to explore cost containment strategies, such as discontinuing the affordability grant or increasing the waitlist for fee subsidy.

City staff are committed to continuing to work closely with the child care community to ensure a safe and gradual reopening of the licensed child care system.

APPENDICES AND SCHEDULES ATTACHED

None

Hamilton Collaborative Partnership Group
Community Hub/Multi-Sport Indoor Facility Project

July 6, 2020

Chairperson and Members
Emergency and Community Services Committee
Hamilton City Hall
71 Main Street West
Hamilton, Ontario.
L8P 4Y5

Response to City of Hamilton Staff Report HSC20026 (City Wide) dated June 19, 2020

Dear Chairperson and Members.

Our Project Team is comprised of several, dedicated community leaders who have devoted a great deal of personal time and resources towards a proposed Community Hub & Multi-Sport Indoor Facility that will provide significant benefits to over thirty community groups and organizations within our community and in particular programs and services to serve Hamilton's underserviced populations.

On July 8, 2019, members of our group met with Hamilton City Staff to submit our formal proposal which consisted of nearly five hundred pages of details and supporting documentation which could have possibly answered or clarified most of the questions raised at the recent June 19th meeting. I'd also like to point out the obvious difficulties involved with the current restrictions for Public Delegations and the complexities involved within our proposal which is hindering our ability to communicate a clear and accurate message in order to provide you with the opportunity to make informed decision.

The attached Information Report responds to the information submitted by City Staff on June 19th and some of the questions raised by members of your Committee and will hopefully clarify a few of the critical areas of our proposal. In particular the recommended business plan will address current City of Hamilton infrastructure deficiencies and provide a significant cost benefit which offers a fully sustainable, public facility, which will have the potential of generating millions of dollars in economic benefits to our community.

The areas you may find of particular interest include details related to our current Investing in Canada Infrastructure Program (ICIP) funding application and synergies created as a possible joint-project initiative with the proposed Commonwealth Games bid. The "stack funding" scenario being highlighted would provide the City of Hamilton with a direct $44 million dollar contribution towards several proposed Games venues and most of all, $0 additional dollars from Hamilton taxpayers.

Respectfully,

Kevin Gonci
Chairman

Hamilton Collaborative Partnership Group
Community Hub/Multi-Sport Indoor Facility Project

INFORMATION REPORT

Response to City of Hamilton Staff Report HSC20026 (City Wide) dated June 19, 2020

Date: July 3, 2020

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COUNCIL DIRECTION

At its meeting of February 21, 2019, the Emergency and Community Services Committee directed staff to meet with the Hamilton Collaborative Partnership Group and report back to the Emergency and Community Services Committee with any and all options be explored including the feasibility of the City of Hamilton partnering with this group.

FURTHER DIRECTION

At its meeting of October 17, 2019, the Emergency and Community Service Committee passed the Motion which supported the Hamilton Collaborative Partnership Group's submission of an Investing in Canada Infrastructure Program (ICIP) funding application. This motion included:

- The City of Hamilton provide a letter of support for HCPG's Multisport Facility Funding Application;
- That if the HCPG are successful in obtaining Infrastructure funding, HPCG be directed to appear before the Emergency and Community Services Committee with the financial update; and
- That should the HCPG not be successful in obtaining Infrastructure funding for the project, that staff be directed to include this project as part of the Commonwealth Games Facilities Master Plan, should Council approve the Games 100 bid.

BACKGROUND

The Hamilton Collaborative Partnership Group (HCPG) is a non-profit organization which represents a consortium of groups and interests in the City of Hamilton who have collectively expressed the need for additional indoor program space. This need was identified through a comprehensive feasibility study completed by the firm of Architecture 49 and included a series of community online surveys, public consultations, interviews and research.

Based on the results of this study, the community groups and organizations listed in **Table 1** have expressed an interest in making use of the facility for programs, services, activities, special events and competitions.

PROPOSAL OVERVIEW

Ownership Model

We are proposing a City of Hamilton Ownership Model (property/facility/equipment) which will involve a design/build/operation/maintain tendering process and third-party Operational Maintenance Agreement. This model has a proven record of success through the current Four Pad Arena facility between the City of Hamilton and Hamilton Arena Partners in which Nustadia Recreation Inc. is responsible for the day-to-day facility operations. We have identified that this facility would qualify as a Municipal Capital Asset designation which will allow for annual tax savings.

Table 1 – Community Groups and Organizations

Hamilton YWCA
Boys and Girls Club of Hamilton
Aboriginal Health Centre
Indigenous Youth and Employment & Training Program
City Kidz
Redeemer University
Variety Village of Ontario
Hamilton Accessible Sports Council
Canada Basketball
Volleyball Canada
Athletics Canada
Ontario Basketball
Ontario Volleyball
Ontario Lawn Bowling Association
Ontario Special Olympics
Ontario Masters Athletics
Sport Hamilton
Hamilton CANUSA Games
Blessed Sacrament Yellow Jackets Basketball Club
UPLAY Canada Basketball
Hamilton Celtics Basketball
Maga Basketball Camps
Ancaster Lions Volleyball Club
Hamilton Smash Volleyball Club
Mountain Volleyball Club
Mountain Athletics Volleyball Club
Hamilton Olympic Club
Golden Horseshoe Track & Field Council
Royal Canadian Legion – Ontario Command
Niagara Olympic Club
91st Highlanders Athletics Association
Hamilton Elite Athletic Team
Stoney Creek Athletics
Thorold Elite Track & Field Club
Monte Cristo Track Club
Westdale Fencing Club
Pickleball Hamilton
Extreme Dodgeball Hamilton
Hamilton Hornets Rugby Football Club
XCEL Sport Testing
Wishbone Athletics
ALP Training Institute

Facility Operations

Our proposal recommends the creation of an Operational Maintenance Agreement between a third-party operator and the City of Hamilton with a contribution from the Hamilton Collaborative Partnership Group in accordance with an agreed upon Anchor Tennant Agreement. The following points are recommended for inclusion within the Operational Maintenance Agreement.

- Inclusion of a subsidized access policy in accordance with the City of Hamilton Recreation Assistance Program.
- A “break-even” approach to facility operations.
- The creation of a Facility Management Review Team (FMRT) comprised of representatives from the City of Hamilton, Third-Party Operator and Hamilton Collaborative Partnership Group.
- The FMRT will oversee issues related to the operational management of the facility and will report to Hamilton City Council on an annual basis.
- Any operating deficits will be recovered through future surpluses before disbursements of any shared surpluses.
- Any surpluses will be shared between the City of Hamilton and Third-Party Operator and Hamilton Collaborative Partnership Group.
- Conversely, any deficit will be shared equally between the three parties.
- Financial accountability will include an annual audit review by an independent Financial Auditor.
- The third-party operator will receive an annual management fee in addition to a percentage of the gross revenues from sponsorships, advertising, vending, leasing, pouring and naming rights.
- The City of Hamilton will maintain a Capital Reserve Fund used primarily to finance major capital repairs to the facility and any future deficits.

Facility Operation – Hamilton Collaborative Partnership Group

We are proposing that the community stakeholders (comprising the HCPG) would have the capacity to contribute to the facility operations through the following roles/functions/activities:

- Licensed Anchor Tennant Agreement with the City of Hamilton.
- Member of the Facility Management Review Team.
- Guaranteed minimum number of facility booking hours.

- Contribution towards any annual operating deficits.
- Contribution towards Capital Reserve Fund.
- Contribution towards the Operating Stabilization Account.
- Provision and maintenance of program specific equipment.
- Participation in any facility capital fundraising campaigns, including revenue generation activities involving grant applications, sponsorships, advertising and naming rights.
- Coordination of bid submissions o host major events and competitions in conjunction with Hamilton Tourism office.
- Provision of inclusive & accessible community programs & services which target underserviced populations.

Building Program & Conceptual Design Plan

Table 2 refers to the proposed building program and conceptual design plan which was based on a community consultation process and stakeholder engagements.

Our estimates should be treated as a preliminary starting point and does not necessarily reflect the final plan which will require further stakeholder commitments and City of Hamilton input.

Table 2 – Building Program & Conceptual Design Plan

Building Program	Square Meters	Square Feet
Level 1		
Field House with IAAF 200m track & field area with optional turf infield or three multi-court areas with spectator seating.	6,131.6	66,000
6 Multi-Court Gymnasiums.	5,470	58,879
Change Rooms (Male/Female/Family	1,115	12,000
Fitness/Sports Therapy Space	836	9,000
Community & Cultural Centre Space.	857	9,222
Lobby, Café, Reception, Circulation	1,579	17,000
Storage/Receiving/Mechanical/Electrical	249	2,680
Sub-Total Level 1	16,238	174,781
Level 2		
Administration/Sport Offices/Meeting Rooms	1,498	16,119
Restaurant & Washrooms	845	9,100
Sub-Total Level 2	2,343	25,219
Total Building Area	18,580.6	200,000

CAPITAL FUNDING PLAN

Our Capital Funding Plan is based on the successful submission and approval of the recently announced Investing in Canada Infrastructure Program (ICIP) funding application which involves a typical cost-sharing system involving federal, provincial and municipal or community contributions.

Summary

- Approximately 200,000 sf facility.
- Based on $300.00 per square feet – (See Cost Per Square Foot Calculation).
- Federal contribution $24 million.
- Provincial contribution $19.9 million.
- Municipal/Community contribution $16 million (split equally) – See "Community Contribution" and "City of Hamilton Cost Recovery".

Cost Per Square Foot Calculation

Our Capital Building Cost estimate is based on industry standards in accordance with the various building systems available. Final decisions towards the preferred building system or combination of two or more systems (such as fabric/dome, pre-fabricated or bricks & mortar) will determine the final building cost total and will be based on budgetary considerations, functionality and location.

The bench mark used to calculate our estimated building cost was based on a "high-end" square footage calculation. The availability of alternative building material options can result in a significant building cost reduction of approximately $20 million dollars.

Community Contribution

We have secured up to $10 million dollars in conditional funding involving debt financing and capital contributions as well as identifying alternative funding strategies (totalling $10 million dollars) available through eligible grants, sponsorships and naming rights.

City of Hamilton Cost Recovery

We are proposing that the City of Hamilton contribution will be recovered through annual operational revenues and any non-eligible "tax" costs will be recovered through projected Development Charges (DC) between $4 to $6 million dollars and eligible community partner tax rebates.

Cost Remediation Strategies

Similar to the Arena Four Pad Development (which was completed under budget) we are proposing that an "on budget" stipulation be included with the public tendering process. Combined with a 25% contingency allowance, we do not anticipate any project cost overruns.
We are proposing a flexible square footage calculation based on variable building materials which can result in an overall building cost reduction of up to $20 million dollars. We have also identified other planning and design efficiencies which have the potential of providing nearly $2 million dollars in additional building cost savings including:

- Roofing materials $1.3 million.
- Inner partitions $56,000.
- Floor coverings $168,000.
- Gymnasium flooring $36,000.
- Acoustics $100,000.

CAPITAL COST PROJECTIONS

Table 3 provides a summary of the identified capital cost projections consisting of the "soft" cost estimates including ICIP eligibility.

Table 3 – Summary Capital Cost Projections

COST	ICIP ELIGIBLE	NOTE
Development Charges (DC)	YES	$4 to $6 million
Contingency	YES	Up to 25% or $15 million
Legal	NO	$10,000 to $25,000
Project Management	YES	$300,000 to $400,000
Taxes	NO	$7 to $8 million - Recovered through Development Charge fees.
Land/Property	NO	Proposed City of Hamilton contribution.
Design	YES	$2 to $3 million
Geotech Report	YES	$25,000 to $30,000
Financing	NO	
Climate Lens Assessment	YES	
Community Employment Plan	YES	
Permits	YES	$8,000 to $10,000
Site Services/Utilities	YES	$180,000 to $300,000
Surveys	YES	$30,000 to $40,000
Furnishing & Equipment	YES	$250,000 o $300,000

Considerations

Our initial per square foot cost calculation included many of the Capital Cost Projections identified in Table 3. The uncertainty of the cost estimate arises because the scope of the project is defined at only a conceptual level and there are many uncertainties including:

- Geotechnical considerations such as soil bearing capacities;
- Location;
- Servicing, including requirements for storm water management and drainage, water, sanitary, gas and electric services;
- Construction timing;
- Desired level of finishes;
- Changes in the facility program;
- Market conditions (such as the price of steel).

BENCHMARK PROJECTS

To validate our conceptual estimate, it is useful to examine similar recent projects identified in **Table 4.**

Table 4 – Comparable Benchmark Comparisons.

PROJECT	DESCRIPTION	COST	COST/SF
Lakeshore Multi-Use Recreational Facility (Phase 1)	17,000 sf (2014) 3 pad arenas, indoor walking track, gymnasium, library branch and community spaces.	$43.8 M	$267
Libro Credit Union Centre	165,000 sf (2010) twin pad arena, indoor regulation soccer field, track, meeting and banquet facilities.	$23.9 M	$164
Young's Sportsplex (Welland)	127,700 sf (2012) Indoor regulation soccer field, 4 tennis courts, offices and ancillary facilities.	$15.8 M	$134

LOCATION

Our Project Group has not established a preferred site and our various community partners have indicated a commitment regardless of location. To this end, we have recently identified several possible options which would include both cost-effective benefits and joint development opportunities which align with the City of Hamilton Recreation Strategic Plan. Although we have proposed a variety of different property options, we would recommend a City of Hamilton property contribution or possible available land swap alternative.

FACILITY REVENUE

We are proposing a fully sustainable facility operation based on diversified funding sources from various operations as indicated within **Table 5** including:

- Track & Field Facility operations.
- Multi-Court Facility Operations.
- Turf Field Facility Operations.
- Commercial Leased Space Operation.
- Food Services (Restaurant/Snack Bar/Vending) Operations.
- Multi-Use Room Space Operations.
- Potential Outdoor Space Operations.
- Corporate Sponsorship & Advertisements.

Table 5 – Summary of Estimated Annual Revenue

Track & Field Area	$646,968.00
Multi-Court Area	$1,079.680
Turf Field Area	$329,600
Leased Space Area	$617,800.00
Misc. Other Revenue	$626,000
Total estimated annual revenue	$3,300.048.00

FACILITY EXPENSES

The annual facility operational and management costs are detailed within **Table 6.**

Table 6 – Summary of Annual Operational and Management Costs

Costs	Year 1	Year 2	Year 3	Year 4	Year 5
Salaries & Wages	$649,795	$662,791	$676,047	$689,568	$703,359
Utilities	$250,000	$255,000	$260,100	$265,302	$270,608
Facility Management Fees	$150,000	$153,000	$156,060	$159,181	$162,365
Repairs, Maintenance, Supplies	$100,000	$102,000	$104,040	$106,121	$108,243
Insurance	$50,000	$51,000	$52,020	$53,060	$54,122
Marketing & Advertising	$36,000	$36,720	$37,454	$38,203	$38,968
Other	$50,000	$51,000	$52,020	$53,060	$54,122
Total Costs	**$1,285,795**	**$1,311,511**	**$1,337,741**	**$1,364,495**	**$1,391,787**

FACILITY NET PROFIT/LOSS

Our Net Profit/Loss calculation is determined by calculating the total annual revenue minus annual costs as indicated within **Table 7.**

Table 7 – Summary of Net Profit/Loss Assessment

Revenue	
Track & Field Area	$646,968.00
Multi-Court Area	$1,079.680
Turf Field Area	$329,600
Leased Space Area	$617,800.00
Misc. Other Revenue	$626,000
Total estimated facility revenue	**$3,300.048.00**
Costs	
Operational Costs	$636,000
Personnel Costs	$649,795
Total estimated facility costs	**$1,285,795**
Net Benefit Calculation (costs subtracted from revenue)	**Net $2,014,253.00**

ECONOMIC BENEFITS – SPORTS TOURISM

For the purpose of calculation, we have used the Ministry of Tourism, Culture and Sport (MTCS) TRIEM model to assess the overall estimated economic impact of our facility based on the identified user groups. Data input was derived from benchmark events previously hosted in other jurisdictions in conjunction with stakeholder input or expressions of interest towards hosting future events/competitions. The following calculations are based on the estimated total number of visitors to our community taking into consideration the number of days visited (overnight stays) and historical spending patterns previously documented for Sporting Events.

We have completed 34 TRIEM Reports representing four specific sport areas including: Indoor Track & Field; Basketball; Volleyball; and Multi-Sport/Other who have collectively reported to have the interest and capacity to host nearly 90 major events and competitions through the use of our facility.

Table 8 – Summary of Sports Tourism Events & Economic Impact

Basketball	Events (11)	$2,554,094
Track & Field (Sub-Total)	Events (10)	$676,581
Volleyball (Sub-Total)	Events (6)	$744,928
Multi-Sport/Other (Sub-Total)	Events (9)	$724,205
Combined Total Economic Impact	Total Events (36) *Total Eligible Events (90)	$4,699,808

OTHER ECONOMIC BENEFITS

Construction Jobs - Proposed facility will create an average of **1,040 construction jobs** over the scheduled construction period of the build. (Source: Toronto Construction Association, which estimates that 20 person years of employment are created for each $1 million in construction cost.).

- Employment – Proposed facility will employ the equivalent of **13 FTE permanent jobs**.
- Estimated Economic Spin-offs **of $6.5 million for first year** - based on the following assumptions:
    - Total Net revenues collected $1.7 million.
    - Estimated spending on third lease tenants – food & beverage, sport retail, fitness centre, sport injury clinic etc. $3 million.
    - Approximately $4.7 million in revenue a year would flow directly in the local economy resulting in new investment, job creation and additional consumer spending.
    - Using an average industry multiplier of 2.0, our proposed facility will provide an estimated $9.4 million in economic spin-offs annually.

CITY OF HAMILTON RECREATION STRATEGIC PLAN – STATUS QUO

The current City of Hamilton Recreation Strategic Plan has identified the future need for Recreation Centre facilities in Binbrook and Waterdown. **Table 9** illustrates a comparison between a Status Quo approach and the facility development plan we are proposing. Both options are presented based on the current ICIP funding model.

Table 9 – Status Quo Comparison

City of Hamilton Recreation Centre		Hamilton Collaborative Partnership Group Multi-Sport Facility
54,000 sf	SIZE	200,000 sf
$28 million dollars	COST	$60 million dollars
$7.3 million dollars	ICIP CONTRIBUTION	$8 million repayable dollars
100% Tax Payer Supported	TAXPAYER IMPLICATIONS	Fully sustainable
N/A	ANNUAL REVENUE	$2 million dollars
$0	ECONOMIC IMPACT	$14 million dollars

POTENTIAL JOINT – PROJECT OPPORTUNITIES

The Hamilton Collaborative Partnership Group is committed to addressing the needs of our community and values the cost-effective synergies which potentially exist through joint-project initiatives. We have identified up to three potential joint-project initiatives which we are willing to explore however are unable to commit unless our ICIP funding application is approved. It is unlikely that our proposed facility development will succeed without this funding however, if approved, will be very difficult to execute with City of Hamilton involvement.

Potential Joint-Project Opportunities

1. Multi-Purpose Community Hub for Diverse & Marginalized Communities proposal.
2. Indoor Soccer Facility proposal.
3. Commonwealth Games proposal.

INVESTING IN CANADA INFRASTRUCTURE PROGRAM (ICIP) – APPLICATION STATUS

Overview

- Athletics Ontario is the Provincial Sport Governing Body for Athletics in the Province of Ontario and has agreed to serve as the Lead Applicant for our application in collaboration with thirty community partner groups and organizations.
- We have been advised by Provincial Intake Staff that unresolved areas of our application (partnership with the City of Hamilton, location, confirmed funding commitments) do not disqualify us from

submitting an application, however, these areas will need to be resolved before final funding decisions are approved.

- Applications are currently being reviewed at the Provincial level and should be completed by the end of August 2020.
- Successful Provincial applications will be forwarded for Federal approval with decisions being made in the fall of 2020.
- It is highly recommended that the City of Hamilton consider joining our application as a "Joint Partner" in order for our application to be successful.
- We would recommend that the unresolved areas (partnership with the City of Hamilton, location, confirmed funding commitments) be resolved before our application advances to the Federal review in the fall of 2020.
- Timeline - Projects must be completed by March 31, 2027.
- Joint project initiatives are highly recommended.
- Stack funding allows for multiple funding sources to be combined to create larger project outcomes.

COMMONWEALTH GAMES VENUE OPTION

Initial projections have indicated that the City of Hamilton will be asked to contribute an estimated $100 million dollars towards hosting the Commonwealth Games. We are proposing that our ICIP funding application has the potential of contributing approximately $60 million dollars towards this total.

We have also confirmed that this option would qualify as a joint-project initiative and be eligible for "stack funding" contributions which equals to $0 additional dollars being required from the City of Hamilton and provide for a significant cost savings to Hamilton tax payers.

Our proposed facility has the potential of serving as a stand-alone Commonwealth Games venue or has the potential of being severed into multiple projects which can serve as Commonwealth Games venues or infrastructure.

Taking into consideration our current ICIP funding application amount, we have identified the potential direct financial benefit of up to three possible venue developments including:

- $20 million dollars (Multi-Sport Facility) Waterdown.
- $20 million dollars (Multi-Sport Facility) Binbrook.
- $20 million dollars (Track & Field venue) Mohawk Sports Park.

Table 10 – Sample of ICIP Contribution towards Commonwealth Games Venue Plan (Stack Funding)

City of Hamilton Commonwealth Games Contribution	$100 million dollars
ICIP Application - Federal Contribution	$24 million
ICIP Application – Provincial Contribution	$20 million
ICIP Application – Municipal Contribution	$0

Benefits

- Up to $44 million dollars available as part of the City of Hamilton CWG contribution amount.
- Resulting in a $44 million dollar savings for Hamilton taxpayers.
- Providing up to $44 million dollars towards potentially three CWG venue developments.

CITY OF HAMILTON CONTRIBUTION – SUMMARY

1. $8 million dollars direct capital contribution. – Payable over a four-year period (2021 to 2024).

2. Up to $8 million dollars in debt financing provided to Community Partner Group if unsuccessful at capital fundraising campaign - Any debt financing contribution will be repaid through the projected facility operational revenues.

3. 50% of “Non-Eligible” ICIP funding costs (financing, taxes, legal) totalling approximately $5 million dollars (City portion) - Recovered through project Development Charges (DC) estimated at approximately $6 million dollars. Remaining 50% or $5 million dollars (community portion) to be rolled into the debt financing portion.

4. Land contribution from available City inventory or suitable land swap option. – Exact acreage requirement will be determined by final building plan requirements.

RECOMMENDATION

That Hamilton City Council approve a Memorandum of Understanding between the Hamilton Collaborative Partnership Group and the City of Hamilton to allow City Staff to accurately assess the feasibility of a collaborative, joint-project initiative and to present these findings and recommendations to the Chairperson and members of the Emergency & Community Services Committee.

Delegation to Chair and Members of Emergency and Community Services Committee

July 13th, 2020

RE: Homeless Encampments

Thank you for accepting my delegation today. And thank you for all of your work throughout these unprecedented times.

Since the start of the pandemic, Hamilton has seen an increasing number of people experiencing homelessness who are choosing to sleep outside or "sleep rough". This is certainly not a new phenomenon and there are many reasons that people avoid the shelter system. Some people find the rules too restrictive at shelters (there are curfews and bed checks in place). Others lament all the theft that occurs and simply don't feel secure sleeping in a dorm style setting. Still others have pets that are not welcome in shelters and when people have so few supports in their lives, sometimes their pets take precedence above all else. As you know, people who are homeless suffer from a disproportionately high level of mental health issues and we often see people who are simply too anxious or too paranoid to be in close contact with so many people. Other people want to avoid the drug use that is often rampant in shelters. And on the flip side of that there are people who use drugs who are repeatedly evicted from shelters due to their drug use. Many times people are asked to leave shelters just because they have drug use paraphernalia on them. Peoples belongings are routinely searched and a clean needle or an unopened can of beer is enough to be restricted from a shelter. Lastly, there are very few shelter beds open for couples so different-sex couples are either forced to go to different shelters or opt to sleep outside so that they can stay together.

These are all reasons that people choose to sleep rough. Then you add a pandemic on top of that and hearing the repeated message that people living in congregate sleeping settings are at highest risk can be an added worry for people.

I have been working with many people who are sleeping rough during this pandemic. From a health perspective, I see how unwell these individuals often are. I have seen people with severe life-threatening infections, people who have untreated spinal cord issues that put them at risk of becoming paraplegic, women who are in their last few weeks of pregnancy, and so many folks who have addictions that they are desperate to get help with but lack the stability in their lives to make that possible. Imagine trying to get to a pharmacy every day for a dose of methadone when you don't know where your next meal is coming from, you have to somehow protect your belongings from theft, find a place to charge a cell phone so that you won't miss a call from your housing worker and acquire water for your dogs. Never mind finding a place to simply relieve yourself in the morning.

I know that in the past the City has felt they had to dismantle homeless encampments in response to complaints from residents. We saw that at Sir John A McDonald, Jackie Washington

Park and Ferrie Street not long ago. When this happens the connections that were made with people are lost. The outreach workers who have been working on housing applications, the health care workers who have been working on the physical and mental health piece – these connections are all lost when people are told to move along. I was working with an elderly gentleman with a fever and pneumonia who could not do much more than lay on the floor of his tent but refused to go to hospital. With minimal notice he was told to move along and I have not seen him since.

The city has slowed down on dismantling homeless encampments in recent weeks and I am grateful for that, as are my patients. I am asking that this continue to be the overarching principle in dealing with homeless encampments: let them be. This pandemic is unprecedented. We can't expect that responses that might have seemed reasonable in the past are appropriate during a pandemic. People do not cease to exist when they are told to move along. They still need a place to be and by virtue of sleeping rough they have shown that they do not fit into the current shelter system as it is**. The Centre for Disease Control (CDC) has issued guidelines stating that "Unless individual housing units are available, do not clear encampments during community spread of COVID-19. Clearing encampments can cause people to disperse throughout the community and break connections with service providers. This increases the potential for infectious disease spread."**

We are imploring you to recognize the severe health consequences facing people who do not have housing, to recognize that we are in a new era where the old rules are not necessarily the best ones and to refrain from moving encampments along whenever possible. From our perspective, it would only be acceptable to move people along when they are either being moved to housing units with appropriate supports or to an ultra low-barrier, highly supportive shelter model that will give them a chance of success. Moving people into one of the current shelters or hotels to have them evicted two days later only further decreases the trust that people have in the system, making them less likely to engage in the future.

We need to recognize that the current shelter system does not meet the needs of many of these individuals. I ask that, in the re-imagining of our city's response to homelessness that the pandemic has instigated, we make this group of high-needs individuals who sleep rough a priority. Currently, we see many of these folks being service restricted from all of the shelters in the city and turned down from city-run hotels due to the fact that their needs are too high. In the healthcare world, that is like saying that you are too sick so we are not going to offer you any care. Instead of turning our backs on them and continually telling them to move somewhere else so that they won't be seen, we need to find something that WILL work for them. What about a motel space that is as low-barrier as possible with intensive social and health supports? Other jurisdictions in Canada have done this with great success. The city has recently made a precedent of helping two people get directly from a homeless encampment into permanent housing. This was successful and there is no reason that it would not work for other folks as well. What this group needs are options and at this point viable options for them do not exist.

I understand that the focus for you right now is likely the encampment outside of First Ontario Centre. But our concerns about this issue predate that encampment. Part of the reason the FOC encampment developed was due to smaller encampments in the city being dismantled – groups of two or three tents at the back of a park that were told to move along, or a single tent along the rail trail somewhere. Another group of people outside FOC are people who have been service restricted from all of the shelters in the city. And other people sleeping outside of FOC have been illegally evicted from their residential care facilities (RCF's). The encampment developed in that particular spot likely because of the neighbouring shelters that offered community to people as well as the fact that amenities existed in that area. Toilets and meals have not been as easy to come by during the pandemic and people will go to areas where services exist.

So please, stop dismantling homeless encampments for the duration of the pandemic unless people are being moved to an indoor space where they will have a modicum of success. This is not only a matter of public health and best practise as per the Centre for Disease Control, it is also a matter of human dignity and human rights. We need to recognize that the current system does not work for many people who are sleeping rough and work to either get them directly into permanent housing with appropriate supports or accommodate them in a shelter/motel that is low-barrier and high-support enough to meet their needs. Barring that, our city needs to be following an evidence-based approach to this issue, follow the international health guidelines that are available to us and stop dismantling homeless encampments.

Dr Jill Wiwcharuk and Dr Tim O'Shea, Hamilton Social Medicine Response Team (HAMSMaRT)

KEEPING SIX HAMILTON
HARM REDUCTION ACTION LEAGUE

July 13, 2020

Dear Chair and Members of the Emergency and Community Services Committee,

Thank you for receiving our delegation. We are writing to you today on behalf of Keeping Six, Hamilton Harm Reduction Action League to request that the City re-evaluate and change its approach to encampments to better support the needs of those living in them and to facilitate service provision and access to housing. We believe that this can be accomplished in the following ways:

- that there be an explicit acknowledgement that the shelter system (including the pandemic hotels) do not meet the needs of many, and this is a significant contributing factor to the encampments in the city
- by including people with lived experience of living in encampments in the City led Encampments working group and providing the supports necessary for participation
- that people living in encampments be prioritized for supportive housing
- that ultra-low barrier shelter option or options be created
- that in the absence of suitable housing or shelter, people be offered the option of sanctioned encampments in locations suitable to the City and the encampments' inhabitants
- that, barring an alternative suitable to the people or person in question, a person's housing not be dismantled, at least for the duration of the pandemic, as recommended by the Center for Disease Control.

Let us begin by saying that we appreciate that this is a difficult subject and that you face extra-ordinary pressure from the tax and voting base to "get rid" of this problem and restore access to perceived security and tranquil green space. We also acknowledge that the issue has been hurtled into the minds and emails of many because of the highly visible First Ontario Centre Encampment.

As a group comprised of people and supporters of people living or who have lived in such encampments, we need for you to understand that the problem for us is broader than FOC and more pressing than access to green space. Further, we are not the pariah that people want to make us out to be, and that the moral leadership of the city on this issue could go a long way toward shifting that narrative and building a more inclusive city.
A mainstay of our work as an organization led by people with lived experience is being connected to the people on the ground. A constant refrain from the streets is that people are exhausted and undermined by being in a perpetual state of dislocation. Always being moved

along. It is next to impossible to make any *progress* in life while being consumed by sorting out where to be.

Another pillar of our work is to insist that the voices of people impacted by policy create that policy, or at least have a hand in it. Nothing about us, without us. This is of course about representation but also practicality; you would be surprised by how smart we are, how well we understand the issues and their nuance, and the ways in which we are able to propose realistic solutions and create buy in for them.

Our community has several times raised the idea of sanctioned sites, where we could establish some modicum of stability by doing away with the perpetual need to find a new place to live and acquire new belongings destroyed in the dismantlement. While it may not seem obvious at first glance, the stability and predictability of sanctioned or tacitly supported sites will decrease the problems associated with encampments, not increase them. Firstly, we will have an opportunity to create stable community and a sense of cohesion and ownership which fosters accountability to one another, our surroundings, and the community. Second, it facilitates access and continuity to services that might help us gain access to more stable housing (one of our number one goals), and health care. There is successful precedent for this in other cities in Canada and we would be happy to connect you to folks doing that work. K6 would also be first to engage people in such an encampment and would make it a priority for our existing outreach program.

Finally, a note to say, it gives us no great joy to come before you today and beg for people to be left to camp in the city. It is not what most of us want. But in the acknowledged absence of an alternative, with a run of systems failures that cross all levels of government, it is what we are left with.

The existing services for shelter in the city are valued and have hard working dedicated people in them and, we acknowledge, consume a great deal of resources. But we are all in agreement that the existing services do not meet some people's needs. Some of us simply do not succeed in them. Teams of people worked extremely hard to humanely and respectfully clear people from the Sir John A encampment. On a Friday most if not all were in shelter or hotel. By Monday many were discharged and back on the street.

Now, we can discuss why that it is and disagree about where to "lay the blame" as it were, but the facts the ground remain that as it stands, it doesn't work for some. We and many before us have long been in discussion about what could work. At every turn to every suggestion we hear: there are no resources for that, we have no funds, no staff. Excellent supportive programs like HOMES are oversubscribed and have long waitlists. The reality is that our current suite of Housing First services in Hamilton does not meet the housing needs of people who experience the most complex barriers to housing. The encampments we are talking about today are exacerbated by that gap in services.

This plea to not move encampments unless an acceptable alternative is available is an acceptance of that proposition, that the resources to solve this crisis don't currently exist. Our preference is definitely for people to have access to suitable indoor living arrangements. But in the current climate, we know that this is not possible. In a time when everyone comes to the city asking for

everything, we are asking for an end to the resource intensive perpetual make work project of moving people around from place to place, which only undermines any effort to “get rid of people”, because no matter what the complaining tax payers or voters want, moving us on does not make us evaporate. We need to be somewhere.

We appreciate that it is a complex subject that lends itself best to conversation and answering of questions. We have tried to anticipate some of your questions in the appendix and provide brief answers. We are happy to sit down at any time to discuss further how this shift in strategy could work.

Sincerely,

Jody Ans
Founding member of K6

Lisa Nussey
Co-coordinator of K6

Frequently Asked Questions

What is an encampment?

There is no agreed upon definition of an encampment. To us, in this submission, it means a person or group of people sleeping outdoors in temporary shelter, like a tent or an impermanent structure fashioned out of any number of materials, like tarps, umbrellas, wood, etc.

Don't people just want to sleep rough?

This may *occasionally* be true, but this choice is the exception, not the rule. People who are truly choosing to sleep rough are few and far between, and they are not the subject of this submission.

Aren't encampments dangerous to the people living in them?

Yes. Sleeping on the street is dangerous. There have been instances fires in some encampments. There have also been incidents of violence between people in encampments. This is part of the reason why we advocate first for safe, dignified housing for all. Until that is possible, however, people will sleep rough. This means that we must do our best to make rough sleeping safer. Moving people does not remove the potential for fire or violence. It simply displaces it and frankly aggravates it, by making people more on edge. Further, the stability of not moving encampments allows for us to make them safer by building community and supplying people with safety equipment.

Aren't encampments dangerous to people living near them?

We do not have good evidence to answer this question. Without oversimplifying, our intuition and experience is that when people are treated with respect and kindness, they largely give the same in return. Certainly, reduced displacement is a gesture of respect and provides opportunity for building links across differences in communities. There is some evidence out of the US to show that broadly speaking, crime stays the same or goes down in neighborhoods around sanctioned or tacitly supported encampments. There have always been similar arguments leveled again the creation of sanctioned Consumption and Treatment Centres, and this fear of increased crime has not borne out in reality.

What do we mean by a sanctioned site?

A sanctioned encampment is one where the City either explicitly or implicitly permits people to erect temporary shelter, offering the continuity and stability required to take some next steps in the journey toward housing. Beyond that, there could be on site hygiene facilities like toilets and handwashing stations. Services can be brought on site and more reliably connect with people. Food delivery by area agencies could take place. Regular garbage pickups could be organized. Resident led systems of governance and accountability could be fostered. There is some preliminary evidence out of the US that shows that this strategy could be successful in reducing homelessness.

Understanding Encampments of People Experiencing Homelessness and Community Responses

Emerging Evidence as of Late 2018

U.S. Department of Housing and Urban Development | Office of Policy Development and Research

Understanding Encampments of People Experiencing Homelessness and Community Responses:

Emerging Evidence as of Late 2018

January 7, 2019

Submitted by:
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Abt Associates

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Introduction

Cities, suburban communities, and rural areas across the United States have seen in recent years the rise of groups of people experiencing unsheltered homelessness together. The term *encampment* is widely used by journalists and researchers to describe these groups, but other terms include *tent cities, homeless settlements,* and *homeless camps.* Although their existence is not unprecedented, media reports suggest that the number of encampments has increased sharply in recent years (National Law Center on Homelessness and Poverty, 2017).

People experiencing unsheltered homelessness may perceive staying in an encampment as a safer option than staying on their own in an unsheltered location or in an emergency shelter; however, encampments can create both real and perceived challenges for the people who stay in them as well as for neighbors and the broader community. As community leaders seek to develop and deploy a response, they often are called on to balance multiple, sometimes competing priorities and demands from a diverse group of stakeholders, including community residents, business owners, public health and safety officials, and advocates for disadvantaged populations—as well as the people living in the encampments.

This paper documents what is known about homeless encampments as of late 2018, based on a review of the limited literature produced thus far by academic and research institutions and public agencies, supplemented by interviews with key informants. This paper is part of a larger research study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research. This study's goal is to contribute to our understanding of homelessness, including the characteristics of homeless encampments and the people who stay in them, as well as local ideas about how to address encampments and their associated costs.

What Are Encampments, and What Do We Need to Know About Them?

The term *encampment* has connotations of both impermanence and continuity. People are staying in temporary structures or enclosed places that are not intended for long-term continuous occupancy on an ongoing basis. Inhabitants may be a core group of people who are known to one another and who move together to different locations when necessary, or they may be a changing group of people who cycle in and out of a single location. The physical structures that make up encampments can take many forms, including tents on pallets and shanties, or lean-to shacks built with scavenged materials. Structures may be simple or complex multiroom compounds. People experiencing homelessness in encampments may also stay in groups of cars or vans or in manmade tunnels and naturally occurring caves.

Community reactions to encampments have taken a variety of forms. Some communities send police to quickly clear ("sweep") encampments, with no attempt to provide services or referrals to help people at the encampment find another place to stay. At the other end of the spectrum, some communities permit ("sanction") encampments formally. Local government or community organizations provide running water and places to prepare food and dispose of waste, as well as healthcare and other services.

The research questions that guided this review are shown in Exhibit 1. In the larger research study, we will attempt to provide information about encampments and the people who are staying in them and to answer these research questions. We sought preliminary information for these questions through a formal examination of the peer-reviewed literature; we also identified and examined non-peer-reviewed reports by academic institutions, public agencies, and other organizations (sometimes called *gray literature*). In addition to conducting literature reviews, we interviewed several key informants who are subject matter experts on encampments. We selected them because they are conducting research on encampments and related topics or they are helping communities devise and implement best practices for dealing with encampments.

Exhibit 1. Research Questions for the Study of Encampments

Understanding Encampments

1. What factors are driving the increase in people living in encampments?
2. What infrastructure or state or local ordinances or other policies impede or promote the establishment of encampments?
3. Who lives in encampments? Are there some subpopulations of people experiencing homelessness who are more likely to form or attach themselves to homeless encampments? Do people staying in the same encampment share certain characteristics? Are there any differences between the unsheltered population living in encampments and those who are unsheltered in other locations?
4. How large are encampments? Do their characteristics vary by size?
5. What types of social structures characterize encampments?
6. Why do people choose to live in encampments? What are the "pull" and "push" factors?

Community Efforts to Address Encampments

7. What steps are communities taking to prevent the establishment of encampments?
8. How are communities responding to encampments? What are the major activities, and which stakeholders are engaged?
9. Can approaches to encampments be categorized—for example, as sanctioning, clearing, or relocating?
10. How do responses to encampments relate to the broader homelessness services system?
11. How do responses to encampments differ across different types of communities?
12. In what ways do these efforts differ from efforts to serve the unsheltered population not living in encampments?

Costs Associated with Encampments

13. What are the direct costs incurred by communities in their efforts to address encampments?
14. How do costs differ depending on different community approaches?
15. How do the costs of managing or addressing encampments compare with the cost of emergency shelter and the cost of permanent supportive housing?
16. What health and safety issues have communities encountered with people staying in encampments?
17. What are the broader societal costs associated with encampments?

We summarize the nascent evidence on encampments in the following two sections. *Understanding Encampments* reviews what we know about why encampments form and what they look like. *Community Responses to Encampments* describes the factors that lead communities to adopt various approaches and what we know so far about their effectiveness. Then we describe the *Limitations of the Current Evidence on Encampments,* including some suggestions for additional research beyond the scope of this study. Finally, Appendix A describes how we conducted the literature review and key informant interviews, Appendix B provides additional details on selected studies that were particularly informative as we completed our review, and Appendix C summarizes selected practitioner resources to assist with addressing encampments.

Understanding Encampments

This section describes what we know as of late 2018 about encampments: why there has been a sudden increase in encampment homelessness in the past few years and how encampments vary in resident characteristics, in social structure, and regionally. As discussed herein, conditions can be harsh, volatile, and unhealthy. Still, people may live in encampments (rather than shelters or in other, unsheltered locations) for a variety of reasons, including factors that lead them to reject other types of shelter and factors that attract them to encampments. Section 3 will cover what we know about emerging community responses to encampments.

Explanations for the Increase in Encampments

Researchers generally agree that increases in homelessness are first and foremost the result of severe shortages of affordable housing, combined with a lack of political will to dedicate sufficient resources to address this problem (Shinn and Khadduri, forthcoming). According to a key informant who is helping communities understand how to deal with encampments, when people are in crisis, their decisions about where to stay represent pragmatic choices among the best available alternatives, based on individual circumstances at a particular moment in time. Encampments form in response to the absence of other, desirable options for shelter.

Within this underlying context, several related factors seem to influence whether people experiencing homelessness form or go to encampments rather than stay in shelters or on their own in unsheltered locations. Primary among those factors are (1) shortcomings in the shelter system, (2) a sense of safety and community within encampments, and (3) a desire for autonomy and privacy. Only one peer-reviewed article (Herring, 2014) mentions the potential for greater access to food and services or other material comforts as reasons that people congregate in encampments rather than stay on their own in unsheltered locations. Key informants and other peer-reviewed articles did not identify this as a primary factor influencing the decisions of people experiencing homelessness.

The Shelter System Falls Short

Shortcomings in the shelter system are consistently identified as a primary factor that "pushes" people to congregate in encampments. Many communities have literal shortages in the capacity of the shelter system to provide beds for everyone experiencing homelessness (Herring and Lutz, 2015; National Coalition for the Homeless, 2016; National Law Center on Homelessness and Poverty, 2014; Speer 2018a). In other communities, shelter beds are available but go unused because of regulations or conditions that are incompatible with potential clients' expectations or needs. Exhibit 2 lists some of the reasons cited in the literature and in key informant interviews why people experiencing homelessness may eschew shelters in favor of encampments. The availability and type of shelter available seem to be key drivers of encampments, as people weigh the disadvantages of staying in a shelter against their tolerance for the difficulties of staying in an unsheltered location (City of San Francisco, 2015; Herring and Lutz, 2015; National Law Center on Homelessness and Poverty, 2014).

Exhibit 2. Shortcomings in the Shelter System

Specific shortcomings in the shelter system that may contribute to increased numbers of people congregating in encampments:

- A supply of shelter beds insufficient to meet the demand; this problem may be exacerbated by limited funding for emergency shelters and by community opposition to creating new or expanded shelter and bridge housing facilities or permanent supportive housing.
- Restrictions in shelters that would result in separation from a partner, family member, or pet.
- Shelter entry/exit times and locations that are inconvenient or incompatible with people's daily routines, including work schedules.
- Concerns about the security of personal belongings; restrictions on the ability to store belongings and difficulty moving belongings in and out of shelters on a daily basis.
- Concerns about personal safety and exposure to germs and disease within shelters.
- Specific barriers to entry, including sobriety requirements and entry fees.
- General perceptions of shelters as "inhospitable," "alienating," "demeaning," and offering little or no support or case management to find permanent housing.

Sense of Safety and Community

People who stay in encampments may see them as offering greater safety and protection from police harassment and aggression (Burness and Brown, 2016), and from assaults or the theft of belongings (Donley and Wright, 2012; Speer, 2017), than if they were unsheltered on their own. This sense of "safety in numbers" may be particularly prevalent in long-standing and highly organized encampments, in which residents have established around-the-clock security patrols and mutually enforced norms and standards for behavior (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). In high-cost cities in particular, individuals' decision to congregate in an encampment may be influenced by the behavior of their peers, according to a key informant who is conducting research on encampments. Once a critical mass of people has determined that encampments are a way of dealing with their housing crisis, others may feel emboldened to follow suit. Some cities respond to the presence of an established encampment by providing bathroom facilities and other basic services, making encampments seem to be a reasonable alternative to constant moving, threats of eviction, or shelters.

Desire for Autonomy and Privacy

In contrast to the rules that govern many aspects of shelter stays, staying in an encampment means that people can generally come and go as they please. The ability to exercise autonomy and freedom of movement appears to be a powerful factor that draws some people to encampments (Lutz, 2015; National Law Center on Homelessness and Poverty, 2014; Sparks, 2017a). This independence is sometimes eroded in communities that "normalize" encampments, introducing regulations that restrict residents' activities in the process. When that happens, encampments may in effect become an extension of the same shelter system that people reject in favor of encampments (Herring, 2014; Speer, 2018a).

Access to Illegal Substances

Residents of encampments may or may not be using illegal substances. Nothing in the literature suggests that most or even many encampments are where people congregate primarily to support their drug addiction. That said, in at least one high-profile example, the location of an open-air drug market directly influenced the formation and continued existence of an encampment, according to a key informant studying encampments. In that instance, the availability of a dependable supply of heroin close-by led addicts to stay in encampments in the Kensington area of Philadelphia even though the city had available shelter space.

Variation in Encampments

Researchers and other experts have not yet developed a single, standard set of criteria defining a group of people experiencing unsheltered homelessness as an "encampment." In this review, the definition we used encompasses a wide variety of scenarios—from established settlements that have a well-defined set of mutually agreed-on and enforced rules to loose congregations that have little to no organization or cohesion. In this section, we describe what our literature search and key informant interviews revealed about the variation among encampments in resident characteristics and social structure; we then summarize how encampments may vary in different parts of the United States.

Resident Characteristics, Social Structure, and Motivations of Residents

The literature has little to say about characteristics that distinguish people experiencing unsheltered homelessness in encampments from those who experience unsheltered homelessness on their own. The U.S. Interagency Council on Homelessness is leading an effort to analyze data records for people experiencing homelessness, along with partner organizations including U.S. Department of Housing and Urban Development, the National Alliance to End Homelessness, California Policy Lab (a nonprofit partnership between the Universities of California Los Angeles and Berkeley), and the consulting firm OrgCode. That effort will provide insights into the characteristics and experiences of people experiencing homelessness in unsheltered locations, including whether they are distinctly different from people who experience sheltered homelessness; however, the data will not make it possible to distinguish people in encampments from people in unsheltered locations generally.

Some studies describe variations in the racial and ethnic composition of encampments. For example, one study conducted outside Orlando, Florida, engaged 39 people staying in encampments in focus groups. Nearly three-fourths of participants were men, and most were White—a demographic composition characterized by the local outreach team as generally representative of people experiencing unsheltered homelessness in the area. In contrast, downtown shelters in Orlando had a much larger population of African Americans (Donley and Wright, 2012). Seattle's evaluation of its sanctioned encampments also found fewer people of color in encampments relative to emergency shelters (City of Seattle, 2017). The demographic makeup of people staying in encampments in Oakland, California, seems to include a larger share of people of color, but individual encampments are segregated along racial and ethnic lines (Jones et al., 2015).

The internal organization and motivations of residents significantly vary among encampments. Some encampments have a strong social structure and organization, sometimes with oversight or assistance from local charitable or faith-based organizations. Residents may be required to assume responsibility

for day-to-day operations, including security patrols and other duties (City of Seattle, 2017; Lutz, 2015). Residents may vote in governance decisions, and they may be expected to attend weekly resident meetings in accordance with an encampment-wide code of conduct (Sparks, 2017a). A key informant conducting research on encampments described the social structure established by a group of mothers staying with their children in a recently cleared encampment in Oakland, California. Residents of the encampment prohibited drug use and shared responsibility for childcare. These expectations promote a sense of community and have been credited with helping encampment residents "feel human" and believe that they have something to contribute (Sparks, 2017b).

Other encampments have less cohesion and more informal rules and structure, which may on occasion result in friction and conflict among residents (Sparks, 2017a). Larger encampment "communities" may be less cohesive than smaller groups composed of family members and friends (City of San Francisco, 2015). In addition, the potential for exploitation exists in encampments, according to key informants conducting research on encampments. For example, younger people may offer to provide protection to older residents but then expect some form of compensation in exchange. Encampments formed around access to opioids in Philadelphia seem to have no leadership structure at all; however, according to a key informant conducting research on encampments, rarely do people living in an encampment have a complete lack of interaction with each other. People staying together in encampments tend to look out for one another and have some sense of solidarity.

Motivations of encampment residents may differ, as well. According to key informants who are helping communities develop responses to encampments, some residents of encampments are eager to access services and permanent housing. Others clear out in advance of a sweep, even if the sweep may provide them with access to services. Such variation might occur within one encampment if it is large enough. For example, when more than 700 people were cleared from the Santa Ana River encampment in Orange County, California, some people accepted help and were able to find housing or went to drug treatment centers, whereas others simply left for another encampment. When encampments have formed in areas that provide dependable access to illegal drugs in general and opioids in particular, referrals to housing and services are likely to be met with a mixed reaction, depending on the timing of individual residents' addiction trajectories and the characteristics of the shelters that are an alternative to staying in the encampment.

Regional Differences in Encampments

Cities in the Northeast, where winters can be harsh, are more likely than cities in other parts of the country to have relatively large shelter systems. According to a key informant who is conducting research on homelessness, this difference in the homelessness services system is reflected in the characteristics of people experiencing unsheltered homelessness, including those who stay in encampments. According to her observations, in cities with large numbers of shelter beds, the unsheltered population tends to have high rates of disability and mental health issues, which may create challenges to entering shelters. In contrast, in West Coast cities with limited shelter availability (or where barriers to shelter use are higher), the unsheltered population represents a greater mix of people, including those who do not have behavioral health disabilities but are unable to access shelter for other reasons. They may be recently homeless and unfamiliar with the shelter system, or they could be unwilling or unable to comply with the requirements of relatively high-barrier shelters on the

West Coast, or they may simply be unable to find an available shelter bed. As on the East Coast, many people in West Coast encampments are not able to tolerate or navigate the shelter system because of mental health or substance abuse disorders; however, West Coast encampments are also likely to include people who do not face those challenges.

According to researchers in the San Francisco Bay Area, those who stay in encampments may even have support from family members who visit regularly and bring food and medication or who invite them in to shower and do laundry (Jones et al., 2015). According to key informants who are researching encampments in the West, people who are now staying in encampments in western states could maintain stable housing without supportive services if they had rental assistance or other income support. For those individuals, the lack of access to affordable housing and shortages of shelter beds are the primary factors driving them to experience homelessness in encampments.

The physical nature of encampments often reflects regional differences in the geographic setting, including the natural features and available land. For example, an encampment in Southern California's Coachella Valley consists of a variety of structures detached and spread out across a contiguous area. In Columbus, Ohio, encampments are composed of tightly clustered tents and lean-tos. In San Francisco, people form encampments along the edges of highways and train tracks and under elevated freeways. In Las Vegas, encampments can be found in an underground tunnel system. The location of encampments balances two factors: maximizing convenience (that is, ease of access to the resources people use to address their daily needs) and minimizing visibility (that is, avoiding complaints to the city that could result in the encampment being cleared) (City of San Francisco, 2015).

Regional variation in encampments may also reflect the different ways that cities respond to encampments. Section 3 presents a typology of community responses to encampments and discusses the evidence—at this point, scant—on the effectiveness of those various approaches.

Community Responses to Encampments

Local responses to encampments are evolving in many communities, as stakeholders seek to identify the best strategies to address this growing phenomenon. Approaches vary along many dimensions but can be broken into four basic categories, as described in Exhibit 3. Specific activities range from sending police to quickly clear ("sweep") the encampment—providing little or no support to help people find another place to stay—to formally sanctioning encampments and providing onsite services.

Communities commonly use more than one response at a time to manage encampments, depending on resource availability, the location of encampments, and the characteristics of people congregating in encampments. For example, Las Vegas has created the Courtyard, a one-stop resource center that includes secure space to sleep outside, but it also deploys outreach teams that include law enforcement officers to clear encampments. Jurisdictions within the same region may adopt different strategies to address encampments. According to key informants helping communities to develop responses to encampments, communities may need to use a variety of approaches at the same time to serve populations that have different needs. When those efforts are not well coordinated across departments or neighboring jurisdictions, however, they may act at cross-purposes. For example, a jurisdiction that clears encampments, with little notice and no support, may undermine efforts to build relationships and trust in a neighboring jurisdiction that tacitly approves encampments.

Exhibit 3. Typology of Responses to Encampments

Category	Characteristics
Clearance With Little or No Support	• Notice of pending sweeps provided only a few days in advance, if at all • Belongings stored for a short period of time, if at all • Few or no shelter or service referrals provided • Regulatory or physical barriers to secure the site of the former encampment and keep it from being reoccupied
Clearance With Support	• Notice of pending sweeps provided weeks in advance, often by trained outreach workers who have experience working with people experiencing unsheltered homelessness • Longer term storage of belongings available • Referrals to shelter or services provided by outreach workers, who also accompany the first responders and sanitation crews who clear encampments

Category	Characteristics
Tacit Acceptance	• Encampments allowed to persist regardless of whether laws or ordinances explicitly authorize or prohibit their existence • Longer term storage of belongings available • Basic services or infrastructure provided, in particular to address public health and sanitation concerns (for example, portable toilets, showers, and potable water) • Outreach workers may visit the encampment to provide referrals to permanent housing, shelter, and services
Formal Sanctioning	• Encampments permitted by law or ordinance on public and or privately owned property, usually only in designated locations • May have established rules that govern the size, location, or duration of encampments • May have a public agency or nonprofit organization manage encampments • Infrastructure and public services—which may include laundry and potable water, common spaces for eating and meeting, lockers for storing belongings (including on a longer term basis), meal services and food donations, job training programs, access to mail and voice mail services—provided by the municipality and private or faith-based organizations and volunteers • May provide case management, including assistance applying for transitional or permanent housing and other benefits, appealing denials, and managing funds

Cities also use strategies to prevent encampments from forming. Some communities enact laws prohibiting activities associated with encampments, such as lying down or erecting structures on public space. More than one-third of U.S. cities have adopted camping bans, citing health and safety concerns (National Coalition for the Homeless, 2016). Researchers at the University of Denver identified more than 350 antihomelessness ordinances in Colorado's largest cities (Adcock et al., 2016). Other approaches include physical modifications to the built or natural environment, such as securing vacant lots and buildings to restrict access, clear-cutting brush that could provide cover for encampments, and installing sprinklers in areas where encampments might form (Chamard, 2010; National Law Center on Homelessness and Poverty, 2014). When an encampment is cleared, with or without support, the community may also impose new regulatory or physical barriers to keep the encampment from reemerging in the same location or in other parts of the community.

Factors that Drive Local Responses

Cities respond to encampments for a variety of reasons, and the goals of the interventions may vary—from cleaning up a business area, to helping people access shelter, to helping people obtain permanent housing. Even within the same jurisdiction, different stakeholders may have different definitions of success in dealing with encampments. For example, the transit authority may have a goal of breaking up encampments adjacent to a railroad bed, the department of public health may want to prevent the

spread of disease, the housing department may be working to end homelessness, and community homeless advocates may be focused on avoiding adverse consequences for the encampment population. Those differing views will also influence the strategy, or set of strategies, used by the city to address encampments (Burness and Brown, 2016; Jones et al., 2015) and can make comparing interventions across communities difficult. The factors that were most commonly cited in the literature as influencing cities' approaches to encampments are (1) community and political pressure, (2) resource availability, and (3) fear of litigation.

Community and Political Pressure

According to researchers and key informants who are helping communities devise strategies to address encampments, the "nuisance" factor is the key policy driver. Outreach teams or police usually are deployed only when community residents or other stakeholders complain about an encampment. At that point, interventions need to be visible and quick to demonstrate responsiveness to community concerns and to relieve political pressure (National Law Center on Homelessness and Poverty, 2014). In the absence of sufficient resources to move everyone into permanent housing, communities often employ a clearance strategy, with or without support, that moves people out of sight or farther from central business districts, where their presence can affect economic growth (Speer, 2018b).

Cities typically prioritize efforts in neighborhoods where political pressure is greatest. Not surprising, those neighborhoods often are not the locations with the highest levels of unsheltered homelessness and encampments, according to key informants who are helping communities devise strategies to address encampments. In areas with low visibility, with little or no community pressure, cities may pursue a policy of tacit acceptance—even if encampments exist in violation of a no-camping ordinance (Herring, 2014).

Resource Availability

Concern for community and resident well-being would, ideally, be the primary factor shaping cities' encampment response strategies; however, resource limitations may require city leadership to make trade-offs and choose an approach that works within existing constraints (Herring and Lutz, 2015; Loftus-Farren, 2011; National Law Center on Homelessness and Poverty, 2014). In Philadelphia, for example, according to a key informant conducting research on encampments, recent efforts that could be characterized as clearance with a high level of support were limited to two of four known opioid encampments because the city lacked funding to provide services and shelter for people congregating in all four. Without the ability to provide rent assistance or needed services, the city adopted a policy of tacit acceptance at the remaining two encampments. Cities may also create sanctioned encampments in lieu of providing permanent rent subsidies, or cities may pursue clearance with little or no support if they lack the resources to provide any additional assistance.

Fear of Litigation

Fear of legal challenges influences how cities approach closing encampments. Local jurisdictions want to avoid being taken to court over due process and cruel and unusual punishment challenges, according to a key informant engaged in research on encampments. This concern is likely to grow following the September 2018 ruling of the Ninth Circuit Court of Appeals in *Martin v. City of*

Boise.[1] Courts have found that depriving homeless people of the rights to perform survival activities in public spaces when no alternatives are available violates the 1st, 4th, 5th, 8th, and 14th Amendments to the Constitution (Kieschnick, 2018; National Law Center on Homelessness and Poverty, 2014). In *Martin v. City of Boise*, the court held that "as long as there is no option of sleeping indoors, the government cannot criminalize indigent, homeless people for sleeping outdoors, on public property."

Some legal challenges have resulted in settlements, which generally call for minimum notice before clearance of encampments, requirements for storage of personal belongings, and compensation for people who are swept from encampments and for their attorneys (National Law Center on Homelessness and Poverty, 2017). In January 2018, advocates brought a lawsuit against officials in Orange County, California, following the clearance of a massive encampment along the Santa Ana riverbed. As of October 2018, elements of a preliminary settlement agreement were more expansive and included a commitment to provide proactive outreach and engagement, as well as referrals to services, before evicting people from encampments; development of "standards of care" by the county for homelessness services programs; drawdown of funds already available to support "programs, services, and activities" for people experiencing homelessness; adoption of due process protections; establishment of a method for formally addressing requests for accommodations under the Americans with Disabilities Act; and referrals to collaborative courts[2] to handle citations.[3]

Effectiveness of Various Responses

The effectiveness of responses to encampments may be thought of as creating positive outcomes for the people who stay in encampments, creating positive outcomes for the broader community, or both. At this point, research that attempts to measure any such outcomes in a rigorous way is limited. Findings from anecdotal reports in individual cities are not broadly generalizable or transferable. To begin to address gaps in existing knowledge, the National Alliance to End Homelessness, U.S. Interagency Council on Homelessness, and U.S. Department of Housing and Urban Development are working with state and local partners to develop and test strategies for addressing unsheltered homelessness, including encampments. The Arnold Foundation (2018) is exploring the effectiveness of interventions that first responders can use to address unsheltered homelessness. Those projects are still in the early stages and are complicated, according to a key informant, by the absence of baseline data from which to evaluate the effectiveness of the responses. According to a researcher currently working on encampments, intensive outreach work will be needed to establish study samples, and a

[1] The Ninth Circuit has jurisdiction over nine states in the western United States, including Alaska and Hawaii, as well as the District of Guam and the District of the Northern Mariana Islands.

2 Collaborative courts are an alternative justice model that focuses on treatment and behavior change (rather than sentencing) to help defendants improve their lives. Homeless courts are one type of collaborative court. According to the California Association of Collaborative Courts, these are "special court sessions held in a local shelter or other community site designed for homeless citizens to resolve outstanding misdemeanor criminal warrants." https://www.ca2c.org/types-of-collaborative-justice-courts/

[3] Orange County Catholic Worker et al. v. County of Orange et al., Joint Statement of Settlement Progress (Central District of California, 2018) https://scng-dash.digitalfirstmedia.com/wp-content/uploads/2018/10/oc-homeless-plaintiffs-lawsuit-settlement.pdf.

high level of resources will be required to track people's experiences over time and to measure outcomes, but those efforts will be necessary to develop appropriate policy responses.

Without the availability of strong evidence, cities adopt approaches that seem to be best practices. Local responses also depend on the community's goals and priorities, which may include reducing crime, eliminating health hazards, or improving a business district—and may or may not include housing people experiencing homelessness. In the following sections, we provide descriptive and inferential information on the factors that may determine the effectiveness of responses, including the approach selected, the characteristics of encampment populations, and available resources. We summarize the current state of knowledge for various types of approaches.

Clearance with Little or No Support

Cities that adopt a policy of clearance with little or no support may justify this approach as "tough love" that encourages people in encampments to enter city-operated shelters (Lutz, 2015; National Coalition for the Homeless, 2016). The literature and key informants, however, agree that sweeps of encampments do little to increase shelter usage or otherwise resolve the problem of encampments (National Law Center on Homelessness and Poverty, 2014). Especially in communities with many low-visibility places, people are likely to simply pack up and move on to another location (Junejo, Skinner, and Rankin, 2016) or reestablish the encampment at the former site once the city has cleaned the area.

Clearance with little or no support may actually *reduce* the likelihood that people will seek shelter because it erodes trust and creates an adversarial relationship between people experiencing homelessness and law enforcement or outreach workers. In a survey of encampment residents in Honolulu, 21 percent of respondents said that they were less able or likely to enter shelters after sweeps, and 68 percent said that the sweeps had no effect on whether or not they went to shelters, although those responses seem mostly to be the result of undesirable shelter conditions (Dunson-Strane and Soakai, 2015). Another study conducted in Seattle finds that only one-third of encampment residents "accepted offers of alternative shelter after a sweep" (Junejo, Skinner, and Rankin, 2016: 16). Analyzing interviews with both outreach staff and encampment residents in Oakland, California, Jones and his colleagues hypothesized that continuous sweeps cause people experiencing unsheltered homelessness to "focus on short-term needs and immediate coping strategies," disrupting the level of stability necessary for encampment residents to engage in long-term planning (2015: 82). People forced to relocate during a sweep may have difficulty reconnecting with outreach workers who have been working with them, and any progress made toward moving into housing or accessing services could be lost. Experiences in Honolulu, Seattle, and Oakland suggest that sweeps are disruptive to people who are attempting to stabilize their lives and find a pathway to housing, and they may have lasting traumatic psychological and emotional impacts (Jones et al., 2015; Junejo, Skinner, and Rankin, 2016).

Clearance with Support

The support provided in responses that can be characterized as clearance with support may include extensive outreach in advance of clearance and referrals to existing shelters or housing programs. Communities may also make changes to policies on eligibility and rules for supportive housing or

drug treatment programs. They may create entirely new programs to facilitate entry by people formerly staying in encampments. For example, San Francisco created a new type of shelter, Navigation Centers, to provide shelter-averse people with room and board and access to case management and other services provided by public, nonprofit, and faith-based partners. The low-barrier model waives many of the policies commonly cited as obstacles to shelter: Navigation Centers do not have sobriety requirements, and people may come with their pets and partners, bring their belongings, and stay all day—there are no required entry or exit times. Space in the Navigation Centers is limited, however, and drop-ins are not accepted; instead, access is determined by the city's Homeless Outreach Team (SF HOT) case by case as space becomes available, with a focus on serving the most vulnerable people in San Francisco's encampments. Considerations by the outreach team include the length of time someone has been experiencing homelessness, shelter usage over a 6-month period, and motivation to move to permanent housing (San Francisco Health Network, 2018). Some evidence suggests that people strategically make themselves visible on the street in areas where the SF HOT will be making referrals so that they can gain access to the Navigation Centers, but no evidence indicates that people leave shelters in pursuit of a referral to a Navigation Center (City of San Francisco, 2015).

An evaluation of efforts to clear two encampments in Philadelphia's Kensington neighborhood provides a comprehensive look at another approach to clearance with support. After intensive and continuous outreach to and engagement of people staying in the Kensington encampments, outreach workers offered their clients emergency shelter in low-barrier "respite" and "navigation" centers, with access to case management and drug treatment services. The city also relaxed shelter admission requirements and rules and expectations for residents (Metraux et al., 2019). According to key informants developing policies to address such "drug encampments," enrolling people who are addicted to opioids and other substances into rehabilitation services may be difficult. Efforts to streamline access to drug treatment, however—including waiving requirements for identification and preauthorization and helping people get their documents in order—may ensure that treatment is available to them when they are ready to accept it.

Several key informants reported that communities are beginning to add social workers or community mental health workers to outreach teams. Law enforcement officials often are the only people on call to handle complaints around the clock, and community members may be more likely to call the police than to call a homeless hotline. When outreach teams include trained members, they can offer referrals to services and can begin to establish trust and build relationships with people experiencing homelessness in encampments. Without adequate funding for affordable, bridge, or permanent supportive housing, however, clients may end up back in encampments despite a robust outreach effort.

As of this review, policymakers and practitioners are developing promising practices to support residents of cleared encampments, and researchers are developing descriptive data and hypotheses for testing that approach.

Tacit Acceptance

Some cities tacitly accept encampments, not through sanctioning by law but by a lack of enforcement or by selective enforcement. Cities may tacitly accept homeless encampments to reduce the costs of

enforcing anti-camping ordinances or ordinances that prohibit lying down or sitting down in public places. Homeless people are permitted to congregate in areas that do not generate complaints from local businesses and residents (Herring, 2014). In Fresno, California, for example, police have carried out a more active clearance approach in the higher rent, downtown business districts, but they take a hands-off approach within an abandoned industrial zone (Herring, 2014; Speer, 2018b). In some cases, cities may provide basic services, such as potable water and security, without formally sanctioning the encampment (Loftus-Farren, 2011), and outreach workers charged with helping people resolve unsheltered homelessness may focus on people staying in the tacitly accepted encampments. In addition to having political reservations to sanctioning encampments, city officials may refuse to formally sanction encampments "on the grounds of increased liability, expenditures, and conflicts with health and zoning codes" (Herring, 2014: 298).

The literature we reviewed did not provide any indication of the effectiveness of tacit acceptance of encampments either in helping people resolve the circumstances that made them homeless or in limiting the negative consequences of encampments for the community.

Formal Sanctioning

Some cities formally sanction encampments through a variety of mechanisms: issuing temporary use permits; changing land use and zoning ordinances to permit encampments (which may place limits on the duration and number of people at each site); and creating designated campgrounds that have standards for operations and services to be provided on site. Some sanctioned encampments are managed publicly; others are self-governed but have public and private assistance and oversight.

- ***Publicly managed encampments.*** In some cases, sanctioned encampments are created and operated by the city, sometimes with nongovernmental community partners. Establishment of those encampments often is motivated by a desire to contain people who are unsheltered in a specified area where service delivery can be concentrated and public health risks controlled. For example, in 2017, the City of Las Vegas established the Courtyard Homeless Resource Center, where people can sleep in a secure, open-air, and sheltered courtyard with access to an array of amenities. The Courtyard is funded with public dollars and is currently operated by the city, with medical, employment, and other services provided on site through a variety of partners (City of Las Vegas, 2018).

- ***Safe parking programs*** provide similar structure and access to services for people who are experiencing homelessness and using a car, van, or RV as their primary place of shelter. People staying in their vehicles apply for a permit to safely and legally park overnight in designated lots that typically have some form of security and access to restrooms and other sanitation facilities. These programs are intended to offer transitional assistance for people who are interested in securing permanent housing and, as such, the programs provide access to extensive case management and other social services. Most programs use background checks to screen out sex offenders and recent violent felons, and program participants are required to have their own car insurance and comply with program rules and regulations. Safe parking programs are most common in West Coast cities. Program data from local jurisdictions in California indicate that participants have successfully accessed housing,

although rates of placement vary widely, from 5 percent in Santa Barbara to 65 percent in San Diego (Homelessness Policy Research Institute, 2018).

- ***Self-governed encampments with public and private assistance and oversight.*** Rather than establishing new areas for unsheltered people to congregate, some cities sanction existing encampments. This process typically involves establishing a legal framework for their continued existence and organizing services but allowing the encampment to continue as a self-governed enterprise. In 2011, the Seattle City Council adopted an ordinance to permit transitional encampments as an "accessory use" on land owned or controlled by a religious organization and established health and safety standards for those encampments. A similar ordinance passed in 2015 extended those standards to city-owned or private, nonreligious property. Seattle's Human Services Department selected several nonprofit organizations with experience supporting unsheltered homeless people to provide service-enriched case management, including referrals to diversion programs and shelters, access to legal services and rapid rehousing programs, and employment training and educational referrals at three newly established, permitted encampments (City of Seattle, 2017).

  In a city-sponsored evaluation (City of Seattle, 2017) that attempted to assess the effectiveness of formal sanctioning, Seattle documented a positive response from communities around the new encampments. Data and information about crime levels collected by the Seattle Police Department suggest that crime has not significantly increased in the areas surrounding the encampments since they were established. Authors of the evaluation view the self-managed governance structure positively, as an opportunity for residents to build confidence and leadership skills. Between September 2015 and May 2017, 759 people stayed in Seattle's six permitted encampments, and 16 percent (121 people) transitioned to permanent housing. It is unclear how generalizable these findings are to other communities.

Sanctioned encampments are best understood as an interim solution to address the immediate conditions of people experiencing unsheltered homelessness. Such encampments are not themselves a solution to homelessness, and cities will need to invest in permanent solutions, such as housing that is affordable to extremely low-income people, permanent supportive housing, mental health services, affordable healthcare, and perhaps also supervised drug consumption sites and low-barrier employment opportunities (Junejo, Skinner, and Rankin, 2016; Loftus-Farren, 2011; Parr, 2018). Currently, limited evidence suggests that sanctioned encampments help to reduce homelessness; we also do not know whether certain types of sanctioned encampments are more effective than others.

Limitations of the Current Evidence on Encampments

In this section, we describe limitations in the rigor and scope of the literature considered in preparing this review, as well as challenges to collecting data on the encampment population. We conclude with some recommendations for additional research found in the published literature or made by key informants interviewed as part of this scan of current evidence on encampments.

Scope and Rigor of the Current Literature on Encampments

Research on the nature and causes of homeless encampments is still in the nascent stages, as is evaluation of community responses to encampments. In many ways this is parallel to the state of research on homelessness during the 1980s, when modern homelessness, sheltered and unsheltered, first became apparent and was the focus of news reports and efforts to document and understand the phenomenon. As of late 2018, the research literature on encampments is primarily descriptive, relying on reviews of articles in the news media, along with some ethnographic research and fieldwork that includes interviews with encampment residents, service providers, city staff, and community members. Administrative data are used in only a few cases (Metraux et al., 2019; Speer, 2017). In general, sample sizes are small, with analysis limited to interviews with a small number of community stakeholders or encampment residents.[4] Researchers almost exclusively use convenience samples rather than representative samples of encampment populations. Evaluators have not yet begun to use methods that compare the results of a response to encampments with what would have happened in the absence of the policy or practice.

So far the literature focuses heavily on West Coast cities, especially Fresno and San Francisco, California; Portland, Oregon; and Seattle, Washington. An exception is a descriptive study by the National Law Center on Homelessness and Poverty (2014) that deliberately focuses on East Coast and Southern cities.[5] The ethnographic research reviewed for this paper focuses on people in encampments that are sanctioned, either formally or tacitly. This type of research, which relies on observation of people and conditions within encampments, would be more difficult to carry out in communities that have an encampment clearance policy.

Our scan of the literature identified only one study that begins to develop standards for evaluating the effectiveness of various responses to encampments. Jones and his colleagues (2015) provided standards for three criteria—effectiveness, equity, and implementation feasibility—and use them in connection with resident, service provider, and stakeholder interviews to assess whether alternative approaches would be more effective than a current policy of clearing encampments in Oakland, California (see Appendix B for a description of the study). Some local jurisdictions have started to track housing placements among people who formerly stayed in publicly sanctioned encampments

[4] Research methods and rigor differ little between the peer-reviewed literature and the reports of public agencies and other organizations. Both types of literature rely heavily on media reports and on qualitative interviews.

[5] The cities are Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida.

(City of Seattle, 2017; Hunter et al., 2016), but assessing how rigorous and successful those tracking efforts will be is difficult.

Little information is available on the direct and indirect community costs associated with encampments. Some reports provide partial accounts of the costs of various activities associated with local responses to encampments. None attempt a rigorous analysis of the costs of a response type or a comparison with the costs of other interventions for people experiencing homelessness. Adcock and her colleagues (2016) provided a thoughtful methodology for calculating the cost of enforcing ordinances that criminalize homelessness in Denver and the state of Colorado, but that analysis pertains to unsheltered homelessness in general; it is not limited to encampments. Some case studies report expenditures associated with various activities related to encampments (City of Seattle, 2017; Jones et al., 2015). Complicating the documentation of costs, encampment-related expenditures often are spread across multiple agencies and contracts (for example, department of public works for refuse disposal, department of human services for case management), sometimes without a budget category or line item specific to encampments (Junejo, Skinner, and Rankin, 2016).

Challenges to Collecting Data on People in Encampments

Some local jurisdictions have started to collect and report data on the characteristics of people who stay in encampments. The types of information collected include these:

- Basic demographic data, such as gender, age, race, veteran status and discharge type, and first language (City of Seattle, 2017; Metraux et al., 2019)
- Earned income or benefits receipt (City of Seattle, 2017)
- History of domestic violence (City of Seattle, 2017)
- Physical and mental health conditions (City of Seattle, 2017)
- Duration of homelessness (City of Seattle, 2017; Hunter et al., 2016; Metraux et al., 2019)
- Current living conditions (Metraux et al., 2019)
- Where they were staying before the encampment (City of Seattle, 2017; Hunter et al., 2016)
- Potential barriers to entering shelter, such as pets, partners, or a significant number of belongings (Hunter et al., 2016)

That type of data may be collected during the intake process at sanctioned encampments, through outreach to people staying in tacitly accepted encampments, or during the process of encampment clearance. One of the key challenges of any data collection effort associated with encampments is capturing a representative sample of people. As described by a key informant who is conducting research on encampments, people who stay in unsanctioned encampments often strive to keep off the public radar, and they may differ in important ways from the subset of people who are visible for data collection efforts. According to this key informant, outreach workers are generally better received when they make low demands, offer something that people in encampments might want or need, and share demographic characteristics or lived experiences with those in encampments. People who stay

in encampments may be wary of authority figures and are more likely to welcome outreach workers who do not act or present as such. These same considerations may also apply to sanctioned encampments.

Data collection efforts are also hampered by the transient nature of people experiencing unsheltered homelessness and the limited capacity of outreach teams to comprehensively canvas the less visible and less accessible geographies within their communities. Intensive and time-consuming outreach and follow-up efforts are required to collect information about encampment residents over time. Mental illness and substance use can also complicate data collection because the responses of affected individuals to questions may be unreliable.

Suggestions for Additional Research

As part of this review of the current evidence base on encampments, we gathered suggestions from the key informants we interviewed—people who are conducting research on encampments or advising communities on strategies for addressing encampments—for additional research that could advance the field in a variety of ways. Some of the published literature we reviewed also included suggestions for additional research that would support deeper understanding of the nature of encampments and would inform program design going forward. These ideas for additional research include the following:

- ***Understanding the characteristics of people who are living in encampments.*** What are the characteristics of people in encampments, including their immediate past experience? Are they different in meaningful ways from other people experiencing unsheltered homelessness? Are there significant differences in the characteristics of people who live in different types of encampments—for example, in groups of cars or other vehicles compared with encampments of tents or other structures? How long have they lacked stable housing? Where were they living before their stay in the encampment? What were their circumstances that contributed to them staying in an encampment? How often are families with children living in encampments, and how are their characteristics, needs, and vulnerabilities different from those of individual adults? This type of information could help to improve the targeting of efforts to prevent homelessness and stays in encampments.

- ***Understanding the experience of people experiencing unsheltered homelessness in encampments***. How do they spend their days? How long do people stay in encampments, and where do they go when they leave encampments (how often do people continue to experience unsheltered homelessness, how often do they find housing, and how often do they go to shelters or other settings, including treatment programs)? What are their service utilization patterns and the costs of their service use? With a better understanding of the behaviors and needs of people who are living in encampments, practitioners and policymakers can design and implement more effective interventions that meet those needs. Research projects can draw on integrated data systems, real-time surveys, and interviews with people with lived experience. Some of the best early opportunities may be in states and local jurisdictions that already link data systems.

- ***Understanding the relative effect of interventions currently in use.*** Do people who receive extensive outreach and referrals in advance of an encampment clearance fare better than those who stay in formally sanctioned encampments? Do outcomes vary depending on who conducts the outreach? Do sanctioned encampments achieve higher rates of exits from homelessness than do other approaches to ending homelessness for unsheltered people? Do the outcomes of people who formerly stayed in encampments differ over time, depending on the type of assistance they receive?

- ***Exploring racial/ethnic disparities in access to the homeless services system.*** Studies in Oakland, Orlando, and Seattle point to the possibility of racial segregation, and perhaps self-segregation, of encampment populations—and, by inference, of populations using shelters. Research could explore the reasons for these patterns, including possible barriers to entry into shelters or to programs providing permanent housing that affect particular racial/ethnic groups.

- ***Understanding community responses to the presence of encampments.*** What are community members' expectations regarding responses to unsanctioned encampments in their neighborhoods and approaches to resolving them? How are community members' responses shaped by stigma or bias related to race, homelessness, poverty, mental health needs, and substance use? How do community members respond to sanctioned encampments, and are factors present that determine whether sanctioned encampments experience more or less acceptance? What strategies can public and private agencies use to keep community members informed of their approaches to assist people living in encampments?

Conclusion

In recent years, encampments of people experiencing homelessness have become pervasive in communities across the United States. They can be found in busy neighborhoods in large cities, isolated rural areas, and everywhere in between. Encampments may be as small as a cluster of 8 to 10 households next to a highway entrance ramp, or they may encompass multiple structures scattered across several acres of parkland or industrial areas. The encampments that are visible to outside observers take many forms, including tents, lean-to shacks and shanties, and groups of cars or vans; other encampments that are not so visible are hidden in manmade infrastructure or natural features. The motivations and circumstances of people staying in encampments are as varied as their size, shape, and location.

Despite this diversity, at the root of all encampments is a need for greater investment of resources to address severe shortages of affordable housing. Absent this commitment, people experiencing homelessness are forced to find other places to stay, and encampments may be the best alternative among a limited set of options. Articles in the peer-reviewed and gray literature document a consistent set of factors that contribute to people's decisions to stay in encampments rather than in shelters or in other, unsheltered locations. Shortages in the availability of shelter beds, policies that create barriers to entry, and undesirable conditions inside shelters all influence people to seek an alternative place to stay. When shelters cannot fulfill their needs for safety, sense of community, and the freedom to come and go at will, people experiencing homelessness may decide to stay in encampments.

Local jurisdictions are pursuing a variety of strategies to address encampments and the challenges they pose to health, safety, and well-being. The most rudimentary of those approaches is to "sweep" encampments, the primary goal of which is clearing out the people staying in them. Preliminary evidence suggests that this response of clearance without support results in disruption and trauma for inhabitants of the encampments but does little to resolve the problem. Encampments are quickly reestablished in a new location or even back on the recently cleared site. We know little about the effects of other responses that provide support to people in encampments, including responses that allow encampments to persist—through either tacit acceptance or formal sanctioning—and clearance efforts that are accompanied by outreach and referrals to housing and services.

Communities are experimenting with new service approaches to assisting people living in encampments. The Navigation Centers that were first established in San Francisco now are being replicated elsewhere but, so far, not based on strong evidence of their effectiveness. The logic is that removing many of the barriers that cause people to seek alternatives to emergency shelters and including intensive case management to help clients secure permanent housing will prevent encampments from forming and provide a transition to permanent housing for people moved out of encampments. Other cities are relaxing admission requirements for drug treatment programs to expedite entry by people in encampments. Still others are pairing first responders with trained outreach workers who can help make connections to appropriate services. More research will be needed to assess the results of these and other initiatives.

We do not know enough about the characteristics and experiences of people who stay in encampments. Collecting even baseline information can be difficult when many people actively try to escape public notice. Data collection challenges also complicate efforts to understand the costs and effectiveness of public responses to encampments. Practical and political barriers will have to be overcome to arrive at meaningful findings that can inform policymaking and practice.

This review of what we know as of late 2018 about encampments is part of a larger study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research that will help increase the body of knowledge. We will use interviews with stakeholders in nine communities and site visits to four communities to collect information on the causes and characteristics of encampments and on community responses to encampments. The site visits to four communities also will attempt to document the public costs of various strategies for addressing encampments.

Appendix A. Methods Used to Conduct the Literature Review and Interviews with Key Informants

Scan of Peer-Reviewed Literature

To identify relevant peer-reviewed literature, we searched EBSCO Discovery Service, which provides a comprehensive search of academic journals and databases, and Google Scholar. Specific search strings and limiters used are listed in Exhibit 4.

Exhibit 4. Search Strings and Limiters

Search string used:

- "homeless encampment" OR "tent city" OR "homeless settlement" OR "homeless camp"

Limiters used:

- Peer-reviewed journals
- Published on or after January 1, 2011
- Published in English

We compiled references and abstracts from all database returns using Zotero software. We then reviewed all abstracts, identifying 43 articles for retrieval and further review. We excluded articles if they focused on encampments serving a non-homeless population, such as refugees or protesters. We also excluded research on homeless encampments in an international context because experiences with encampments and unsheltered homelessness in other countries diverge in important ways from the experience in the United States.

We identified 16 articles from more than 500 returned results that addressed the research questions shown in Exhibit 1 in the introduction. Those 16 articles include several written by the same primary author that draw on a single dataset. Under other circumstances, we might exclude a portion of the similar articles from review; however, given the small body of research on encampments, we opted to consider them all.

Scan of Gray Literature

We searched websites of government agencies, nongovernmental organizations, and academic institutions to supplement the peer-reviewed literature and identify relevant unpublished literature, white papers, presentations, and research briefs. When a website included a search function, we used the search string identified in Exhibit 4 to identify relevant resources. We also scanned relevant website sections for pertinent materials.

We found reports, publications, and conference proceedings on the official websites of the following agencies and organizations: U.S. Department of Justice, National Alliance to End Homelessness, National Coalition for the Homeless, National Law Center on Homelessness and Poverty, Seattle University School of Law, University of Denver Sturm College of Law, and San Francisco Office of

the Controller. We identified 41 documents through this process, 17 of which were determined to be relevant to this project.

We identified additional resources during interviews with key informants and by following references in the peer-reviewed and gray literature.

Interviews with Key Informants

We conducted interviews with key informants to augment information collected during the literature reviews. We identified an initial list of interviewees based on recommendations from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and the U.S. Department of Housing and Urban Development, Office of Policy Development and Research staff and from project team members with expertise in homelessness, substance use disorder, and criminal justice. We identified additional individuals by asking at the conclusion of each interview for suggestions of other academics or practitioners who may be studying encampments.

Exhibit 5 lists the key informants we interviewed.

During the interviews, we asked about ongoing research projects focused on the recent growth in unsheltered homelessness and encampments; the characteristics of people in encampments and the factors that lead them to congregate there; and communities' responses, including their costs and effectiveness. We also asked key informants targeted questions about specific research projects or programs, based on our background research.

Exhibit 5. Key Informants

Name	Title	Affiliation	Date Interviewed
Sharon Chamard, PhD	Associate Professor	University of Alaska, Anchorage	November 8, 2018
Dennis Culhane, PhD	Dana and Andrew Stone Professor of Social Policy; Co-Principal Investigator, Actionable Intelligence for Social Policy	University of Pennsylvania	October 16, 2018
Margot Kushel, MD	Professor; Director of the Center for Vulnerable Populations	University of California, San Francisco	October 25, 2018 December 27, 2018
Stephen Metraux, PhD	Associate Professor; Director of the Center for Community Research & Service	University of Delaware	October 26, 2018
Colleen Murphy	Manager, Coordinated Entry System Access	Los Angeles Homeless Services Authority	November 16, 2018
Barbara Poppe	Founder and Principal	Barbara Poppe & Associates LLC	November 2, 2018
Kelly Robson	Chief Social Services Officer	HELP of Southern Nevada	October 29, 2018
Nan Roman	President and CEO	National Alliance to End Homelessness	November 1, 2018

Appendix B. Summaries of Selected Studies

In this appendix, we provide details on the approach, methodology, limitations, and key findings from selected studies in the peer-reviewed and gray literature. These studies were particularly informative as we completed our review.

City of Seattle, Human Services Department. (2017). *Seattle Permitted Encampment Evaluation.* Seattle, WA: City of Seattle.

This internal evaluation assesses the performance of three temporary, permitted encampments in the City of Seattle in 2016: Ballard, Interbay, and Othello. The encampments were created by the city on public land. They are operated by nonprofit partners with oversight from the city's Human Services Department. The authors used HUD's Annual Performance Report, Seattle Police Department data, and stakeholder interviews to inform their analysis, which focuses on (a) determining whether temporary, permitted encampments are an effective homelessness response strategy, and (b) identifying areas where the model works well or could be improved. Data collection challenges include people departing from the encampment before they interact with a case manager, case manager staff turnover, and missing responses (client doesn't know/client refused, data not collected).

The Human Services Department found that several features contributed to the success of the encampments:

- Inhabitants of encampments benefited from being able to stay in one location for a longer period, as they could make progress toward stability goals and build relationships with the community.
- The self-management model used at all three encampments empowered inhabitants and enabled them to build confidence, camaraderie, and leadership skills.
- The provision of structured case management services, including referrals to local shelters and rapid rehousing when appropriate, referrals to employee training and education, domestic violence services, and access to a mobile medical van.

The evaluation concludes that Seattle's sanctioned encampment model is successfully serving people who have been living outside in greenbelts, on the streets, in cars, and in otherwise hazardous situations. The neighboring communities have responded positively, and crime did not increase significantly when a permitted encampment was established.

Donley, A., and J. Wright. 2012. "Safer Outside: A Qualitative Exploration of Homeless People's Resistance to Homeless Shelters," *Journal of Forensic Psychology Practice* 12 (4): 288–306. doi:10.1080/15228932.2012.695645.

This study examines why people experiencing homelessness in Orange County, Florida, stay in encampments instead of available rooms in local shelters. The authors conducted a series of five focus groups with 39 people who lived in the East Orange encampments. All participants were

recruited for the study by the Orlando Homeless outreach team. Each focus group averaged 2 hours in duration and included, on average, eight people from two or three camp sites. The study is limited by the small and localized sample size; in addition, although the study was published in 2012, the focus groups were conducted in February of 2007. The authors do not discuss local preventive or punitive ordinances with regard to encampments in Orange County.

Participants "described their experiences with downtown [Orlando] homeless services and downtown itself in negative terms and said they would not venture back downtown for any conceivable reason, no matter how many services might be available there." Although participants gave many reasons for this decision, the most prevalent themes centered on the undesirable location of shelter facilities, prior negative experiences with shelters, and the sense of companionship, freedom, and safety associated with encampments.

Herring, C., and M. Lutz. 2015. "The Roots and Implications of the USA's Homeless Tent Cities," ***City*** **19 (5): 689–701. doi:10.1080/13604813.2015.1071114.**

Herring and Lutz explain the resurgence of homeless encampments in the United States through comparative case studies of encampments in Fresno, California, and Seattle, Washington. They draw from interviews and field notes completed by both authors between 2009 and 2011, along with the preexisting peer-reviewed and gray literature on encampments. The authors chose to focus on Fresno and Seattle because those cities contain large, persistent camps—including some that are legally recognized and others that are illegal and tacitly accepted.

Herring and Lutz argue that homeless encampments were not rooted in the 2008 recession, nor can they be explained by a general expansion in the homeless population. Using their case studies as supplementary evidence, they conclude that the "crisis of welfare provision in the form of perpetual shelter shortages and repulsive shelter arrangements led homeless people to prefer large encampments and led advocates and city officials to recognize large encampments as legitimate shelter alternatives."

Jones, P., K. Parish, P. Radu, T. Smiley, and J. van der Heyde. 2015. ***Alternatives to Unsanctioned Homeless Encampments.*** **Berkeley, CA: Goldman School of Public Policy, University of California, Berkeley.**

The authors of this report interviewed Oakland, California, encampment residents, service providers, and city stakeholders to understand their needs and concerns. The needs assessment and interviews with Oakland stakeholders revealed that people living in encampments "face serious barriers to both housing and shelter use that makes unsanctioned camps their only viable alternative." Jones and his colleagues then studied best practice examples of two alternatives to Oakland's current approach of clearing encampments: (1) establishing city-sanctioned campgrounds and (2) adopting a Housing First approach. They examined those alternatives in four cities: Nashville, Tennessee; Ontario, California; Portland, Oregon; and Seattle, Washington.

Analyzing the data obtained from interviews in Oakland and the best practices from other cities, the authors assigned a score to each of these approaches (clearance, sanctioned encampments, and Housing First) with respect to three criteria:

- *Effectiveness*, defined as the "degree to which the policy in question addresses the immediate problems associated with homeless encampments, comprehensively and across both the short- and long-term."
- *Equity*, as a measure of the "differential consequences of the policy for different stakeholders or constituents" and that looks at the degree to which an intervention is likely to have disproportionate effects for any particular group.
- *Implementation feasibility*, or a city's capacity to implement each policy according to its original design.

The authors weighted the criteria to reflect stakeholders' stated preferences about the relative importance of each criterion. Effectiveness accounted for 50 percent of the score, equity for 30 percent, and implementation feasibility for 20 percent. Higher scores indicate more preferable alternatives for Oakland.

Jones and his colleagues conclude that Oakland officials could expect a city-sanctioned campground to perform best as measured by effectiveness, equity, and implementation feasibility, followed closely by a Housing First approach. Although the authors found clearing encampments to be the most easily implemented, it scored lowest on effectiveness and equity. Despite efforts to coordinate with outreach services and give sufficient notice to camp residents, the process of clearing camps "prevents residents from complying with important housing or health appointments." In short, the status quo in Oakland as of 2015 "serves as a cyclical disruption for camp residents and creates an additional barrier on their pathway to housing."

Metraux, S., M. Cusack, F. Graham, D. Metzger, and D. Culhane. 2019. *An Evaluation of the City of Philadelphia's Kensington Encampment Resolution Pilot.* Philadelphia, PA: City of Philadelphia.

This report is an independent process evaluation of the City of Philadelphia's Encampment Resolution Pilot (ERP). The ERP is a cross-departmental city initiative that was established to close down two outdoor homeless encampments in May 2018. The ERP process included extensive outreach to and engagement of people staying in the encampments and the establishment of Navigation Centers to provide them with access to housing and drug treatment assistance and intensive case management. The city also took steps to prevent the encampments from re-forming through police monitoring, continued outreach and community involvement efforts, and physical changes to the site.

To evaluate the ERP, Metraux and his colleagues draw on an array of data sources that include city documents and interviews with key stakeholders and persons directly involved with implementing the pilot. In addition, the authors had direct access to planning and operational activities, and they conducted ethnographic observations at the encampments and in the surrounding community. They

used a semi-structured interview guide with a sample of residents at the two encampments targeted by the ERP to elicit open-ended responses in four topic areas: living situation, typical day, background and service use, and perspectives on the encampment closure.

The report uses this information to assess the planning, implementation, and initial outcomes of the ERP and to determine strengths and limitations of the pilot.

National Law Center on Homelessness and Poverty. 2014. *Welcome Home: The Rise of Tent Cities in the United States.* Washington, DC: National Law Center on Homelessness and Poverty.

This report documents the rise of homeless encampments and tent cities across the United States and the legal and policy responses to that growth. The authors reviewed media reports on tent cities published between 2008 and April 2012 as well as existing literature on the subject. They also conducted telephone interviews with experts and service providers. Based on this preliminary research, the authors identified four sites for in-depth case studies: Lakewood, New Jersey; New Orleans, Louisiana; Providence, Rhode Island; and St. Petersburg, Florida. The sites were chosen on the basis of their locations, the size and prominence of the former or current encampments they hosted, and their perceived usefulness for gaining a broader understanding of the causes of and responses to homeless encampments. The authors chose to focus on the East Coast because a report documenting tent cities on the Pacific Coast already existed.

Their media survey found documentation of more than 100 tent communities in 46 states and the District of Columbia. While maintaining that the existence of tent cities itself reflects a severe lack of affordable housing, the report finds that **"**when adequate housing or shelter is not available, forced evictions of tent communities may violate human rights, and may also violate principles of domestic law." The authors argue that tent cities are a result of the absence of other reasonable options. Where alternative housing facilities are insufficient, municipalities should work together with people staying in encampments "in a manner that prioritizes the autonomy and dignity of homeless individuals and allows them to have a voice in the process."

Sparks, T. 2017a. "Citizens Without Property: Informality and Political Agency in a Seattle, Washington Homeless Encampment," *Environment and Planning A: Economy and Space* 49 (1): 86–103. doi:10.1177/0308518X16665360

Sparks, T. 2017b. Neutralizing Homelessness, 2015: Tent Cities and Ten Year Plans. *Urban Geography* 38 (3): 348–356. doi:10.1080/02723638.2016.1247600.

Sparks bases these two articles on his 2006 ethnographic fieldwork, including 6 months living and participating as a resident in Seattle's Tent City 3. In addition to participant observation, during his time in Tent City 3, he conducted 50 in-depth interviews with people staying there.

In "Citizens Without Property," Sparks documents the history of Seattle's encampments and offers an explanation for why people experiencing homelessness often do not to take advantage of social services and shelters, even when they are available. That is, within encampments, people

experiencing homelessness have a venue to "respond, resist, and remake the political landscapes of homelessness" and to "challenge their marginalization and create more habitable and emancipatory spaces." Sparks centers his theory around the social and political structures in Tent City 3, which allow residents to feel responsible, be independent, and participate in camp activities—in contrast to the demeaning treatment received at shelters.

In "Neutralizing Homelessness," Sparks claims that the "medicalization and personalization of homelessness" serves to "stabilize and maintain homelessness in seeming perpetuity"—that is, because of this flawed view of homelessness, people experiencing homelessness are blamed for their situation rather than systems, structures, or societal conditions being blamed. Well-intended service providers accept the narrative of "homeless as pathology" and create an environment that dehumanizes people who might otherwise seek assistance, leading them to stay in encampments, where they can be seen as "normal" people.

Speer, J. 2017. "'It's Not Like your Home': Homeless Encampments, Housing Projects, and the Struggle over Domestic Space" ***Antipode*** **49 (2): 517–35. doi:10.1111/anti.12275.**

Speer, J. 2018a. "The Rise of the Tent Ward: Homeless Camps in the Era of Mass Incarceration," ***Political Geography*** **62: 160–169. doi:10.1016/j.polgeo.2017.11.005.**

Speer, J. 2018b. "Urban Makeovers, Homeless Encampments, and the Aesthetics of Displacement," ***Social & Cultural Geography*** **1–21. doi:10.1080/14649365.2018.1509115.**

In these three articles, Speer builds on interviews and ethnographic fieldwork conducted in Fresno, California, in 2013. Of the 24 people Speer interviewed, 9 were officials involved in homeless management, 8 were homeless, and 7 were local activists. She selected homeless participants from multiple racial/ethnic backgrounds, genders, and ages. The author returned to Fresno in 2016 to volunteer at an activist-led encampment and follow up with former research participants. To supplement fieldwork, Speer also relied on two local media sources and reviewed policy reports, legal documents, and online videos and radio programs depicting homeless activism and evictions. Speer believes Fresno to be an ideal city through which to examine the politics of home in relation to homelessness because of its large-scale encampments and intensive housing subsidy program.

"'It's Not Like Your Home'" focuses on how people staying in encampments define *home*. Participants appreciate the sense of community within encampments and the opportunities to exercise autonomy. Speer demonstrates that, by staying in encampments, "homeless Fresnans were creating a new kind of home in which individuals and families were part of a larger collective tied to each other through relations of mutual care."

"Urban Makeovers" probes the motivations behind Fresno's varying responses to homeless encampments. Drawing on personal interviews, media articles, and statements made by city officials and politicians, Speer claims that in the Fresno political discourse, homeless encampments are framed as "unpleasant objects that must be removed to make way for economic opportunities." Thus, "efforts to reinforce a 'live play work' aesthetic resulted in a politics of displacement and criminalization" as city officials worked to move those in encampments to the margins of town, sanction those marginalized encampments, and make them visually uniform and uncluttered.

"The Rise of the Tent Ward" goes beyond Fresno to look at city-sanctioned and -controlled encampments in King County, Washington; Ontario, California; Portland, Oregon; Reno, Nevada; and St. Petersburg, Florida. Speer terms these encampments as *tent wards* to reflect "how incarceration becomes enmeshed with the provision of care and shelter." She argues that these encampments "are not simply a cost effective form of shelter: they are a new node in a wider network of quasi-carceral spaces that govern homeless mobility" that "undermine structural efforts to address poverty and housing inequality."

Appendix C: Selected Practitioner Resources

In the course of conducting this literature review, the study team identified a number of resources that did not meet our criteria for inclusion in the review but may be informative for local leaders and practitioners who are seeking practical guidance on how to address encampments in their communities. We provide links to these resources below.

United States Interagency Council on Homelessness (USICH)

Following conversations with advocates, housing and services providers, and government officials, USICH prepared a suite of resources intended to help local communities develop an action plan to connect people experiencing homelessness in encampments with permanent housing. Those resources include a paper that discusses the key components of an action plan, a quick guide that provides an introduction to the concepts covered in the paper, and a planning checklist with action steps for each of the key components. Those resources were published in 2015 and are available for download at www.usich.gov/tools-for-action/ending-homelessness-for-people-in-encampments/.

USICH has also prepared a series of case studies of communities that are implementing strategies to address the housing and services needs of people experiencing homelessness in encampments. Published in 2017, the case studies describe lessons learned from the local experience in six communities: Charleston, South Carolina; San Francisco, California; Seattle, Washington; Chicago, Illinois; Philadelphia, Pennsylvania; and Dallas, Texas. Topics covered include the evolution of the city's approach to addressing encampments, key stakeholders and tips for engaging them, and challenges or surprises encountered in the implementation process.

In May 2018, USICH published a brief titled Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones". The brief urges communities to proceed with caution when considering the establishment of sanctioned encampments and lists key points to consider for those who decide to proceed. The brief concludes with a list of links to additional USICH resources.

Corporation for Supportive Housing (CSH)

CSH has made available for download an extensive set of templates, provider tools, and draft policies for addressing unsheltered homelessness. Although not specific to encampments, many of these resources may be helpful in working with people experiencing unsheltered homelessness in encampments. All resources are available for download at www.csh.org/communityresponse/.

National Alliance to End Homelessness

The National Alliance to End Homelessness publishes presentation notes and slide decks from sessions at its national conferences. Several sessions at recent conferences address encampments, including the following:

- Resolving Encampments: Evaluating Different Approaches (July 2018)
- Sanctioned Encampments: Questions You Should Ask (July 2018)
- Understanding Unsheltered Homelessness: What We Know So Far (July 2018)
- A Growing Unsheltered Population: Addressing Encampments (August 2016)

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July 10, 2020
VIA EMAIL

TO: Chair and Members of the Emergency and Community Services Committee

Re: Dismantlement of Homeless Encampments

Thank you for approving our written delegation. We submit this delegation on behalf of the Hamilton Community Legal Clinic and we have further partnered with Wade Poziomka, a partner with Ross & McBride, to highlight concerns relating to the dismantlement of homeless encampments.

The Hamilton Community Legal Clinic has worked with HAMSMaRT and Keeping Six with respect to the ticketing of individuals experiencing homelessness for offences under the *Emergency Management and Civil Protection Act* (*"EMCPA")* and related by-laws.

We appreciate that homeless encampments present unique challenges for the City, and that the City is required to respond to resident complaints with respect to same. In the midst of gaining compliance with *EMCPA*, the *Trespass to Property Act*, and local by-laws regarding the usage of park or public spaces, it is imperative to ensure that vulnerable groups, especially those who are experiencing homelessness, are not being penalized because of their socio-economic circumstances and/or disabilities, including mental health disabilities.

Throughout the duration of the pandemic, HAMSMaRT and Keeping Six have repeatedly implored the City to either not remove individuals from encampments, or to ensure that they are transitioned to stable housing. They have cited the CDC Guidelines, Interim Guidance on Unsheltered Homelessness and Coronavirus Disease 2019 (COVID-19) for Homeless Service Providers and Local Officials, (https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html), which recommend that people not be moved from encampments "*unless individual housing units are available*" *(Emphasis Added).* Without going into detail, the Guidelines further explain the personal and public health risks involved in displacing people during the pandemic.

We agree that there are significant health-related reasons not to remove individuals experiencing homelessness from their encampments. We further submit that there are significant legal reasons to refrain from this conduct. The issue of homeless encampments, specifically during COVID-19, is not unique to Hamilton. Other municipalities have had to grapple with how to respond to public concerns while protecting private and public health interests. In Toronto, a coalition of legal clinics and advocates for individuals experiencing homelessness recently filed a lawsuit against the City which alleged, amongst other things, that the City failed to provide physical distancing standards across the shelter system. The litigation alleged that, by failing to ensure physical distancing within the shelter system, the City had infringed on the shelter residents' life, liberty, and security of the person, and their right to equal treatment (guaranteed under sections 7 and 15 of the *Charter of Rights and Freedoms* respectively).

The City of Toronto entered into an Interim Settlement Agreement and committed to numerous enforceable commitments relating to conditions in all shelter, respites, drop-ins and COVID-19 homelessness response hotel rooms operated or funded by the City. As of this week, the same coalition is taking the City back to court for failure to comply with the settlement terms. It is important to note that the declined capacity of the shelter system and failure to provide alternatives to congregate shelter has led hundreds of people to remain in encampments and to continue sleeping rough.

There is also precedent for jurisdictions moving in the right direction. In London, the City made the decision to allow temporary encampments and individual tents on municipal property for the duration of the pandemic with the ultimate goal of getting people housed. On July 7, Kingston City Council voted to extend by-law exemptions allowing an encampment to remain until at least July 31.

In British Columbia, the issue of dismantling homeless encampments as a *Charter* issue was specifically dealt with in two cases. In *Victoria (City) v. Adams*, 2009 BCCA 563 and *Abbotsford (City) v. Shantz*, 2016 BCSC 2437, the application of parks and streets bylaws prohibiting erecting a shelter was challenged primarily under section 7 of the *Charter*. The Courts found that, insofar as the by-laws prevented people from erecting temporary shelter for protection from the elements, this was a violation of their section 7 rights, and consequently of no force and effect. From our perspective, the right to erect temporary shelter for protection from the real and legitimate risk presented by COVID-19, when no other viable options for some individuals, presents a parallel fact pattern.

Housing is a basic human right. The right to adequate, safe housing, is further heightened during the era of COVID-19. Dismantling homeless encampments, in light of the significant risks to the individuals who are forced to move, infringes on their right to life, liberty, and security of the person. Given that many of the affected individuals are racialized, and/or have mental health, addiction and physical disabilities, these groups are also disproportionately impacted by displacement.

The City has a legal duty to accommodate individuals staying in encampments pursuant to its obligations under the *Human Rights Code* (the "*Code*"). As you know, there are many reasons why individuals "sleep rough" in encampments. Some of those reasons are unique to COVID-19 (a legitimate fear of exposure while in shelter). Other reasons for residing in encampments are directly related to *Code*-protected grounds. For example:

- Some individuals have mental health challenges that effectively preclude them from functioning in a shelter setting;
- Some individuals have drug or alcohol dependencies (addictions), and are ejected from shelters as a result of use (a symptom of their disability);
- Some individuals are unable to give up an animal, often the only companion they have and a necessity for emotional regulation, because some shelters do not permit animals, and
- Some individuals are married or in common law relationships, and most shelters do not accommodate couples.

The list of reasons why people may occupy encampments is extensive – what is clear is that those reasons are frequently related to *Code*-protected grounds. The fractures that exist in the shelter systems during the best of times are highlighted and exacerbated during the pandemic we are all experiencing. Rather than engage in knee-jerk reactions that results in dismantlement, it is imperative the City to work with social service organizations, local communities and experts to fully understand the situation and take steps to correct the problems with the system. The City needs to look at this situation holistically, instead of in a piecemeal fashion primarily focused on the rights of property owners and an unrealistic assessment of the threat posed by encampments.

It is essential that the City follow the principles set out in the Ontario Human Rights Commission's "Policy Statement on a Human-Rights Approach to Managing the COVID-19 Pandemic" to ensure that everyone's human rights are protected. Without these considerations, low income, racialized, Black, and First Nations, Inuit and Métis communities, persons with physical and mental health disabilities, youth, and the 2S & LGBTQQAI+ communities may be disproportionately impacted in the course of enforcement.

It is also essential that the City follow the principles developed by the UN Special Rapporteur on the Right to Housing in "A National Protocol for Homeless Encampments in Canada: A Human Rights Approach" calling for a rights-based response to encampments. Such a response requires that:

1. All government action with respect to homeless encampments upholds the human rights and human dignity of their residents;
2. Governments will not resort to criminalization, penalization or obstruction of homeless encampments;
3. Governments must explore all viable alternatives to eviction and may not remove residents from encampments without identifying alternative places to live that are acceptable to them;
4. Governments provide adequate alternative housing to all residents prior to any eviction.

5. Residents will meaningfully participate in all decision-making processes that directly affect them and engage in any decisions regarding relocation;
6. Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships.

There have been several incidents of the City dismantling homeless encampments during the pandemic: from small groups or individuals along railways, to Sir John A. MacDonald, Jackie Washington and Ferrie St. While efforts were made to connect displaced individuals with supports, those efforts fell short of meeting actual needs. Several of the individuals placed in hotels or shelters were discharged shortly after for being unable (by virtue of disability) to conform to shelter and hotel rules. Others simply moved on, and have lost contact with the crucial medical and social supports previously accessed.

We acknowledge, and are thankful that the City has refrained from further dismantling in recent weeks. We also understand that there is an expiration date on current encampments, and that the City is facing considerable pressure from residents to move people along. The difficulty is that the City does not have a viable plan for many of those individuals. We therefore call on the City to immediately change its policy on homeless encampments as follows:

1. The City will not dismantle homeless encampments and/or displace of its residents unless it has first arranged for and/or secured inside spaces such as shelters, hotels, interim housing and/or individual housing units in stable, secure housing with appropriate supports. We encourage the City to prioritize individuals experiencing homelessness for urgent housing placement. In the context of shelter and hotel placements, the City must consult with stakeholders in the homelessness/shelter community to determine what supports are needed, how to remove barriers from hotel stays, and how existing shelter rules may need to be changed in order to accommodate individual needs.
2. Where inside spaces are not available, the City will not dismantle homeless encampments and/or displace of its residents. Such objective can be accomplished by one of the following initiatives:
    a. The designation of specific parks/public lands wherein individuals experiencing homelessness are allowed to set up tents/temporary structures. The City should consult with stakeholders prior to the designation to ensure that the sites are appropriately accessible for individuals and their support network;
    b. In the alternative, a streamlined, low-barrier, accessible process of issuing permits allowing for tents/temporary structures;
    c. Where encampments are located on private property, refraining from any enforcement measures save and except where property owners have made complaints. Any individuals removed would then be directed to a viable alternative as set out in subparagraphs a. and b. above.

We acknowledge the complexity of homeless encampments and appreciate the fact that encampments are not a solution to homelessness. However, we submit that it is critical that the City not dismantle homeless encampments until it can provide encampment residents with adequate housing with appropriate supports. Failure to do this will result in a violation of the basic human rights and dignity of all encampment residents in the City of Hamilton.

Respectfully,

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This guidance is an update of https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html

Summary of Recent Changes

A revision was made on 4/21/2020 to reflect the following:

- Revisions to document organization for clarity
- Description of "whole community" approach
- Description of considerations for facility layout
- Description of considerations for facility processes
- Revisions with the understanding that many people might be asymptomatically infected with COVID-19
- Clarification of cloth face covering use by clients and staff
- Clarification of personal protective equipment use by staff
- Updated resources

Interim guidance for homeless service providers to plan and respond to coronavirus disease 2019 (COVID-19)

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This interim guidance is based on what is currently known about Coronavirus Disease 2019 (COVID-19). The Centers for Disease Control and Prevention (CDC) will update this interim guidance as needed, and as additional information becomes available.

People experiencing homelessness are at risk for infection during community spread of COVID-19. This interim guidance is intended to support response planning by emergency management officials, public health authorities, and homeless service providers, including overnight emergency shelters, day shelters, and meal service providers.

COVID-19 is caused by a new coronavirus. We are learning about how it spreads,, how severe it is, and other features of the disease. Transmission of COVID-19 in your community could cause illness among people experiencing homelessness, contribute to an increase in emergency shelter usage, and/or lead to illness and absenteeism among homeless service provider staff.

Early and sustained action to slow the spread of COVID-19 will keep staff and volunteers healthy, and help your organization maintain normal operations.

Community coalition-based COVID-19 prevention and response

Planning and response to COVID-19 transmission among people experiencing homelessness requires a "whole community" approach, which means that you are involving partners in the development of your response planning, and that everyone's roles and responsibilities are clear. Table 1 outlines some of the activities and key partners to consider for a whole-community approach.

Table 1: Using a community-wide approach to prepare for COVID-19 among people experiencing homelessness

Connect to community-wide planning
Connect with key partners to make sure that you can all easily communicate with each other while preparing for and responding to cases. A community coalition focused on COVID-19 planning and response should include: • Local and state health departments • Homeless service providers and Continuum of Care leadership • Emergency management • Law enforcement • Healthcare providers • Housing authorities • Local government leadership • Other support services like outreach, case management, and behavioral health support
Identify additional sites and resources

Continuing homeless services during community spread of COVID-19 is critical, and homeless shelters should not close or exclude people who are having symptoms or test positive for COVID-19 without a plan for where these clients can safely access services and stay. Decisions about whether clients with mild illness due to suspected or confirmed COVID-19 should remain in a shelter, or be directed to alternative housing sites, should be made in coordination with local health authorities. Community coalitions should identify additional temporary housing and shelter sites that are able to provide appropriate services, supplies, and staffing.

Ideally, these additional sites should include:

- Overflow sites to accommodate shelter decompression (to reduce crowding) and higher shelter demands
- Isolation sites for people who are confirmed to be positive for COVID-19
- Quarantine sites for people who are waiting to be tested, or who know that they were exposed to COVID-19
- Protective housing for people who are at highest risk of severe COVID-19

Depending on resources and staff availability, non-group housing options (such as hotels/motels) that have individual rooms should be considered for the overflow, quarantine, and protective housing sites. In addition, plan for how to connect clients to housing opportunities after they have completed their stay in these temporary sites.

Communication

- Stay updated on the local level of transmission of COVID-19 through your local and state health departments.
- Communicate clearly with staff and clients.
    - Use health messages and materials developed by credible public health sources, such as your local and state public health departments or the Centers for Disease Control and Prevention (CDC).
    - Post signs at entrances and in strategic places providing instruction on hand washing and cough etiquette, use of cloth face coverings, and social distancing.
    - Provide educational materials about COVID-19 for non-English speakers or hearing impaired, as needed.
    - Keep staff and clients up-to-date on changes in facility procedures.
    - Ensure communication with clients and key partners about changes in program policies and/or changes in physical location.
- Identify platforms for communications such as a hotline, automated text messaging, or a website to help disseminate information to those inside and outside your organization. Learn more about communicating to workers in a crisis.

- Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information to workers, volunteers, and those you serve. Learn more about reaching people of diverse languages and cultures.

Supplies

Have supplies on hand for staff, volunteers, and those you serve, such as:

- Soap
- Alcohol-based hand sanitizers that contain at least 60% alcohol
- Tissues
- Trash baskets
- Cloth face coverings
- Cleaning supplies
- Personal protective equipment (PPE), as needed by staff (see below)

Staff considerations

- Provide training and educational materials related to COVID-19 for staff and volunteers.
- Minimize the number of staff members who have face-to-face interactions with clients with respiratory symptoms.
- Develop and use contingency plans for increased absenteeism caused by employee illness or by illness in employees' family members. These plans might include extending hours, cross-training current employees, or hiring temporary employees.
- Staff and volunteers who are at higher risk for severe illness from COVID-19 should not be designated as caregivers for sick clients who are staying in the shelter. Identify flexible job duties for these higher risk staff and volunteers so they can continue working while minimizing direct contact with clients.
- Put in place plans on how to maintain social distancing (remaining at least 6 feet apart) between all clients and staff while still providing necessary services.
- All staff should wear a cloth face covering for source control (when someone wears a covering over their mouth and nose to contain respiratory droplets), consistent with the guidance for the general public. See below for information on laundering cloth face coverings.
- Staff who do not interact closely (e.g., within 6 feet) with sick clients and do not clean client environments do not need to wear personal protective equipment (PPE).
- Staff should avoid handling client belongings. If staff are handling client belongings, they should use disposable gloves, if available. Make sure to train any staff using gloves to ensure proper use and ensure they perform hand hygiene before and after use. If gloves are unavailable, staff should perform hand hygiene immediately after handling client belongings.
- Staff who are checking client temperatures should use a system that creates a physical barrier between the client and the screener as described here.

    - Screeners should stand behind a physical barrier, such as a glass or plastic window or partition that can protect the staff member's face from respiratory droplets that may be produced if the client sneezes, coughs, or talks.
    - If social distancing or barrier/partition controls cannot be put in place during screening, PPE (i.e., facemask, eye protection [goggles or disposable face shield that fully covers the front and sides of the face], and a single pair of disposable gloves) can be used when within 6 feet of a client.
    - However, given PPE shortages, training requirements, and because PPE alone is less effective than a barrier, try to use a barrier whenever you can.
- For situations where staff are providing medical care to clients with suspected or confirmed COVID-19 and close contact (within 6 feet) cannot be avoided, staff should at a minimum, wear eye protection (goggles or face shield), an N95 or higher level respirator (or a facemask if respirators are not available or staff are not fit tested), disposable gown, and disposable gloves. **Cloth face coverings are not PPE and should not be used when a respirator or facemask is indicated.** If staff have direct contact with the client, they should also wear gloves. Infection control guidelines for healthcare providers are outlined here.
- Staff should launder work uniforms or clothes after use using the warmest appropriate water setting for the items and dry items completely.
- Provide resources for stress and coping to staff. Learn more about mental health and coping during COVID-19.

Facility layout considerations

- Use physical barriers to protect staff who will have interactions with clients with unknown infection status (e.g., check-in staff). For example, install a sneeze guard at the check-in desk or place an additional table between staff and clients to increase the distance between them to at least 6 feet.
- In meal service areas, create at least 6 feet of space between seats, and/or allow either for food to be delivered to clients or for clients to take food away.
- In general sleeping areas (for those who are not experiencing respiratory symptoms), try to make sure client's faces are at least 6 feet apart.
    - Align mats/beds so clients sleep head-to-toe.
- For clients with mild respiratory symptoms consistent with COVID-19:
    - Prioritize these clients for individual rooms.
    - If individual rooms are not available, consider using a large, well-ventilated room.
    - Keep mats/beds at least 6 feet apart.
    - Use temporary barriers between mats/beds, such as curtains.
    - Align mats/beds so clients sleep head-to-toe.
    - If possible, designate a separate bathroom for these clients.
    - If areas where these clients can stay are not available in the facility, facilitate transfer to a quarantine site.
- For clients with confirmed COVID-19, regardless of symptoms:
    - Prioritize these clients for individual rooms.

  - If more than one person has tested positive, these clients can stay in the same area.
  - Designate a separate bathroom for these clients.
  - Follow CDC recommendations for how to prevent further spread in your facility.
  - If areas where these clients can stay are not available in the facility, assist with transfer to an isolation site.

Facility procedure considerations

- Plan to maintain regular operations to the extent possible.
- Limit visitors who are not clients, staff, or volunteers.
- Do not require a negative COVID-19 diagnostic test for entry to a homeless services site unless otherwise directed by local or state health authorities.
- Identify clients who could be at high risk for complications from COVID-19, or from other chronic or acute illnesses, and encourage them to take extra precautions.
- Arrange for continuity of and surge support for mental health, substance use treatment services, and general medical care.
- Identify a designated medical facility to refer clients who might have COVID-19.
- Keep in mind that clients and staff might be infected without showing symptoms.
  - Create a way to make physical distancing between clients and staff easier, such as staggering meal services or having maximum occupancy limits for common rooms and bathrooms.
  - All clients should wear cloth face coverings any time they are not in their room or on their bed/mat (in shared sleeping areas). Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Regularly assess clients and staff for symptoms.
  - Clients who have symptoms may or may not have COVID-19. Make sure they have a place they can safely stay within the shelter or at an alternate site in coordination with local health authorities.
  - An on-site nurse or other clinical staff can help with clinical assessments.
  - Provide anyone who presents with symptoms with a cloth face covering.
  - Facilitate access to non-urgent medical care as needed.
  - Use standard facility procedures to determine whether a client needs immediate medical attention. Emergency signs include:
    - Trouble breathing
    - Persistent pain or pressure in the chest
    - New confusion or inability to arouse
    - Bluish lips or face
  - Notify the designated medical facility and personnel to transfer clients that the client might have COVID-19.

- Prepare healthcare clinic staff to care for patients with COVID-19, if your facility provides healthcare services, and make sure your facility has supply of personal protective equipment.
- Provide links to respite (temporary) care for clients who were hospitalized with COVID-19 but have been discharged.
    - Some of these clients will still require isolation to prevent transmission.
    - Some of these clients will no longer require isolation and can use normal facility resources.
- Make sure bathrooms and other sinks are consistently stocked with soap and drying materials for handwashing. Provide alcohol-based hand sanitizers that contain at least 60% alcohol at key points within the facility, including registration desks, entrances/exits, and eating areas.
- Cloth face coverings used by clients and staff should be laundered regularly. Staff involved in laundering client face coverings should do the following:
    - Face coverings should be collected in a sealable container (like a trash bag).
    - Staff should wear disposable gloves and a face mask. Use of a disposable gown is also recommended, if available.
    - Gloves should be properly removed and disposed of after laundering face coverings; clean hands immediately after removal of gloves by washing hands with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer with at least 60% alcohol if soap and water are not available.
- Clean and disinfect frequently touched surfaces at least daily and shared objects between use using an EPA- registered disinfectant.

COVID-19 Readiness Resources

- Visit www.cdc.gov/COVID19 for the latest information and resources
- Printable Resources for People Experiencing Homelessness
- Guidance Related to Unsheltered Homelessness
- Department of Housing and Urban Development (HUD) COVID-19 Resources
- ASPR TRACIE Homeless Shelter Resources for COVID-19

A HUMAN RIGHTS APPROACH

A National Protocol for Homeless Encampments in Canada

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Homeless encampments threaten many human rights, including most directly the right to housing. People living in encampments face profound challenges with respect to their health, security, and wellbeing, and encampment conditions typically fall far below international human rights standards. Residents are frequently subject to criminalization, harassment, violence, and discriminatory treatment. Encampments are thus instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims,* advanced in response to violations of the right to housing.

Ultimately, encampments are a reflection of Canadian governments' failure to successfully implement the right to adequate housing.

As encampments increasingly emerge across Canada, there is an urgent need for governments to interact with them in a manner that upholds human rights. This Protocol, developed by the UN Special Rapporteur on the Right to Housing and her lead researcher, Kaitlin Schwan, with the input of many experts, outlines eight Principles to guide governments and other stakeholders in adopting a rights-based response to encampments. While encampments are not a solution to homelessness, it is critical that governments uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol are based in international human rights law, and the recognition that encampment residents are rights holders and experts in their own lives. The Protocol is intended to assist governments in realizing the right to adequate housing for this group.

PRINCIPLES

Principle 1: Recognize residents of homeless encampments as rights holders

All government action with respect to homeless encampments must be guided by a commitment to upholding the human rights and human dignity of their residents. This means a shift away from criminalizing, penalizing, or obstructing homeless encampments, to an approach rooted in rights-based participation and accountability.

Principle 2: Meaningful engagement and effective participation of homeless encampment residents

Residents are entitled to meaningful participation in the design and implementation of policies, programs, and practices that affect them. Ensuring meaningful participation is central to respecting residents' autonomy, dignity, agency, and self-determination. Engagement should begin early, be ongoing, and proceed under the principle that residents are experts in their own lives. The views expressed by residents of homeless encampments

must be afforded adequate and due consideration in all decision-making processes. The right to participate requires that all residents be provided with information, resources, and opportunities to directly influence decisions that affect them.

Principle 3: Prohibit forced evictions of homeless encampments

International human rights law does not permit governments to destroy peoples' homes, even if those homes are made of improvised materials and established without legal authority. Governments may not remove residents from encampments without meaningfully engaging with them and identifying alternative places to live that are acceptable to them. Any such removal from their homes or from the land which they occupy, without the provision of appropriate forms of legal protection, is defined as a 'forced eviction' and is considered a gross violation of human rights. The removal of residents' private property without their knowledge and consent is also strictly prohibited.

Common reasons used to justify evictions of encampments, such as 'public interest,' 'city beautification', development or re-development, or at the behest of private actors (e.g., real estate firms), do not justify forced evictions.[1]

Principle 4: Explore all viable alternatives to eviction

Governments must explore all viable alternatives to eviction, ensuring the meaningful and effective participation of residents in discussions regarding the future of the encampment. Meaningful consultation should seek to maximize participation and should be supported by access to free and independent legal advice. Where personal needs differ amongst residents of encampments such that a singular best alternative is not unanimous, governments will have to develop several solutions each of which is consistent with the principles outlined in this Protocol.

Principle 5: Ensure that relocation is human rights compliant

Considerations regarding relocation must be grounded in the principle that "the right to remain in one's home and community is central to the right to housing."[2] Meaningful, robust, and ongoing engagement with residents is required for any decisions regarding relocation. Governments must adhere to the right to housing and other human rights standards when relocation is necessary or preferred by residents. In such cases, adequate alternative housing, with all necessary amenities, must be provided to all residents prior to any eviction. Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships.

Principle 6: Ensure encampments meet basic needs of residents consistent with human rights

Canadian governments must ensure, at a minimum, that basic adequacy standards are ensured in homeless encampments while adequate housing options are negotiated and

[1] A/HRC/43/43, para 36.
[2] A/73/310/Rev.1, para 26.

secured. Governments' compliance with international human rights law requires: (1) access to safe and clean drinking water, (2) access to hygiene and sanitation facilities, (3) resources and support to ensure fire safety, (4) waste management systems, (4) social supports and services, and guarantee of personal safety of residents, (5) facilities and resources that support food safety, (6) resources to support harm reduction, and (7) rodent and pest prevention.

Principle 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for homeless encampment residents

Governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments. This means that Canadian governments must move, on a priority basis, towards the full enjoyment of the right to housing for encampment residents. Any decision that does not lead to the furthering of inhabitants' human rights, that does not ensure their dignity, or that represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

Principle 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with homeless encampments

Governments' engagement with Indigenous Peoples in homeless encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. This begins with recognition of the distinct relationship that Indigenous Peoples have to their lands and territories, and their right to construct shelter in ways that are culturally, historically, and spiritually significant. Governments must meaningfully consult with Indigenous encampment residents concerning any decisions that affects them, recognizing their right to self-determination and self-governance. International human rights law strictly forbids the forced eviction, displacement, and relocation of Indigenous Peoples in the absence of free, prior, and informed consent.

Given the disproportionate violence faced by Indigenous women, girls, and gender diverse peoples, governments have an urgent obligation to protect these groups against all forms of violence and discrimination within homeless encampments, in a manner that is consistent with Indigenous self-determination and self-governance.

A National Protocol for Homeless Encampments in Canada: A Human Rights Approach

I. Introduction

1 In the face of escalating homelessness and housing affordability crises, many cities across Canada have seen a rise in homeless encampments. In various Canadian communities, people experiencing homelessness have turned to living in s, vehicles, or other forms of rudimentary or informal shelter as a means to survive.[3] While they vary in size and structure, the term '*encampment*' is used to refer to any area wherein an individual or a group of people live in homelessness together, often in tents or other temporary structures (also referred to as *homeless camps*, *tent cities*, *homeless settlements or informal settlements*).

2 Homeless encampments in Canada must be understood in relation to the global housing crisis and the deepening of housing unaffordability across the country. Encampments must also be understood in the context of historical and ongoing structural racism and colonization in Canada, whereby Indigenous peoples have been systemically discriminated against and dispossessed of their lands, properties, and legal systems. Other groups have also endured systemic and historical disadvantage that has created barriers to accessing housing and shelters, including 2SLGBTQ+, Black and other racialized communities, people living with disabilities, and people who are criminalized. While encampments are often framed and discussed as matters of individual poverty or deficiency, they are the result of structural conditions and the failure of governments to implement the right to housing or to engage with reconciliation and decolonization materially and in good faith.

3 Homeless encampments threaten many human rights, including most specifically the right to housing. In international human rights law, homelessness - which includes those residing in encampments - is a prima facie violation of the right to adequate housing.[4] This means that governments have a positive obligation to implement an urgent housing-focused response, ensuring that residents have access to adequate housing in the shortest possible time and, in the interim, that their human rights are fully respected.

4 Government responses to homeless encampments often fail to employ a rights-based approach. Residents of encampments are frequently the victims of abuse, harassment, violence, and forced evictions or 'sweeps.' In many cases, the issues

[3] Encampments have arisen in cities across the country, including: Abbottsford, Vancouver, Victoria, Edmonton, Toronto, Ottawa, Gatineau, Peterborough, Winnipeg, Montreal, Nanaimo, Calgary, Saskatoon, Fredericton, Moncton, Oshawa, Halifax, and Maple Ridge.
[4] A/HRC/31/54, para. 4.

associated with encampments are within the jurisdiction and responsibility of municipal authorities, including through bylaws specific to policing, fire and safety, sanitation, and social services. This has led to a pattern whereby municipal governments deploy bylaws, local police, and zoning policies that displace people in encampments, in turn compromising the physical and psychological health of people who have no place else to go and who rely on encampments to survive, absent accessible alternatives.[5]

5 Provincial, territorial, and federal governments have historically left engagement with encampments to city officials, who receive little (if any) guidance and support. Municipal authorities are often unaware of their legal obligations under international human rights law, including with respect to the duty to ensure the dignity and security of encampment residents.[6] Further, accountability mechanisms with respect to the right to housing remain weak in Canada, meaning that people living in encampments have limited avenues through which to claim this right.

6 Ensuring a human rights-based response to homeless encampments should be a key concern for every Canadian city, and all governments should employ a human rights-based framework to guide their engagement with encampment residents.

II. Purpose of the National Protocol on Homeless Encampments

7 The purpose of this document is to provide all levels of government with an understanding of their human rights obligations with respect to homeless encampments, highlighting what is and is not permissible under international human rights law. This Protocol outlines 8 broad human rights-based Principles that must guide state[7] action in response to homeless encampments of all kinds.

8 This Protocol does not attempt to foresee every possible context or challenge that may arise within encampments. Governments and relevant stakeholders must apply human rights principles as described in the Protocol to each case as it arises, endeavouring at all times to recognize and respect the inherent rights, dignity, and inclusion of encampment residents.

9 This Protocol has been developed by the UN Special Rapporteur on the right to housing in consultation with a range of experts from across Canada, including those

[5] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1

[6] A/HRC/43/43, para 7.

[7] 'State' refers to all levels and branches of government and anyone exercising government authority.

with lived expertise of homelessness, urban Indigenous leaders, community advocates, researchers, lawyers, and experts in human rights law.[8]

III. Encampments in Canada in the context of the Human Right to Adequate Housing

10 Under international human rights law, everyone has the right to adequate housing as an element of the right to an adequate standard of living.[9] This requires States to ensure that housing is accessible, affordable, habitable, in a suitable location, culturally adequate, offers security of tenure, and is proximate to essential services such as health care and education.[10] The right to adequate housing includes the right to be protected from: arbitrary or unlawful interference with an individual's privacy, family, and home; any forced eviction (regardless of legal title or tenure status); and from discrimination of any kind.[11]

11 Homelessness constitutes a prima facie violation of the right to housing. It is a profound assault on a person's dignity, security, and social inclusion. Homelessness violates not only the right to housing, but often, depending on circumstances, violates a number of other human rights, including: non-discrimination; health; water and sanitation; freedom from cruel, degrading, and inhuman treatment; and the rights to life, liberty, and security of the person.[12]

12 Encampments constitute a form of homelessness, and thus are a reflection of the violation of residents' right to adequate housing. People living in encampments typically face a range of human rights violations and profound challenges with respect to their health, security, and wellbeing. Encampment conditions typically fall far below international human rights standards on a variety of fronts, often lacking even the most

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[8] This Protocol was prepared by: Leilani Farha and Kaitlin Schwan with the assistance of Bruce Porter, Vanessa Poirier, and Sam Freeman. Reviewers include, among others: Margaret Pfoh (Aboriginal Housing Management Association), Cathy Crowe (Shelter and Housing Justice Network), Greg Cook (Sanctuary Toronto), Tim Richter (Canadian Alliance to End Homelessness), Anna Cooper (Pivot Legal Society), Caitlin Shane (Pivot Legal Society), Emily Paradis (University of Toronto), Emma Stromberg (Ontario Federation of Indigenous Friendship Centres), and Erin Dej (Wilfred Laurier University).

[9] United Nations Committee on Economic, Social and Cultural Rights Committee's General Comments No. 4 (1991) on the right to adequate housing and No. 7 (1997) on forced evictions.

[10] United Nations Committee on Economic, Social and Cultural Rights Committee's General Comment No. 4 (1991) on the right to adequate housing. At the domestic level, adequate housing and core housing need is defined in relation to three housing standards: adequacy, affordability, and suitability. The Canadian Mortgage and Housing Corporation defines these housing standards in the following ways: "(1) Adequate housing are reported by their residents as not requiring any major repairs; (2) Affordable dwellings cost less than 30% of total before-tax household income; and (3) Suitable housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements."

[11] A/HRC/43/43.

[12] A/HRC/31/54; A/HRC/40/61, para 43.

basic services like toilets.[13] Residents of encampments are also frequently subject to criminalization, harassment, violence, and discriminatory treatment.[14]

13 In the face of poverty and deep marginalization, people without homes face many untenable choices. For example, they may be forced to choose between 'sleeping rough' on their own (putting themselves at risk of violence and criminalization), entering an emergency homeless shelter (which may be inaccessible or inappropriate for their needs, or in which their autonomy, dignity, self-reliance, and/or independence may be undermined), or residing in a homeless encampment (in which they may lack access to basic services and face threats to their health). These choices are further narrowed for those living in communities that lack any emergency shelters, or where existing shelters are at (or over) capacity.

14 For people without access to adequate housing, the availability, accessibility, appropriateness, and adequacy of shelters plays a significant role in determining whether or not a person chooses to reside in a homeless encampment. In some cities, emergency shelters operate at 95-100% capacity,[15] necessitating that some individuals sleep rough or reside in an encampment. Existing shelters may also not be low-barrier, wheelchair accessible, trans-inclusive, or safe for people experiencing complex trauma or other challenges. Homeless persons with mental health challenges, drug or alcohol dependencies, or pets may find themselves barred from shelters. Under such conditions, some individuals may prefer, or feel they have little choice but to, reside in an encampment. Encampments thus may become a necessity or the best option available for some of those the most marginalized people in Canadian society.

15 For Indigenous peoples, a desire to avoid state surveillance and a mistrust of institutional settings, including shelters, may be a factor in turning to or living in an encampment. Negative or harmful interactions with colonial institutions, such as residential schools, the child welfare system, corrections, hospitals, asylums or sanitoriums, and shelters, may be intergenerational in nature and highly traumatic. For these reasons and others, Indigenous peoples are overrepresented in homeless populations across Canada, and further to this, are more likely to be part of "outdoor" or "unsheltered" populations – including homeless encampments.[16]

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[13] See Cooper, A. (2020). *Why People Without Housing Still Need Heat*. Pivot Legal Society. Available from: http://www.pivotlegal.org/why_people_without_housing_still_need_heat

[14] A/HRC/43/43, para 31; see also *Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations*. Available from: https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn35305-eng.pdf

[15] Employment and Social Development Canada. (2018). *Shelter Capacity Report 2018*. Ottawa. Available from https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/shelter-capacity-2018.html

[16] See Ontario Federation of Indigenous Friendship Centres. (2020). *Indigenous Homelessness in the 20 Largest Cities in Canada.* Submission to the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, Canada.

16 Regardless of the reasons why a person resides in a homeless encampment, homeless encampments *do not* constitute adequate housing, and do not discharge governments of their positive obligation to ensure the realization of the right to adequate housing for all people. Under international human rights law, "States have an obligation to take steps to the maximum of their available resources with a view to achieving progressively the full realization of the right to adequate housing, by all appropriate means, including particularly the adoption of legislative measures."[17] As part of these obligations, States must prioritize marginalized individuals or groups living in precarious housing conditions - including residents of homeless encampments.[18]

17 Governments have an urgent, positive obligation to provide or otherwise ensure access to adequate housing - for residents of encampments as they do for all people experiencing homelessness. Governments must act to immediately pursue deliberate, concrete, and targeted efforts to end homelessness by ensuring access to adequate housing. In the interim, governments must ensure the availability of sufficient shelter spaces - accessible and appropriate for diverse needs - where dignity, autonomy, and self-determination are upheld.

18 The fact that encampments violate the right to housing does not in any way absolve governments of their obligations to uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol seek to support governments and other stakeholders to ensure that their engagements with encampments are rights-based and recognize residents as rights holders, with a view to realizing the right to adequate housing for these groups while respecting their dignity, autonomy, individual circumstances, and personal choices.

19 International human rights law does not permit government to use force to destroy peoples' homes, even if they are made of canvas or improvised from available materials and constructed without legal authority or title. States may not remove residents from encampments without meaningfully engaging them to identify alternative places to live that are acceptable to them. Any such removal from their homes or from the land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection, consistent with international human rights law is defined as a 'forced eviction' and is considered a gross violation of human rights.

20 Unfortunately, such forced evictions or sweeps have become common in Canada. Evictions have contravened international law by being carried out without meaningful consultation with communities and without measures to ensure that those affected have access to alternative housing. They have been justified on the basis that the

[17] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).
[18] A/HRC/43/4.

residents are there illegally, are at risk to themselves, are on land that is slated for development, or are obstructing the enjoyment of the community by others. Declining conditions at encampments and public health and safety concerns are also frequently the grounds on which local governments and provinces seek injunctions for removal. The impact of municipalities' failure to proactively provide resources and services to mitigate or improve those conditions and concerns is most often ignored. Some communities have engaged bylaw officers or local police to tear down encampments at first sight.[19]

21 None of these reasons, however, justify forced evictions under international law. Forced evictions often have harmful or disastrous consequences for encampment residents.[20] Victims may face life-threatening situations that compromise their health and security, or result in the loss of access to food, social supports, social and medical services, and other resources.[21]

22 Few governments have recognized encampments as a response to violations of fundamental human rights and a response to the isolation and indignity of homelessness. They have failed to treat those living in such encampments as legally entitled to the protection of their homes and their dignity.

IV. Relevant Authority

23 Canadian governments' responsibilities and relevant authority to ensure the right to adequate housing, including for people residing in encampments, is found in: (1) international human rights treaties, (2) the *National Right to Housing Act*, (3) the *Canadian Charter of Rights and Freedoms* and human rights legislation, and (4) the UN *2030 Agenda for Sustainable Development* (*The Sustainable Development Goals*).

1. International Human Rights Treaties

24 Canada has ratified multiple international human rights treaties that articulate the right to adequate housing. In 1976, Canada ratified the *International Covenant on Economic, Social and Cultural Rights*, which contains the chief articulation of the right to housing under Article 11.1 "the right of everyone to an adequate standard of living for [themselves] and [their] family, including adequate food, clothing and housing, and to

[19] Ball, V. (2019). *Encampment residents fear eviction*. The Expositor. Available from: https://www.brantfordexpositor.ca/news/local-news/encampment-residents-fear-eviction
[20] A/HRC/43/43, para 36.
[21] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf; Collinson, R. & Reed, D. (2018). *The Effects of Eviction on Low-Income Households*. Available from: https://www.law.nyu.edu/sites/default/files/upload_documents/evictions_collinson_reed.pdf

the continuous improvement of living conditions."[22] The right to housing and the prohibition against forced evictions has been interpreted in General Comments No. 4 and 7[23] by the UN Committee on Economic, Social and Cultural Rights. In addition, Canada has ratified other treaties that codify the right to adequate housing, including:

- *Convention on the Rights of Persons with Disabilities*
- *Convention on the Rights of the Child*
- *Convention on the Elimination of Racial Discrimination*
- *Convention on the Elimination of Discrimination against Women*

25 Human rights ratified by Canada "extend to all parts of federal States without any limitations or exceptions," thus federal, provincial/territorial, and municipal governments are equally bound by these obligations.[24] In interpreting the right to adequate housing, the Committee on Economic, Social and Cultural Rights has emphasized that "the right to housing should not be interpreted in a narrow or restrictive sense which equates it with, for example, the shelter provided by merely having a roof over one's head or views shelter exclusively as a commodity. Rather it should be seen as the right to live somewhere in security, peace and dignity."[25]

26 Canada has also formally recognized the *UN Declaration on the Rights of Indigenous Peoples*, which also codifies the right to adequate housing and affirms that Indigenous Peoples have the right to be actively involved in developing and determining housing programmes and policies that affect them.[26] Further, Indigenous Peoples' right to land and self-determination is indivisible from the right to housing under international human rights law, meaning that they "shall not be forcibly removed from their lands or territories and that no relocation shall take place without their free, prior and informed consent."[27] All encampments are located on the traditional territories of Indigenous nations, including in cities, towns, and rural areas. On these territories, Indigenous Peoples' right to land and self-determination is in effect, whether or not those lands are subject to land claims or treaty.

1. Canadian Housing Policy and Legislation

27 The right to housing has also recently been recognized in Canadian legislation. In June 2019, the *National Housing Strategy Act* (the *Act*) received royal assent in Canada. The *Act* affirms Canada's recognition of the right to housing as a fundamental human

[22] ICESCR, Article 11, masculine pronouns corrected.
[23] General Comment 4 (1991), UN Doc. E/1992/23; General Comment 7 (1997), UN Doc. E/1998/22.
[24] A/69/274.
[25] General Comment 4 (1991), para 7.
[26] A/74/183.
[27] A/74/183.

right and commits to further its progressive realization as defined under the *International Covenant on Economic, Social and Cultural Rights.*

28 The Preamble and Section 4 of the *Act* underscore the interdependence of the right to housing with other fundamental rights, such as the right to life and an adequate standard of health and socio-economic wellbeing. Specifically, Section 4 states:

> It is declared to be the housing policy of the Government of Canada to:
>
> > (a) recognize that the right to adequate housing is a fundamental human right affirmed in international law;
> >
> > (b) recognize that housing is essential to the inherent dignity and well-being of the person and to building sustainable and inclusive communities;
> >
> > (c) support improved housing outcomes for the people of Canada; and
> >
> > (d) further the progressive realization of the right to adequate housing as recognized in the International Covenant on Economic, Social and Cultural Rights.

2. The Canadian Charter and Provincial/Territorial Human Rights Legislation

29 The government of Canada's international human rights obligations must be considered by courts in Canada when determining the rights of residents of encampments under domestic law,[28] particularly the *Canadian Charter of Rights and Freedoms*.[29] The Supreme Court has recognized that the right to "life, liberty and security of the person" in section 7 of the *Charter* may be interpreted to include the right to housing under international law.[30] Canada has told the UN that it accepts that section 7 at least ensures access to basic necessities of life and personal security.[31]

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[28] It should be noted that a human rights-based approach under domestic law should entail mindfulness about core human rights and equality principles, such as substantive equality and non-discrimination, which recognizes that state interventions be particularly attuned to the specific needs of particular groups, including those impacted by systemic and historical disadvantage. In this regard, a 'one size fits all' approach may not fully capture the distinct needs of groups residing within encampments.

[29] *R. v. Hape,* [2007] 2 S.C.R. 292, 2007 SCC 26, para 56: "In interpreting the scope of application of the Charter, the courts should seek to ensure compliance with Canada's binding obligations under international law where the express words are capable of supporting such a construction."

[30] *Irwin Toy Ltd. v. Quebec* (Attorney General), [1989] 1 S.C.R. 927; See Martha Jackman and Bruce Porter, "Social and Economic Rights", in Peter Oliver, Patrick Maklem & Nathalie DesRosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York: Oxford University Press, 2017), 843-861.

[31] Canada's commitments are described in *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 98-99. Online, http://canlii.ca/t/215hs

30 In Canada, courts have considered the human rights implications of encampments, and have emphasized that Section 7 life and security of the person interests are engaged where state action poses significant harm to the health and wellbeing of persons enduring homelessness and housing insecurity. For example, Canadian courts have recognized that the daily displacement of people experiencing homelessness causes physical and psychological harm. The Court accepted in the case of *Abbotsford (City) v. Shantz*, that "the result of repeated displacement often leads to the migration of homeless individuals towards more remote, isolated locations as a means to avoid detection. This not only makes supporting people more challenging, but also results in adverse health and safety risks." The court recognized that these health and safety risks include "impaired sleep and serious psychological pain and stress."[32]

31 In the case of *Victoria v. Adams,*[33] residents of an encampment challenged a bylaw that prevented them from constructing temporary shelter in a park, on the basis of which city officials had secured an injunction to evict them. The British Columbia Supreme Court agreed that while the *Charter* does not explicitly recognize the right to housing, international law is a persuasive source for *Charter* interpretation and found that the bylaw violated the residents' right to security of the person. The BC Court of Appeal upheld the decision of the BC Supreme Court and other decisions in British Columbia have followed.[34] In *British Columbia v. Adamson* 2016,[35] for example, the court found that in the absence of alternative shelter or housing for all people experiencing homelessness, encampment residents must not be evicted from their encampment. In *Abbotsford v. Shantz* 2015[36] the Court found that denying encampment residents space to erect temporary shelters on public property was "grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."[37]

32 The right to equality is also protected under the Canadian Charter as well as under federal, provincial, and territorial human rights legislation. Not all levels of government interpret or administer human rights codes in the same manner, with each province and territory administering its own human rights codes.[38] Regardless of jurisdiction, the UN Committee on Economic, Social and Cultural Rights has stated that the right to

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[32] *Abbotsford (City) v. Shantz*, 2015 BCSC 1909, paras 213 and 219.
[33] *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 85-100. Online, http://canlii.ca/t/215hs
[34] Key examples of case law includes: *Victoria v. Adams* 2008/ 2009, *Abbotsford v. Shantz* 2015, *BC v. Adamson* 2016, and *Vancouver (City) v. Wallstam* 2017.
[35] *British Columbia v. Adamson* (2016 BCSC 1245). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1
[36] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1
[37] *Abbotsford (City) v. Shantz* (2016 BCSC 2437), para 224. Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1
[38] For an overview of provincial and territorial human rights codes, see: https://ccdi.ca/media/1414/20171102-publications-overview-of-hr-codes-by-province-final-en.pdf

equality should be interpreted to provide the widest possible protection of the right to housing and has urged Canadian courts and governments to adopt such interpretations.[39]

33 While it is clear that the *Charter* provides some protection from forced evictions and sweeps of encampment residents, the extent to which it requires governments to address the crisis of homelessness that has led to reliance on encampments remains unresolved. The Supreme Court of Canada has yet to agree to hear an appeal in a case that would clarify the obligations of governments to address homelessness as a human rights violation. The Supreme Court has, however, been clear that the *Charter* should, where possible, be interpreted to provide protection of rights that are guaranteed under international human rights law ratified by Canada.

34 Governments should not use uncertainty about what courts might rule as an excuse for violating the human rights of those who are homeless. Canadian governments have an obligation, under international human rights law, to promote and adopt interpretations of domestic law consistent with the right to adequate housing. The UN Committee on Economic, Social and Cultural Rights has expressed concern that governments in Canada continue to argue in court against interpretations of the *Canadian Charter* that would protect the rights of homeless persons and residents of homeless encampments.

35 Therefore, it is critically important that, as part of a Protocol based on respect for human rights, municipal, provincial/territorial, and federal governments instruct their lawyers not to undermine international human rights or oppose reasonable interpretations of the *Charter* based on international human rights. They should never seek to undermine the equal rights of residents of homeless encampments to a dignified life, to liberty, and security of the person.

3. UN 2030 Agenda for Sustainable Development

36 In September 2015, member states of the United Nations, including Canada, adopted the *2030 Agenda for Sustainable Development* (*2030 Agenda*). Target 11.1 of the SDGs specifically identifies that by 2030, all States must "ensure access for all to adequate, safe and affordable housing and basic services and to upgrade informal settlements." This means governments must take steps to eliminate homelessness and make cities inclusive, safe, resilient and sustainable. Upgrading informal settlements

[39] CESCR, General Comment No. 9, para 15; E/C.12/1993/5, paras 4, 5, and 30.

includes the upgrading of homeless encampments.[40] States have affirmed that a rights-based approach to the SDG's is critical if they are to be achieved.[41]

V. Key Principles

37 It is critical that all levels of government in Canada employ an integrated human rights-based approach when engaging with encampments. The Principles outlined here aim to support the right to housing for all encampment residents as part of Canada's commitment to the right to housing under international human rights treaties and domestic law.

PRINCIPLE 1: Recognize residents of homeless encampments as rights holders

38 All government action with respect to homeless encampments must be guided by a commitment to upholding the human rights and human dignity of their residents. For many governments and those exercising governmental authority, this will mean a shift away from criminalizing, penalizing, or obstructing encampments, to an approach rooted in rights-based participation and accountability.[42]

39 This will mean understanding encampments as instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims* advanced in response to violations of the right to housing. While encampments arise as a result of governments failing to effectively implement the right to housing, they can also be an expression of individuals and communities claiming their legitimate place within cities, finding homes within communities of people without housing, asserting claims to lands and territories, and refusing to be made invisible. They are a form of grassroots human rights practice critical to a democracy such as Canada's.[43] For Indigenous peoples, the occupation of lands and traditional territories vis-à-vis encampments may also be an assertion of land rights, claimed in conjunction with the right to housing.

40 In recognition of encampments as rights violations and rights claims, governments must rectify the policy failures that underpin the emergence of homeless encampments, while simultaneously recognizing residents as rights holders who are advancing a legitimate human rights claim. Their efforts to claim their rights to home

[40] A/73/310/Rev.1.

[41] The *National Housing Strategy* of Canada mirrors many of the commitments made in the *2030 Agenda*. However, the *Strategy* only commits Canada to reducing chronic homelessness by 50%, despite the *2030 Agenda*'s imperative to eliminate homelessness and provide access to adequate housing for all.

[42] A/73/310/Rev.1, para 15.

[43] A/73/310/Rev.1.

and community must be supported, not thwarted, criminalized, or dismissed as illegitimate or gratuitous protest.[44]

PRINCIPLE 2: Meaningful engagement and effective participation of encampment residents

41 Ensuring encampment residents are able to participate in decisions that directly affect them is "critical to dignity, the exercise of agency, autonomy and self-determination."[45] As rights holders, encampment residents are entitled to "participate actively, freely and meaningfully in the design and implementation of programmes and policies affecting them."[46] Meaningful engagement must be grounded in recognition of the inherent dignity of encampment residents and their human rights, with the views expressed by residents of homeless encampments being afforded adequate and due consideration in all decision-making processes.

42 Governments and other actors must engage encampment residents in the early stages of discussion without using the threat of eviction procedures or police enforcement to coerce, intimidate, or harass.[47] Engagement should proceed under the principle that residents are experts in their own lives and what is required for a dignified life.[48] Indigenous residents of encampments should also be engaged in decision-making processes in a manner that is culturally-safe and trauma informed.

43 In the context of homeless encampments, the right to participate requires that all residents be provided with information, resources, and opportunities to directly influence decisions that affect them. All meetings with government officials or their representatives regarding the encampment should be documented and made available to encampment residents upon request.

44 Participation processes must comply with all human rights principles, including non-discrimination. Compliance with international human rights law requires:

i. Provision of necessary institutional, financial, and other resources to support residents' right to participate

In order to participate in decisions that affect them, encampment residents should be provided with financial and institutional resources (e.g., wifi/internet access, meeting spaces) that support their active participation in decision-making. Such supports should include, but are not

[44] A/73/310/Rev.1.
[45] A/HRC/43/43, para 20.
[46] Ibid. See also the Committee on the Rights of the Child's General Comment No. 21 (2017) on children in street situations.
[47] A/HRC/40/61, para 38.
[48] A/HRC/43/43, para 21.

limited to: legal advice, social service supports, Indigenous cultural supports, literacy supports, translation, mobility supports, and transportation costs to attend consultations or meetings.[49] These resources should support democratic processes within the encampment, including community meetings, the appointment of community leaders, and the sharing of information.[50] Residents must be granted a reasonable and sufficient amount of time to consult on decisions that affect them.

ii. Provision of relevant information about the right to housing
Encampment residents must be provided with information about their right to housing, including information about procedures through which they can hold governments and other actors accountable, as well as specific information about the rights of Indigenous Peoples.[51]

iii. Provision of relevant information concerning decisions that affect residents, ensuring sufficient time to consult
Encampment residents must be provided with all relevant information in order to make decisions in matters that affect them.[52]

iv. Establishment of community engagement agreement between homeless encampment residents, government actors, and other stakeholders
In order to facilitate respectful, cooperative, and non-coercive communication between residents, government, and other stakeholders, government may seek to collaborate with residents to create a formal community engagement agreement (when appropriate and requested by residents).[53] This agreement should outline when and how encampment residents will be engaged,[54] and should be ongoing and responsive to the needs of the encampment residents.[55] It should allow the residents of homeless encampments to play an active role in all aspects of relevant proposals and policy, from commencement to conclusion. Residents should be able to challenge any decision made by government or other actors, to propose alternatives, and to articulate their own demands and priorities. Third party mediators should be available to protect against power imbalances that may lead to breakdown in negotiations or create

[49] Committee on Economic, Social and Cultural Rights' General Comment No. 4, para. 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 39).
[50] A/73/310/Rev.1.
[51] A/73/310/Rev.1, para 19.
[52] A/73/310/Rev.1.
[53] A/73/310/Rev.1.
[54] A/73/310/Rev.1.
[55] United Nations. *Guiding Principles on Extreme Poverty and Human Rights*, foundational principles, para 38.

unfair results.[56] Relevant government authorities and professionals should also be provided with "training in community engagement and accountability."[57]

v. **Provision of equitable opportunities for the meaningful participation of all encampment residents**

As a matter of human rights law, particular efforts must be taken to ensure equitable participation by women, persons with disabilities, Indigenous Peoples, migrants, and other groups who experience discrimination or marginalization.[58] Where possible, members of these groups should be afforded central roles in the process.[59]

Principle 2 in Action – The "People's Process" in Kabul, Afghanistan

The upgrading of informal settlements was identified as a key goal in the *2030 Agenda for Sustainable Development*, committing States to "upgrade slums" by 2030 (target 11.1). As identified by the UN Special Rapporteur on the right to adequate housing, "Participation in upgrading requires democratic processes through which the community can make collective decisions." Under international human rights law, the democratic processes required to upgrade slums mirrors encampment residents' right to participate in plans to resolve their housing needs. As such, democratic processes implemented to upgrade informal settlements in cities around the world can provide helpful examples for Canadian homeless encampments.

One such example is the "people's process" in Kabul, Afghanistan. This process delineates community leadership and control over the upgrading process, and includes an organizational structure that enables the community to engage different levels of government. As part of this process, "local residents elect community development councils responsible for the selection, design, implementation and maintenance of the projects." City staff are trained to work alongside informal settlement residents to implement and complete upgrading.

[56] A/HRC/43/4, para 42.
[57] A/73/310/Rev.1, para 20.
[58] A/HRC/43/4.
[59] Committee on Economic, Social and Cultural Rights, General Comment No. 21 (2009) on the right of everyone to take part in cultural life, in particular para 16.

PRINCIPLE 3: Prohibition of forced evictions of encampments

45 Under international human rights law, forced evictions constitute a gross violation of human rights and are prohibited in all circumstances, including in the context of encampments.[60]

46 Forced evictions are defined as "the permanent or temporary removal against their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection … in conformity with the provisions of the International Covenants on Human Rights."[61]

47 Forced evictions are impermissible irrespective of the tenure status of those affected. This means that the forced eviction of encampments is prohibited if appropriate forms of protection are not provided – including all of the requirements described in this Protocol.[62] It may also be considered a forced eviction when governments' and those acting on their behalf harass, intimidate, or threaten encampment residents, causing residents to vacate the property.[63]

48 Common reasons used to justify evictions of encampments, such as 'public interest,' 'city beautification', development or re-development, or at the behest of private actors (e.g., real estate firms), do not justify forced evictions.[64] Evictions (as opposed to "forced evictions") may be justified in rare circumstances, but they may only be carried out after exploring all viable alternatives with residents, in accordance with law and consistent with the right to housing, as described in this Protocol.

49 Governments must repeal any laws or policies that sanction forced evictions and must refrain from adopting any such laws, including for example anti-camping laws, move-along laws, laws prohibiting tents being erected overnight, laws prohibiting personal belongings on the street, and other laws that penalize and punish people experiencing homelessness and residing in encampments.[65]

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[60] A/HRC/43/43, para 34; CESCR General Comment No.7.
[61] CESCR General Comment No.7.
[62] A/HRC/43/43, para 34; also see: "Security of tenure under domestic law should not, consequently, be restricted to those with formal title or contractual rights to their land or housing. The UN guiding principles on security of tenure (A/HRC/25/54, para. 5), states that security of tenure should be understood broadly as "a set of relationships with respect to housing and land, established through statutory or customary law or informal or hybrid arrangements, that enables one to live in one's home in security, peace and dignity."
[63] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf
[64] A/HRC/43/43, para 36.
[65] See, for example, Ontario's *Safe Street's Act* (1999).

Principle 3 in Action: Forced Eviction & Harassment of Homeless Encampment Residents

In cities around the world, people experiencing homelessness are frequently subject to discriminatory treatment, harassment, and extreme forms of violence because of their housing status. People residing in homeless encampments are exposed to similar or worse treatment, particularly when faced with pressure to relocate or disperse.

In some cases, local laws, policies, or practices can provide the mechanisms for this harassment. For example, in British Columbia local authorities enforced a bylaw prohibiting overnight shelters in parks by using tactics that included spreading chicken manure and fish fertilizer on a homeless encampment. Residents and allies of the homeless encampment subsequently filed a human rights complaint with regard to these practices (*Abbotsford (City) v. Shantz)*, and the BC Supreme Court found that certain bylaws violated encampment residents' constitutional rights to life, liberty and security of the person.

Under international human rights law, such activities are strictly prohibited and constitute instances of forced eviction, even if they align with local laws or policies. Given this, it is critical that Canadian governments review local and national policies and laws to ensure they do not violate the prohibition against the forced eviction of homeless encampments.

PRINCIPLE 4: Explore all viable alternatives to eviction

50 Government authorities must explore all viable alternatives to eviction, in consultation with encampment residents.[66] This means ensuring their meaningful and effective participation in discussions regarding the future of the encampment.

51 Free and independent legal advice should be made available to all residents to help them understand the options, processes, and their rights. Consultations should be conducted at times and locations that are appropriate and accessible for residents to ensure their participation is maximised. Financial and other support should be available to residents so that they can fully participate in all discussions regarding the future of the encampment and so that residents can retain outside consultants (e.g., environmental engineers, architects) where needed to assist them in developing alternative options to eviction.

52 Discussions regarding viable alternatives to eviction must include meaningfully engagement with Indigenous Peoples and be grounded in principles of self-determination, free, prior and informed consent. In urban contexts, for example, urban Indigenous organisations should be engaged early in the planning process to establish service delivery roles and to ensure the availability of culturally appropriate services.

[66] A/HRC/43/4.

53 Where personal needs differ amongst residents of encampments such that a singular best alternative is not unanimous, governments will have to develop several solutions each of which is consistent with the principles outlined in this Protocol.

PRINCIPLE 5: Ensure that any relocation is human rights compliant

54 Homeless encampments are not a solution to homelessness, nor are they a form of adequate housing. Governments have an urgent, positive obligation to ensure encampment residents have access to long-term, adequate housing that meets their needs, accompanied by necessary supports. Rather than eviction, governments must engage with homeless encampments with a view to ensuring residents are able to access such housing.

55 Despite this obligation, many governments respond to encampments by simply moving residents from one bad site to another through the use of law enforcement, physical barriers, or other means, and without meaningfully engaging residents. This in no way addresses the underlying violations of the right to housing experienced by residents of encampments, is often costly, and can contribute to increased marginalization. If relocation is deemed necessary and/or desired by encampment residents, it is critical that it is conducted in a human rights compliant manner.

56 As a starting point, meaningful, robust, and ongoing engagement with residents (as defined in Principle 2) is required for the development of any relocation of homeless encampments or of their residents. Meaningful engagement with communities should ensure the development of plans that respect the rights of residents and can be implemented cooperatively, without police enforcement.[67] Considerations regarding relocation must be grounded in the principle that "the right to remain in one's home and community is central to the right to housing."[68] If relocation is consistent with the human rights of residents, it will almost always be achievable without the use of force.

57 If government authorities propose the relocation of residents of homeless encampments, and the residents desire to remain in situ, the burden of proof is on the government to demonstrate why in situ upgrading is unfeasible.[69]

58 If, after meaningful engagement with those affected, relocation is deemed necessary and/or desired by encampment residents, adequate alternative housing must be provided in close proximity to the original place of residence and source of livelihood.[70] If governments have failed to provide residents with housing options that

[67] A/HRC/40/61, para 38.
[68] A/73/310/Rev.1, para 26.
[69] A/73/310/Rev.1, para 32.
[70] A/HRC/4/18, annex I, para. 60.

they find acceptable, residents must be permitted to remain or be provided with a satisfactory alternative location, while adequate permanent housing options are negotiated and put in place.

59 If, in the exceptional case there is no viable alternative to eviction by authorities, eviction must be compliant with all aspects of international human rights law.[71] Compliance with international human rights law requires:

i. **Prohibition against the removal of residents' private property without their knowledge and consent**
The removal of residents' private property by governments and those acting on their behalf, including the police, without their knowledge and consent, in strictly prohibited.[72] Such actions are contrary to the rights of residents and may contribute to the deepening of residents' marginalization, exclusion, and homelessness.[73] Governments and police must also seek to actively prevent the removal of homeless residents' private property by private actors or any other form of harassment.

ii. **Adherence to the right to housing and other human rights standards when relocation is necessary or preferred**
Adequate alternative housing, with all necessary amenities (particularly water, sanitation and electricity), must be in place for all residents prior to their eviction.[74] Alternative housing arrangements should be in close proximity to the original place of residence and to services, community support, and livelihood.[75] It is critical that all encampment residents be allowed to participate in decisions regarding relocation, including the timing and site of relocation.[76] A full hearing of the residents' concerns with the proposed relocation should be held, and alternatives explored.

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[72] A/HRC/4/18, *Basic Guidelines on Development Based Evictions,* see para 50: "States and their agents must take steps to ensure that no one is subject to direct or indiscriminate attacks or other acts of violence, especially against women and children, or arbitrarily deprived of property or possessions as a result of demolition, arson and other forms of deliberate destruction, negligence or any form of collective punishment. Property and possessions left behind involuntarily should be protected against destruction and arbitrary and illegal appropriation, occupation or use."
[73] National Law Centre on Homelessness & Poverty. (2017). *Violations of the Right to Privacy for Persons Experiencing Homelessness in the United States*. Available from: https://nlchp.org/wp-content/uploads/2018/10/Special-Rapporteur-Right-to-Privacy.pdf. See para 7: "For them, whatever shelter they are able to construct, whether legally or illegally, is their home, and their right to privacy should inhere to that home the same as it would for any regularly housed person. To deny them that right is to further marginalize and dehumanize this already highly marginalized and dehumanized population."
[74] A/73/310/Rev.1, para 34.
[75] Basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 60) and A/HRC/4/18, annex I, para. 60.
[76] A/73/310/Rev.1, para 31.

iii. **Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships**

Relocation must not result in the continuation or deepening of homelessness for residents.[77] Relocation must not require the separation of families or partners, as defined by rights-holders themselves, including chosen family and other kinship networks.[78] Governments should engage encampments with a view to keeping the community intact, if this is desired by the residents.[79] Governments should also ensure that relevant housing policies are supportive of the ways in which rights-holders define their own families, partnerships, communities and extended Indigenous kindship structures, and accommodate these whenever possible in public or social housing.

iv. **Access to justice to ensure procedural fairness and compliance with all human rights**

Access to justice must be ensured at all stages of government engagement with encampment residents, not just when eviction is imminent.[80] Access to justice and legal protection must meet international human rights law standards,[81] including the provision of due process, access to legal aid, access to fair and impartial legal advice, and the ability to file complaints in a relevant forums (including Indigenous forums) that are geographically proximate.[82]

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[77] A/73/310/Rev.1.

[78] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf. See para 52: "States should also ensure that members of the same extended family or community are not separated as a result of evictions."; also, UNHR Summary Conclusions on the Family Unit, Available at https://www.unhcr.org/protection/globalconsult/3c3d556b4/summary-conclusions-family-unity.html , see para 8:"International human rights law has not explicitly defined 'family' although there is an emerging body of international jurisprudence on this issue which serves as a useful guide to interpretation. The question of the existence or non-existence of a family is essentially a question of fact, which must be determined on a case-by-case basis, requiring a flexible approach which takes account of cultural variations, and economic and emotional dependency factors. For the purposes of family reunification, 'family' includes, at the very minimum, members of the nuclear family (spouses and minor children)."

[79] A/HRC/43/43, para 42.

[80] A/HRC/43/43.

[81] Committee on Economic, Social and Cultural Rights, General Comment No. 7, para 3.

[82] It should be noted that broad and inclusive participatory-based processes can potentially foster access to justice for equity-seeking groups, and such processes should be responsive to the unique barriers to justice these groups face.

Principle 5 in Action - *Melani v. City of Johannesburg*

Globally, there are many compelling examples of courts upholding the rights of informal settlements or homeless encampments right to remain in place ("in situ") in their community. One such example is *Melani v. City of Johannesburg* in South Africa. In this case, the Slovo Park informal settlement challenged the City of Johannesburg's decision to relocate the community to an alternative location 11 km away. The court held that the Government's upgrading policy, as required by the constitutional right to housing, envisages "a holistic development approach with minimum disruption or distortion of existing fragile community networks and support structures and encourages engagement between local authorities and residents living within informal settlements." The Court concluded that relocation must be "the exception and not the rule" and any relocation must be to a location "as close as possible to the existing settlement." The Court ordered the City of Johannesburg to reverse the decision to relocate the community, and mandated the city to apply for funding for in situ upgrading.

The South African approach is an example of how some national courts are making the shift to adopt a human rights-based approach to encampments. This is a shift that moves in the right direction and should be applied by all courts in Canada.

PRINCIPLE 6: Ensure encampments meet basic needs of residents consistent with human rights[83]

60 Much of the stigma attached to residents of encampments is a result of governments failing to ensure access to basic services, including access to clean water, sanitation facilities, electricity, and heat, as well as support services.[84] These conditions violate a range of human rights, including rights to housing, health, physical integrity, privacy, and water and sanitation.[85] In these conditions, residents face profound threats to dignity, safety, security, health, and wellbeing.[86] The denial of access to water and sanitation by governments constitutes cruel and inhumane treatment, and is prohibited under international human rights law.[87]

[83] Details regarding securing basic needs consistent with human rights can be found in Schedule B.
[84] A/73/310/Rev.1.
[85] A/HRC/43/4.
[86] UN Water. *Human Rights to Water and Sanitation*. Available from: https://www.unwater.org/water-facts/human-rights/
[87] A/73/310/Rev.1, para 46: "Attempting to discourage residents from remaining in informal settlements or encampments by denying access to water, sanitation and health services and other basic necessities, as has been witnessed by the Special Rapporteur in San Francisco and Oakland, California, United States of

61 Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. Access to safe and clean drinking water

Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."[88] The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.[89]

ii. Access to hygiene and sanitation facilities

Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

iii. Resources and support to ensure fire safety

General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety.

iv. Waste management systems

The lack of waste management systems in encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste. Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the

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America, 29 constitutes cruel and inhuman treatment and is a violation of multiple human rights, including the rights to life, housing, health and water and sanitation."

[88] A/RES/64/292, para 2. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

[89] A/RES/64/292, para 3. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

ground and transmit diseases.[90] The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles. It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems.

v. Social Supports and Services

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

vi. Guarantee Personal Safety of Residents

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,[91] interpersonal violence and exploitation can occur within encampments. interpersonal violence is often exacerbated when people do not have their basic needs met,[92] thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather that reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

vii. Facilities and resources that support food safety

Consuming contaminated food or water can cause a variety of foodborne

[90] CalRecycle. *Homeless Encampment Reference Guide*. Available at: https://www.calrecycle.ca.gov/illegaldump/homelesscamp#SolidWaste

[91] Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

[92] Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, *27*(2), 223-230.

illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements such as refrigeration facilities, which are also important for storing medicines.

viii. Resources to support harm reduction

Governments must provide encampments with the resources to implement effective harm reduction measures. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies.

ix. Rodent and pest prevention

The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments. Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests.

62 In implementing these standards, it must be recognized that residents of encampments are experts with respect to their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, residents must be engaged in planning and carrying out any measures developed to improve access to basic services. Practices, systems, and agreements residents have already put in place should be respected by government officials and should inform any further improvements.

PRINCIPLE 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for encampment residents

63 As a matter of international human rights law, the rights and dignity of residents must be at the heart of all government engagement with homeless encampments.[93] Dignity is an inherent human rights value that is reflected in the *Universal Declaration of Human Rights*. As such, Canadian governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments.

[93] ICESCR.

64 Where Canadian governments at any level make decisions with regards to encampments, it is essential that they do so taking into account the full spectrum of human rights of residents and ensure that their enjoyment of those rights is enhanced by all decisions. Any decision that does not lead to the furthering of human rights, fails to ensure their dignity, or represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

65 More broadly, the Canadian government has an obligation to the progressive realization of the right to housing, alongside all other human rights.[94] A central component of that obligation is to address on an urgent basis the needs of those in the greatest need. This means that Canadian governments must move, as a matter of priority, towards the full enjoyment of the right to housing for encampment residents.[95] When governments fail to bring about positive human rights outcomes for encampment residents, they fail their obligation to progressively realize the right to housing.[96]

PRINCIPLE 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with encampments

66 Indigenous Peoples in Canada experience some of the most severe and egregious forms of housing need, and are dramatically overrepresented in homeless populations across the country, including specifically amongst those who are sleeping rough.[97] Under these conditions, many Indigenous Peoples experience profound violations of the right to housing and the right to self-determination, as well as violations of the right to freely pursue their economic, social, and cultural development.[98]

67 For Indigenous Peoples in Canada, encampments and political occupation may occur simultaneously as a means of survival and a means of asserting rights to lands and

[94] ICESCR, in General Comment No.3 on the nature of states parties' obligations under Art 2(1) of the ICESCR.
[95] ICESCR, Article 2(1).
[96] Further, if governments failed to ensure human rights outcomes were obtained for encampment residents, and residents suffered some detriment to their enjoyment of their rights (e.g., loss of dignity or ended up street homeless without any shelter at all), this might be classed as retrogression and a breach of obligations.
[97] See ESDC (Employment and Social Development Canada). (2019). *Everyone counts highlights: Preliminary results from the second nationally coordinated point-in-time count of homelessness in Canadian communities.* Retrieved from https://www.canada.ca/en/employment-social-development/programs/homelessness/reports/highlights-2018-point-in-time-count.html#3.5. Similarly, the 2018 Toronto Street Needs Assessment documented that 16% of those enumerated were Indigenous, and 38% of those sleeping rough were Indigenous. See also Patrick, C. (2014). *Aboriginal Homelessness in Canada: A Literature Review. Toronto: Canadian Homelessness Research Network Press*. Retrieved from https://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf.
[98] Article 3 of the *Declaration* and article 1 of the *Covenant*.

territories within cities and elsewhere. Whatever the impetus, any government engagement with Indigenous Peoples in encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. These rights are outlined in the United Nations Declaration on the Rights of Indigenous Peoples, as well as many other international human rights treaties.

68 Under international human rights laws, the enjoyment of the right to housing for Indigenous Peoples is "deeply interconnected with their distinct relationship to their right to lands, territories and resources, their cultural integrity and their ability to determine and develop their own priorities and strategies for development."[99] Recognition of the indivisible nature of Indigenous Peoples' human rights, and the obligation to uphold these rights, must shape all government engagement with Indigenous encampment residents, as well as the Indigenous Peoples who own or occupy the land or territories upon which the encampment is located.

69 Compliance with international human rights law requires:

i. Recognition of the distinct relationship that Indigenous Peoples have to their lands and territories

In order to ensure adequate housing for Indigenous Peoples, States, Indigenous authorities, and other actors must recognize the distinct spiritual and cultural relationships that Indigenous Peoples have with their lands and territories.[100] This recognition includes protection for Indigenous residents of encampments, who have the right to utilize their lands and territories in line with their own economic, social, political, spiritual, cultural, and traditional practices (as defined and assessed by the Peoples themselves).[101]

Under international human rights law, governments "should respect those housing structures which an Indigenous community deems to be adequate in the light of their own culture and traditions."[102] In the context of encampments, governments must respect Indigenous Peoples' right to construct shelter and housing in ways that incorporate their lived histories, cultures, and experiences.[103]

ii. Guarantee of self-determination, free, prior and informed consent and

[99] A/74/183, particularly para 6: "The right to adequate housing can be enjoyed by Indigenous Peoples only if its articulation under article 11 (1) of the International Covenant on Economic, Social and Cultural Rights is understood as interdependent with and indivisible from the rights and legal principles set out in the United Nations Declaration on the Rights of Indigenous Peoples."
[100] A/74/183.
[101] A/74/183.
[102] A/74/183, para 62.
[103] A/74/183.

meaningful consultation of Indigenous Peoples

Governments must ensure the participation of Indigenous Peoples in all decision-making processes that affect them.[104] Governments must consult with Indigenous encampment residents in order to obtain their free, prior, and informed consent before taking any action that may affect them.[105] Engagement with Indigenous communities should involve genuine dialogue and should be guided by "mutual respect, good faith and the sincere desire to reach agreement."[106] This consultation process must engage representatives chosen by Indigenous Peoples themselves, in accordance with their own procedures and practices.[107] As outlined in Principle 2, governments must provide Indigenous residents with necessary institutional, financial, and other resources in order to support their right to participate.[108] Indigenous women and girls must be consulted on a priority basis.[109]

iii. Prohibition against the forced eviction, displacement, and relocation of Indigenous Peoples

Indigenous Peoples' access to and control over their lands, territories and resources constitute a fundamental element of the realization of their right to adequate housing.[110] As such, international human rights law strictly prohibits the relocation of Indigenous Peoples in the absence of free, prior, and informed consent.[111]

iv. Protection and guarantees against all forms of violence and discrimination for Indigenous women, girls, and gender diverse peoples

Indigenous women, girls, gender diverse, and Two-Spirit peoples experience particular forms of violence – including sexual violence and

[104] United Nations Declaration on the Rights of Indigenous Peoples.
[105] United Nations Declaration on the Rights of Indigenous Peoples, in particular arts. 10, 19, and 23.
[106] A/74/183, para 56.
[107] United Nations Declaration on the Rights of Indigenous Peoples, art. 18. See also Indigenous and Tribal Peoples Convention, 1989 (No. 169), art. 6(1)(b); American Declaration on the Rights of Indigenous Peoples, arts. XXI (2) and XXIII (1); and A/HRC/18/42, annex (Expert Mechanism advice No. 2 (2011)). See also Human Rights Committee, General Comment No. 23 (1994) on the rights of minorities, para 7.
[108] Committee on Economic, Social and Cultural Rights' General Comment No. 4, para 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para 39).
[109] A/74/183, para 59.
[110] A/74/183, para 51. See also A/HRC/7/16, paras 45–48; The United Nations Declaration of the Rights of Indigenous Art. 26.2: "Indigenous Peoples have the right to own, use, develop, and control the lands, territories and resources that they possess by reason of traditional occupation or use, as well as those which they have otherwise acquired."
[111] United Nations Declaration on the Rights of Indigenous Peoples, Art. 10: "Indigenous Peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the Indigenous Peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return."

homicide – in relation to the intersection of their indigeneity, gender identity, socioeconomic and cultural status, and their housing status.[112] Canadian law recognizes the concept of multiple and intersecting forms of discrimination, and under international human rights law all Indigenous women, girls, and those who are gender diverse or Two-Spirited "must enjoy full protection and guarantees against all forms of violence and discrimination, whether inside or outside their communities."[113]

It is incumbent upon governments to provide Indigenous women and girls protection and guarantee against all forms of violence and discrimination within encampments, including from state authorities, in a manner that is consistent with Indigenous self-determination and self-governance.

[112] A/74/183, para 59.
[113] A/74/183, para. 59.

SCHEDULE A: Select Case Law on Homeless Encampments in Canada

Victoria (City) v. Adams, 2009 BCCA 563[114]

The City of Victoria made an application for an injunction to remove a "tent city" at Cridge Park. The City relied on its *Streets and Traffic Bylaw* and *Parks Regulation Bylaw, which* prohibits loitering and taking up an overnight temporary residence in public places. On appeal, the Court of Appeal established that the Victoria City bylaws violated section 7 of the *Canadian Charter* "in that they deprive homeless people of life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice," and the provisions were not saved by section 1 of the *Charter* (para. 42). The Court of Appeal confirmed that the bylaw was overbroad "because it is in effect at all times, in all public places in the City."[115]

Abbotsford (City) v. Shantz, 2015[116]

The City of Abbotsford applied for an interim injunction requiring the defendants to remove themselves and their encampment from a city park. The Court concluded that the bylaws were "grossly disproportionate" because:

> "the effect of denying the City's homeless access to public spaces without permits and not permitting them to erect temporary shelters without permits is grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."[117]

The Court concluded that allowing the City's homeless to set up their shelters overnight and taking them down during the day would "reasonably balance the needs of the homeless and the rights of other residents of the City."[118]

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[114] *Victoria(City) v. Adams* (2009, BCCA 563). Online, https://www.canlii.org/en/bc/bcca/doc/2009/2009bcca563/2009bcca563.html?resultIndex=1

[115] The Court of Appeal stated at para. 116 that: "The prohibition on shelter contained in the Bylaws is overbroad because it is in effect at all times, in all public places in the City. There are a number of less restrictive alternatives that would further the City's concerns regarding the preservation of urban parks. The City could require the overhead protection to be taken down every morning, as well as prohibit sleeping in sensitive park regions." This case is perhaps one of the most notable successes in homeless litigation in Canada.

[116] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1

[117] Para 224

[118] The Court stated, "The evidence shows, however, that there is a legitimate need for people to shelter and rest during the day and no indoor shelter in which to do so. A minimally impairing response to balancing that need with the interests of other users of developed parks would be to allow overnight shelters to be erected in public spaces between 7:00 p.m. and 9:00 a.m. the following day."[para 276]

British Columbia v. Adamson, 2016 BCSC 584 [*Adamson #1*] and 2016 BCSC 1245 [*Adamson #2*][119]

The Province of BC applied for an interlocutory injunction to restrain the defendant encampment residents from trespassing on the Victoria courthouse green space. On the first application, the court concluded that the balance of convenience did not favour the granting of the injunction, stating

> "the balance of convenience is overwhelmingly in favour of the defendants, who simply have nowhere to move to, if the injunction were to issue, other than shelters that are incapable of meeting the needs of some of them, or will result in their constant disruption and a perpetuation of a relentless series of daily moves to the streets, doorways, and parks of the City of Victoria."[120]

Following this, a second injunction was filed based on new evidence of the encampment deterioration conditions, as well as supporting evidence that the Province would make housing available to encampment residents. The court made an order requiring the encampment to be cleared, but granting residents to stay until alternate housing options were made available to them.[121]

Vancouver (City) v. Wallstam, 2017 BCSC 937[122]

The City of Vancouver applied for an interlocutory injunction requiring encampment residents to vacate and remove all tents and other structures from a vacant city lot. The Court relied on the injunction test set out in *RJR-MacDonald.*[123] The court noted that:

> "The test requires that the *applicant* prove *it will suffer irreparable harm* if the injunction is not granted...When I asked counsel what harm the *City* would suffer if the injunction was not granted, he answered that not granting the injunction would mean that a 'vital social housing project won't go ahead' and that interferes with the public good. He also points out the timeline for development of the project requires the injunction urgently … While everyone can agree that more social housing is an important goal, I must balance that general concern against the position of the occupants that the tent city, as it currently exists, is now providing shelter and safe living space for the occupants."[124]

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[119] *British Columbia v. Adamson* (2016 BCSC 1245). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1

[120] Para 183.

[121] Paras 85-86,

[122] *Vancouver (City) v. Wallstam* 2017 BCSC 937 at para 60. Online, https://www.canlii.org/en/bc/bcsc/doc/2017/2017bcsc937/2017bcsc937.html?resultIndex=1

[123] In *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.C.R. 311

[124] Para 46-47.

The court concluded that the City failed to meet the *RJR-MacDonald* test and dismissed the City's application, but without prejudice to bring it forward again on a more complete factual record.[125]

[125] Para 64.

SCHEDULE B: An Elaboration on Principle 6

Ensure encampments meet basic needs of residents consistent with human rights

Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. Access to safe and clean drinking water

Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."[126] The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.[127]

To ensure access to safe and clean drinking water, governments should provide homeless encampments with resources for:

- On site/close-proximity clean and safe drinking/potable water, ensuring a sufficient number of access points for water relative to the number of residents
- Dishwashing Station(s) with clean water, sufficient in number for the number of residents

ii. Access to hygiene and sanitation facilities

Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

Hygiene and sanitation facilities should include:

- Washing stations, including showers with privacy and safety for women and gender diverse peoples, stocked with soap, water, paper towels

[126] A/RES/64/292, para 2. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.
[127] A/RES/64/292, para 3. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

- Adequate numbers of toilets based on the encampment population which must be accessible for residents with disabilities. Every toilet station must also have a hand-washing station
- Access to cleaning and bathing supplies
- Access to free laundry facilities
- Free feminine hygiene products
- Access to clean bedding

iii. Resources and support to ensure fire safety

General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety. Residents should be provided with resources to support best safety practices, including:

- Fire-safety approved sources of heat (e.g., safe metal vessels for heat)
- Warming tents
- In-tent heat sources
- Fire-proof tents
- Fire evacuation plan
- Signage indicating evacuation plans
- Accessible information on fire safety tips and how to handle and store flammable materials (e.g., gasoline, butane, propane)
- Fire extinguishers appropriately spaced and training for residents on how to operate them
- Electricity/charging stations for phones and laptops
- On-site ashtrays or cigarette disposal posts

iv. Waste management systems

The lack of waste management systems in homeless encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities, including during food preparation or shelter building. Unwanted materials can pile up quickly when there is no waste system in place to remove garbage from the area. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste.

Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the ground and transmit diseases.[128] The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles.

[128] CalRecycle. *Homeless Encampment Reference Guide*. Online at https://www.calrecycle.ca.gov/illegaldump/homelesscamp#SolidWaste

It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems, which should include:

- Weekly garbage and recycling (more frequent if needed)
- Regular service for waste water and portable toilets
- Independent waste bins for flammable/hazardous waste (e.g., fuel, motor oil, batteries, light bulbs)
- Large rodent-proof waste bins with tight fitting lids
- Garbage bags, cleaning supplies, hand soap, hand sanitizer
- Waste water holding tanks (if there are no sewers near encampment)

v. Social Supports and Services

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

i. Guarantee Personal Safety of Residents

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,[129] interpersonal violence and exploitation can occur within encampments. interpersonal violence is often exacerbated when people do not have their basic needs met,[130] thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather that reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

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[129] Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

[130] Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, *27*(2), 223-230.

Any approach to addressing interpersonal safety within encampments must:

- Center on the most vulnerable members of the encampment, namely: BIPOC, women, trans-people and other LGBTQ2S+ persons, persons with disabilities, and other groups who experience discrimination or marginalization.
- Provide resources and supports to allow for Indigenous and other non-colonial approaches to conflict resolution.
- Provide safe, confidential, accessible, and non-coercive mechanisms through which individuals experiencing violence can report these experiences and receive trauma-informed supports and services, ensuring that these individuals are able to access alternative safe housing (as desired).

vi. Facilities and resources that support food safety

Consuming contaminated food or water can cause a variety of foodborne illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements. This includes:

- Rodent-proof storage containers, with lids that can be sealed
- Shelving units to ensure food is stored off the ground
- Soap and sanitizer to clean food preparation surfaces
- Cooling appliance(s) to prevent spoilage
- Cooking appliance(s) to ensure food is thoroughly cooked

vii. Resources to support harm reduction

Governments must provide homeless encampments with the resources to implement effective harm reduction measures within homeless encampments. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies. Encampment residents should be provided with:

- Overdose prevention training (e.g., CPR training)
- Overdose prevention supplies (e.g., Naloxone)
- Overdose Prevention Sites, where possible
- Puncture-proof containers for needle disposal
- Harm reduction outreach supports
- Regular servicing of puncture-proof containers by a certified waste-management company

- Information about available emergency services in the event of overdoses or other health-related crises

viii. Rodent and pest prevention

The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments (e.g., diatomaceous earth). Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests, including:

- Resources and information on rodent and pest prevention
- A bait-station to detract rodents from sleeping tents, regularly serviced and monitored
- Cleaning materials and gloves to dispose of rodents

In implementing these standards, it must be recognized that residents of encampments are the experts of their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, encampment residents must be engaged in planning and carrying out any measures developed to improve access to basic services for the encampment. Practices, systems, and agreements residents already have in place should be recognized by government officials and should inform any further improvements.

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Hamilton Paramedic Service 2019 Annual Report (HSC20021) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Linda Button (905) 546-2424 Ext. 3104
SUBMITTED BY: **SIGNATURE:**	Michael Sanderson Chief, Hamilton Paramedic Service Healthy and Safe Communities Department

COUNCIL DIRECTION

Not Applicable

INFORMATION

The Hamilton Paramedic Service (HPS) 2019 Annual Report (attached as Appendix "A" to Report HSC20021) includes the following highlights:

- Service demand continued to increase in 2019, with paramedics performing 87,037 individual responses to 70,656 events during the year and transporting 53,248 patients to hospitals, an average of 146 patients per day.

- HPS performance as reported annually on the Ministry of Health (MOH) website continues to be better than the Council approved response time standards (Report HES12014). (http://www.health.gov.on.ca/en/pro/programs/emergency_health/land/responsetime.aspx)

- Response time to calls dispatched as a life-threatening (Code 4) emergency at the 90th percentile was 11 minutes and 18 seconds. This reflects the time period from when the MOH Central Ambulance Communications Centre (CACC) assigns the call to paramedics until paramedics arrive on scene.

- Hospital offload delays continued to be a challenge. The provincial guideline for hospital offload is 30 minutes 90% of the time. In 2019, only 41% of transfer of care from paramedics to hospital staff took place in 30 minutes or less. A total of 30,549 staffed ambulance hours were consumed waiting for transfer of care beyond the first 30 minutes after arrival at hospital, an increase from 2018.

- Despite the increasing time spent in offload delay, there were 16 fewer Code Zero events than in 2018 with a total of 80 events in 2019. Through ongoing collaboration with hospital partners, introduction of new programs and improvements to practice, a downward trend in the rates of Code Zero events is emerging.

- One additional staffed ambulance for 24 hours a day, 7 days a week service was implemented in April following Council approval during the 2019 annual operating budget process. This additional resource helped meet service demands amidst growing operational pressures.

- A second additional staffed ambulance, 100% funded through MOH grant funding, was added in July to support the McMaster Children's Hospital (MCH) Neonatal Transport Team in the regional transportation of critically ill babies. When the ambulance is not assigned to MCH neonatal transfers it is used for response to other emergency calls. The arrangement with the MOH for annual funding has been renewed for 2020.

- The Community Paramedicine Program was expanded with the introduction of three new initiatives in the latter part of 2019: Paramedic Palliative Outreach Support Team (PPOST), Flu Response for Emergency Department Diversion (FREDD) and Emergency Department Diversion to Withdrawal Management (EDWIN). All three initiatives aim to divert patients away from the hospital to ease the burden of crowded emergency departments by either treating patients in their place of residence (PPOST, FREDD) or taking them to the appropriate facility (EDWIN).

- Existing Community Paramedicine Programs continued to be successful. For example, the Home Visit program had 653 clients in 2019 and experienced a 50% reduction in ambulance use after clients were enrolled in the program. Also, the Remote Patient Program had an additional 51 patients enrolled in 2019 bringing the total to 74 patients. Analysis conducted by Queens University shows that this program results in a 26% reduction in both 911 calls and emergency department visits.

- Paramedics underwent an aggregated total of over 25,000 instructional hours in 2019. This training ensures that paramedics achieve and maintain the ability to provide excellent clinical care to their patients.

- A variety of continuous improvement initiatives were undertaken in 2019. These projects were aimed at improving processes, policies and services to ensure the provision of optimal care to the community. Staff were engaged for their expertise in a review of the Tiered Response Agreement, equipment upgrade, policy and procedure manual update and user profile development among other initiatives.

- In 2019, paramedics continued to volunteer their time for a range of community events and charities. Their efforts have resulted setting a record for CityKidz Christmas Toy Drive and significant donations of money, food, and clothing for families in need. They also participated in numerous fund and awareness raising activities that benefit the community such as Tim Horton's Camp Day, McDonald's McHappy Day and autism awareness.

In 2019, proposed changes to the provincial structure of healthcare led to uncertainty with regard to the structure of land ambulance service. Although no decision has yet been made the Paramedic Chief's participation on the Hamilton Health Team ensures that the issues and capabilities of the paramedic service will inform the development of a more integrated healthcare system.

Also, in 2020, the Community Paramedicine Program will continue to be enhanced as new initiatives are explored and existing ones are expanded to reach more people in need. In addition, HPS will continue to work with internal and external partners to mitigate offload delays. Public reporting and continuous improvement will also remain a focus to ensure the effective and efficient delivery of quality service and transparency of performance measurements. Furthermore, in 2020, the Hamilton Paramedic ten-year Master Plan will be finalized and shared with this Committee.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report HSC20021: Hamilton Paramedic Service 2019 Annual Report

Hamilton Paramedic Service 2019 Annual Report

Hamilton

HAMILTON PARAMEDIC

May 2020

Our Hamilton Paramedic Service members make it their priority to do whatever it takes to care for someone in need and play a vital role in promoting the health and safety of our community.

They provide medical care, social supports, charitable contributions, education and endless acts of kindness.

They truly help make the City's vision to be the best place to raise a child and age successfully a reality.

Mayor Fred Eisenberger

above & beyond

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Message from the General Manager

As the General Manager of the Healthy and Safe Communities Department, I am proud of all of the people of the Hamilton Paramedic Service whose skill, professionalism and compassion contributes to the health and well-being of our community.

I know that the work of paramedics goes beyond emergency response. They provide education to the public and partners, they organize charitable and informative events, through the Community Paramedicine Program they provide in-home care to people in need and they still find time to volunteer for worthy causes that help the people of Hamilton.

I want to congratulate everyone in the Hamilton Paramedic Service for another year of meeting performance targets in the face of increasing pressures due to a growing and aging population and persistent offload delays at our hospitals. In 2019, under the leadership of Chief Sanderson and with our community partners, new ways to mitigate the burden on emergency departments were explored and implemented, additional resources were acquired – in particular, two additional ambulances including staff, and Hamilton was successful in becoming one of the first Health Teams in Ontario which gives us a unique opportunity to help shape the future of integrated health care.

In the pages that follow, you will see just some of the 2019 achievements of the Hamilton Paramedic Service highlighted. To share all the great work of the people in this service would mean a report that would be at least twice as long. You can visit the Hamilton Paramedic Service web page on the City of Hamilton's website for more information on their programs and services. In addition, the performance data is available on the City's site, Open.Hamilton.ca

With the support of our Mayor, City Council and City Manager we have and will continue to seek out optimal ways to best serve our community. I am thankful to them for their ongoing support and investment in this essential service to ensure we have what we need to be a safe and healthy Hamilton.

I would also like to thank Chief Sanderson, OPSEU, CUPE and all of the staff for delivering exceptional service to people of Hamilton. A special thank you to those who continue to serve the community on their own time. Collectively your efforts make the Hamilton Paramedic Service among the best in the province and provide assurance that ours is a community that is well cared for.

Paul Johnson, General Manager
Healthy & Safe Community Services Department

Message from the Chief

Above and beyond. Two words that describe the performance of the people who, as a team, deliver exemplary services to the residents and visitors in Hamilton. Every day I see examples of our people exceeding what their job requires of them. From the frontline paramedics and supervisors to the schedulers, logistics technicians, support staff, and managers, in every aspect of our operation people consistently surpass expectations. This extends to our community partners who along with us work tirelessly to provide the community with high quality care.

Not surprisingly, 2019 was another busy year with an increase in the number of 911 events, responses and patients transported. And while we had a decrease in code zero events from 2018, we continued to be challenged by a large amount of time in hospital offload delay. Despite all of this, we again met and exceeded the response time criteria set by the City of Hamilton Council and the Ministry of Health (MOH).

I am always impressed, though not surprised, that our people continue to fulfill their duties in the face of compelling challenges yet still manage to do it with empathy, patience and positivity. Furthermore, they find opportunities to make meaningful differences in the lives of the people they serve from seemingly small gestures such as shoveling a patient's snow to bigger endeavors like growing food for food banks.

2019 also brought some uncertainty with regard to the structure of healthcare in the province. While proposed changes to ambulance services are pending, I have been participating on the Hamilton Health Team, one of the first in Ontario under the newly established Ontario Health oversight body. My input at this table will assures that land ambulance services and programs in Hamilton will have an integral role as the province moves toward a more integrated health care system.

In 2019, we were successful in receiving funding from MOH for an ambulance dedicated to neonatal transfer with additional staff. While not in use for neonatal patients the ambulance is in service to response to any emergency call which helps to meet the increasing demand.

I would like to thank Mayor Eisenberger, City Council and the Senior Leadership Team for their active support. I would like to express my appreciation to General Manager Paul Johnson for his leadership and guidance as we continue to navigate through challenges.

Finally, my deepest gratitude to all the people of the Hamilton Paramedic Service whose passion, dedication, innovation and at times self-sacrifice has exemplified the values and priorities of the City of Hamilton. Their extraordinary efforts quite literally change the lives of the people we are privileged to serve.

Michael Sanderson, Chief
Hamilton Paramedic Service

Service Overview

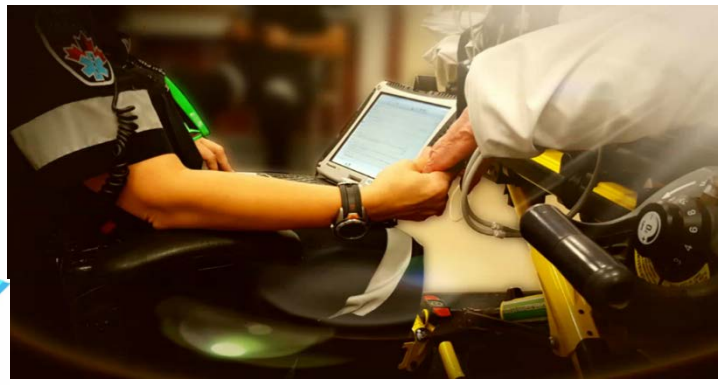
Profile of Hamilton

Hamilton is a mid-size city located in the centre of the Golden Horseshoe between Niagara Falls and Toronto. Hamilton's land area of 1,117 square kilometres consisting of urban and rural areas divided into 15 wards. The city wraps around the westernmost part of Lake Ontario with the northern limit marked by the Hamilton Harbour. The Niagara Escarpment runs through the middle of the entire city dividing the cityscape into lower and upper portions. Hamilton has a population of 536,917 making it the fifth largest municipality in Ontario and tenth largest in Canada. The population density is approximately 480.6 people per square kilometres (Statistics Canada, Census 2016).

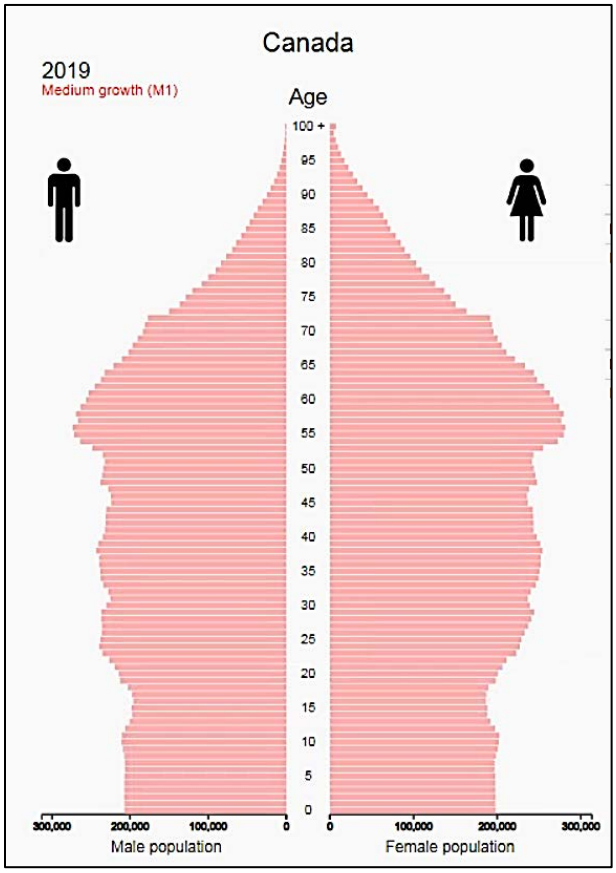
Hamilton's population is an aging one with just over 17% of its residents or approximately 93,000 people aged 65 years or older. Children aged 14 years and under account for a little more than 16% of the city's population. For the first time in Hamilton, seniors outnumber children (Statistic Canada, Census 2016).

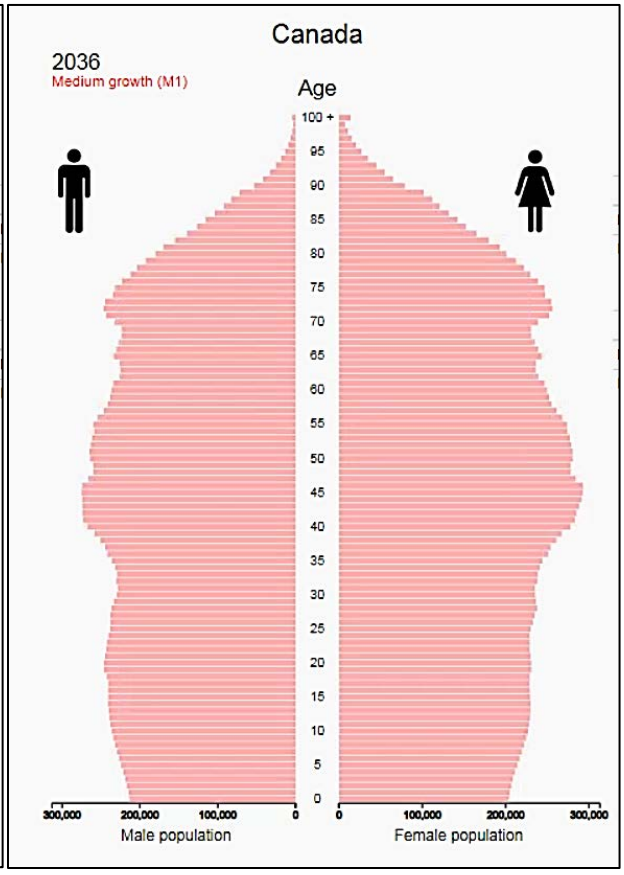
People aged 65 years and older made up 45% of the patients paramedics interacted with in 2019, that is, approximately 68,000 people requiring the care of paramedics were 65 or older. This is an increase of almost 3,000 senior patients from 2018.

In Ontario, the number of seniors aged 65 and over is projected to almost double by 2041. In 2017, seniors made up about 2.4 million or 16.7 per cent of population. This is expected to increase to almost 4.6 million or 24.8 per cent of Ontario's population. The fastest growing group of seniors will be the older seniors. The number of people aged 75 and over is expected to rise from 1 million in 2017 to 2.7 million by 2041. Those people who are aged 90 and older are projected to more than triple in size, from 120,000 to 400,000 (Ontario Ministry of Finance).



According to Statistics Canada (Census 2016) in addition to a growing population Ontario can expect to see a sharp increase in the number of seniors as baby boomers swell the ranks of seniors. As shown below, the proportion of people over the age of 65 is expected to increase from just over 36% in 2019 to almost 49% by 2036.





Number

	0 to 14	15 to 64	65 +
Male	3,098,680	11,780,110	3,055,725
Female	2,960,725	12,018,995	3,594,715

Proportion

	0 to 14	15 to 64	65 +
Male	17.3	65.7	17.0
Female	15.9	64.7	19.4

Number

	0 to 14	15 to 64	65 +
Male	3,426,435	12,394,390	4,854,020
Female	3,275,275	12,687,440	5,448,575

Proportion

	0 to 14	15 to 64	65 +
Male	16.6	59.9	23.5
Female	15.3	59.3	25.4

Source: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/pyramid/pyramid.cfm?type=1&geo1=01

This "grey tsunami" or dramatic increase in the senior population forecasted by Statistics Canada and the Ontario Ministry of Finance will significantly increase the demand on services provided by the HPS over the next 20 years.

HPS Services

The Hamilton Paramedic Service (HPS) is the designated sole land ambulance service provider for the City of Hamilton. Through 66 vehicles and 20 stations in both urban and rural areas of the city, HPS provides pre-hospital advanced medical and trauma care and transport of patients from emergency incidents to health care facilities.

HPS also provides a range of programs and services to promote the health of the community and proactively mitigate the demand on ambulance transports to hospitals. These include:

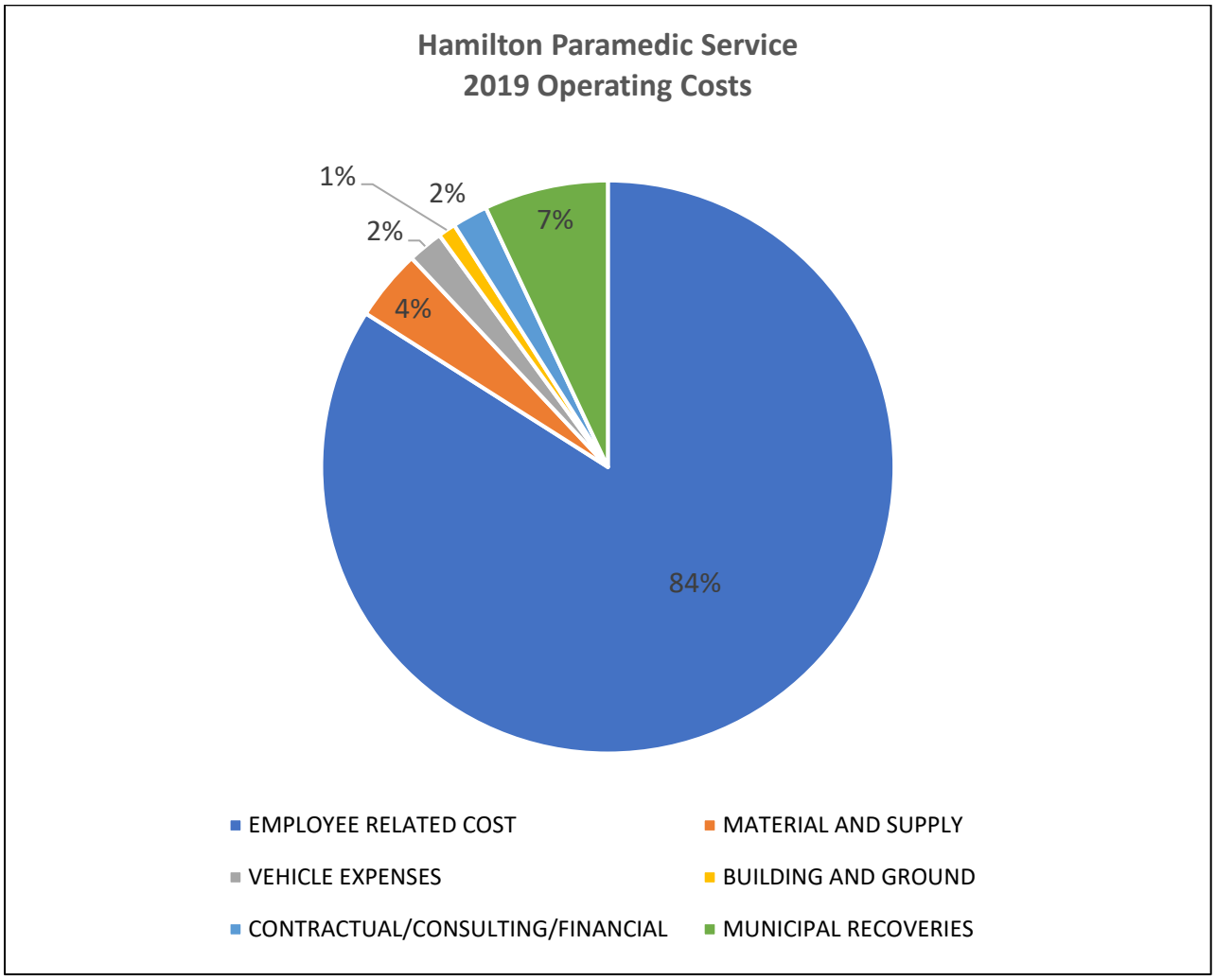
- Seniors Clinics
- Home Visits
- Flu Immunization Clinics
- Remote Patient Monitoring
- Social Navigator Program
- Public Access Defibrillators
- Flu Response for Emergency Department Diversion
- Emergency Department Diversion Withdrawal Management Program
- Public Education
- Community Engagement
- Stakeholder Engagement and Education
- Media Campaigns
- Continuing Education Classes for Hamilton Paramedics

In addition, HPS undertakes a range of initiatives to mitigate offload delay in partnership with Hamilton hospitals. HPS also works with the Ministry of Health (MOH) to ensure effective systems are in place that enable the provision of quality care to the community.

HPS Finances

While HPS had an overall operating budget of $51,115,239 in 2019, the province provided funding for 50% of the costs. The allocation of funds per each cost category and percentage of the overall budget is as follows:

COST CATEGORY 2019	$	%
Employee Related Cost	42,780,569	84
Municipal Recoveries (Excl CA Shop Labour)	3,767,030	7
Material and Supply	2,039,917	4
Vehicle Expenses	1,004,492	2
Contractual/Consulting/Financial	1,193,376	2
Building and Ground	329,855	1
Total	**51,115,239**	**100**



HPS achieves cost effectiveness in operating vehicles through partnerships within the City of Hamilton. With corporate fuel purchasing arrangements and utilizing the Hamilton Fire Department vehicle maintenance services, HPS realizes cost efficiencies without jeopardizing quality service. The costs per response is as follows:

Total Kilometres Travelled

1,909,099

Cost of Materials and Supplies per Response

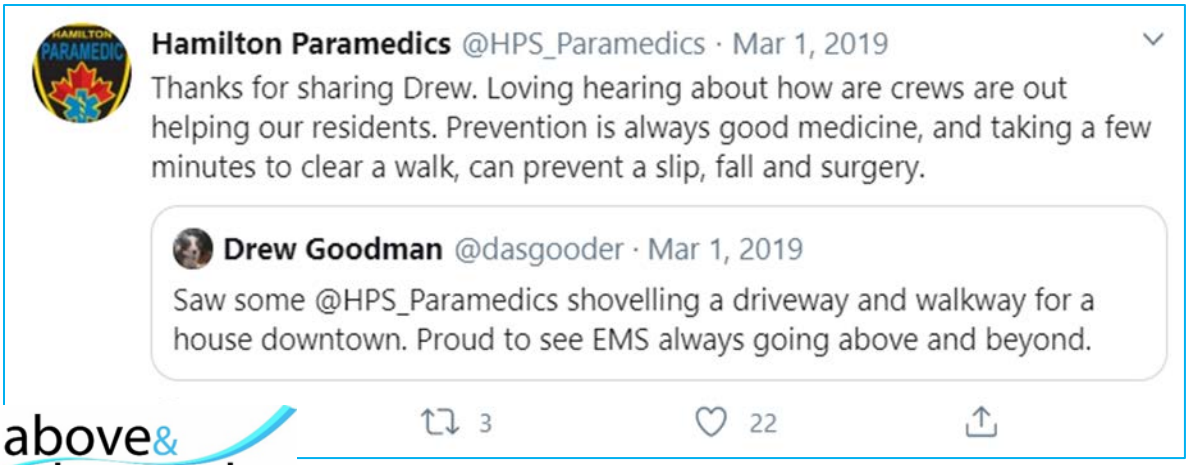
$23.44

Total Cost per Response

$587.28

Vehicle Cost per Kilometre

$0.67



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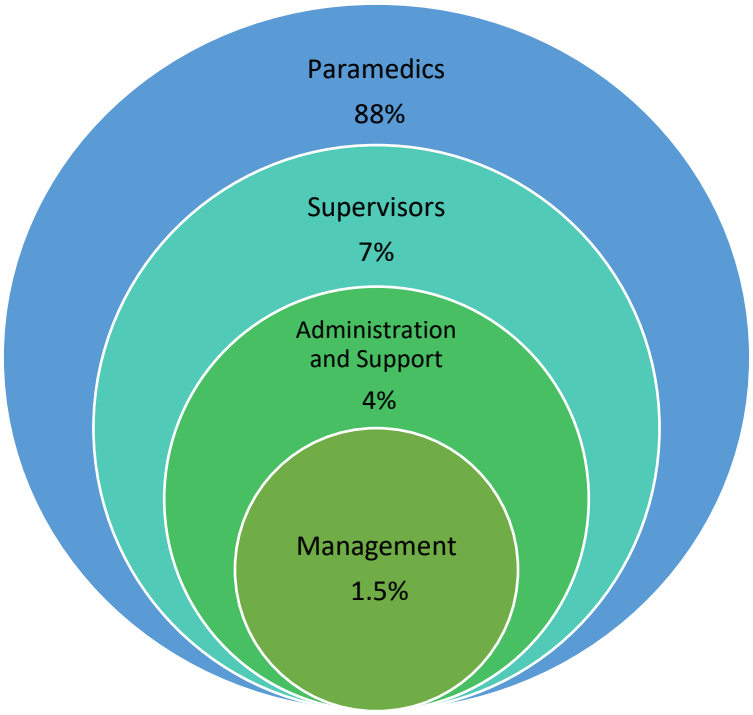
HPS Structure

As an integral part of the health care system, HPS helps to promote the health and safety of Hamilton's residents and visitors through prevention, response and follow-up activities. HPS achieves this best through being situated within the Healthy and Safe Communities Department which enables collaboration with other divisions focused on similar outcomes for the community.

Reporting to the General Manger of the Healthy and Safe Communities Department, the Paramedic Chief is responsible to lead the planning and operationalization of HPS which is comprised of four sections:

- Office of the Chief
  - Responsible for strategic vision, direction, and planning
- Operations Section
  - Responsible for providing oversight of deployment and resource utilization
- Logistics Section
  - Responsible for providing support to all sections through procurement and asset management
- Performance and Development Section
  - Responsible for ensuring regulatory compliance and quality improvement

A total of 398 staff including full and part time made up the workforce of HPS in 2019. Approximately 88% of staff are paramedics with about 19% of those Advanced Care Paramedics. While paramedics provide direct frontline services to the community, supervisors, administration and support staff and management provide a variety of supportive and regulatory functions to meet MOH mandates. HPS workforce breaks down as follows:



Performance Overview

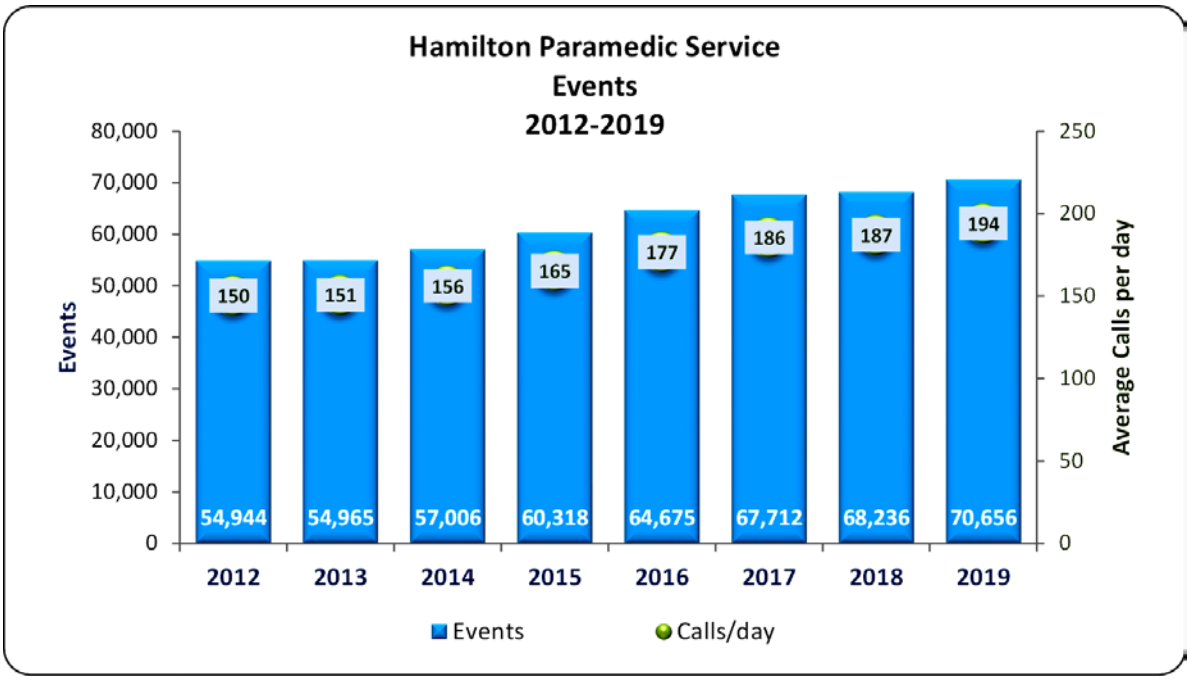
Events

An event is generated every time a person calls 911 and requests the assistance of paramedics through dispatch, the Central Ambulance Communications Centre (CACC). In 2019, HPS continued to see an increase in the number of events with a total of 70,656, an average of 194 events per day.

70,656 Events

194/day
on average

The following chart illustrates the year-over-year increase in events since 2012 along with the average daily events each year.



"In the park I noticed a man having problems…he was inhaling from a spray can. I called 911. When the paramedics attended they addressed him by his name and treated him with respect, dignity and compassion. The first thing the paramedic did was kneel down and held the man's hand explaining he just wanted to make sure he was ok.
Their professionalism was second to none."

above & beyond

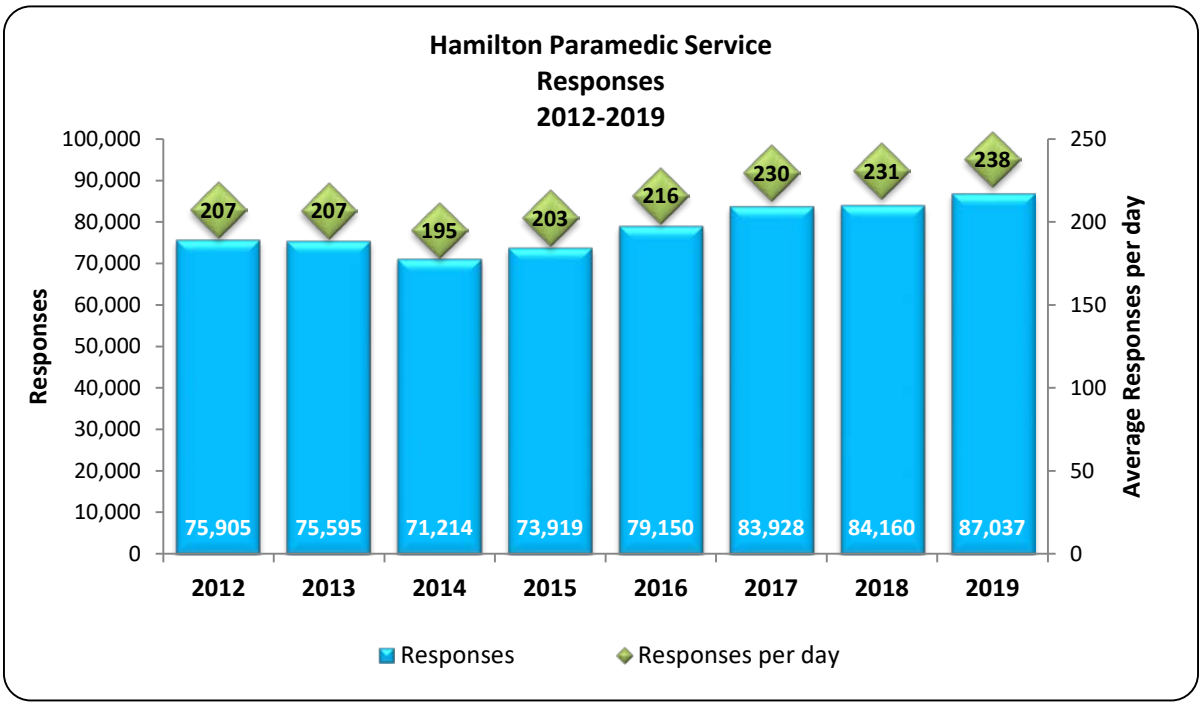
Responses

Responses are the number of paramedic vehicles that are sent to an event. This number is usually higher than the number of events as there is usually more than one vehicle sent to an event. In instances such as motor vehicle collisions and complex medical/traumatic emergencies, multiple paramedic vehicles may be assigned to respond. In 2019, HPS had a total of 87,037 responses with a daily average of 238 responses.

87,037 Responses

238/day
on average

The chart below shows the number of responses per year since 2012 along with the average number of responses a day for each year.



Patient Problem	% of Responses
Dyspnea (shortness of breath)	14
Fall	11
Abdominal/Pelvic/Perineal/Rectal Pain	5
Ischemic Chest Pain	5
Unconscious	4
Unwell	4
Motor Vehicle Collision	4
Behaviour/Psychiatric	3
Musculoskeletal	3
Cardiac/Medical Arrest	3

Complaints

The table to the left shows the top ten reasons patients called HPS for medical assistance in 2019.

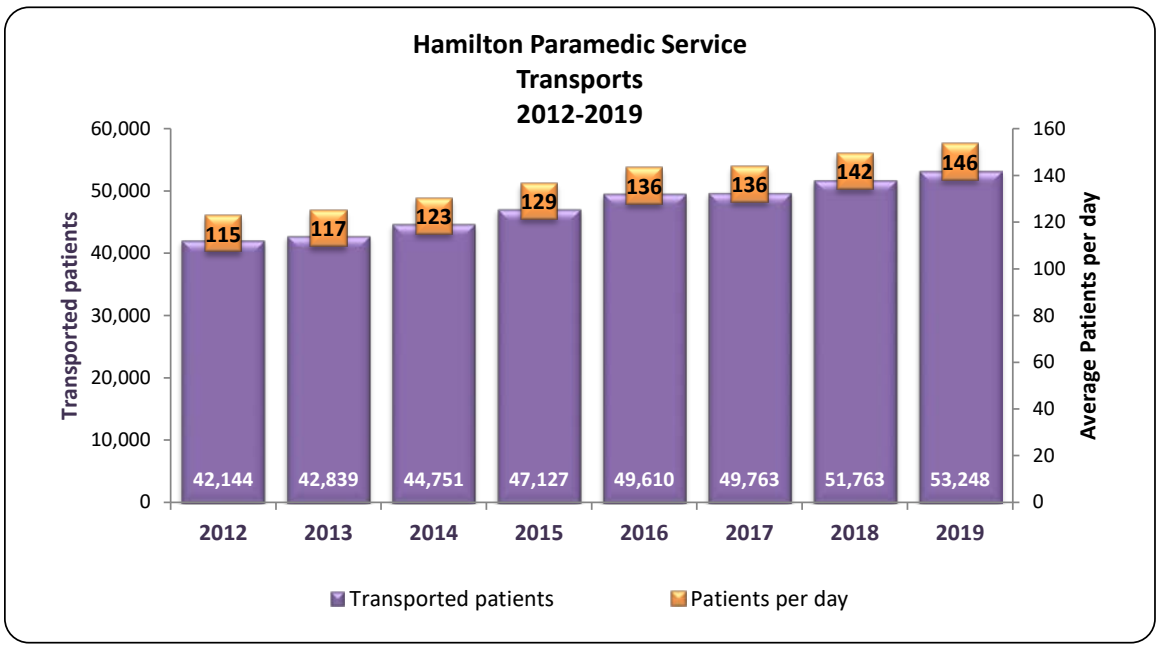
Transports

Transports refers to the number of times patients are transported to hospitals by paramedics. This number is typically lower than the number of events, as some patients decline or do not need to be taken to the hospital once assessed by the paramedics. The number of transports continued to increase in 2019 with a total of 53,248 and an average of 146 per day.

Depicted in the chart below is the continual increase in patient transports since 2012.

53,248 Transports

146/day on average



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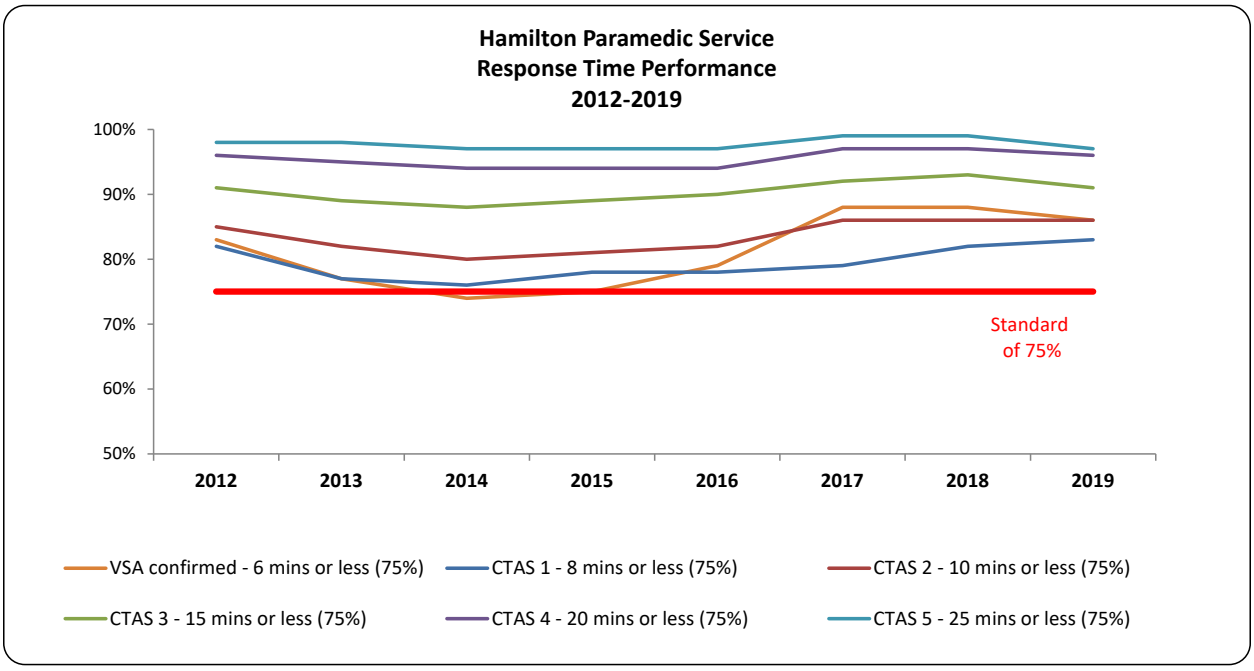
Response Time Compliance

The *Ambulance Act of Ontario* requires that every paramedic operator in Ontario is responsible to establish and publicly report on response time performance. The City of Hamilton and MOH approved target response times based on the Canadian Triage and Acuity Scale (CTAS). CTAS is a triage system that prioritizes patient care by severity of the injury or illness. HPS is expected to achieve the target times in each CTAS category at least 75% of the time.

In 2019, HPS again surpassed the standard of 75% in achieving the target times for each CTAS category.

CTAS Category	Acuity Level	Target Time	Standard % of Time Target Time to be Achieved	% of Time HPS Achieved Target Time
Vital Signs Absent	VSA Confirmed	6 minutes	75	86
1	Resuscitation	8 minutes	75	83
2	Emergent	10 minutes	75	86
3	Urgent	15 minutes	75	91
4	Less Urgent	20 minutes	75	96
5	Non-Urgent	25 minutes	75	97

The graph below shows that HPS continues to meet and exceed the response time standard year over year despite the increase in events, responses and transports each year.

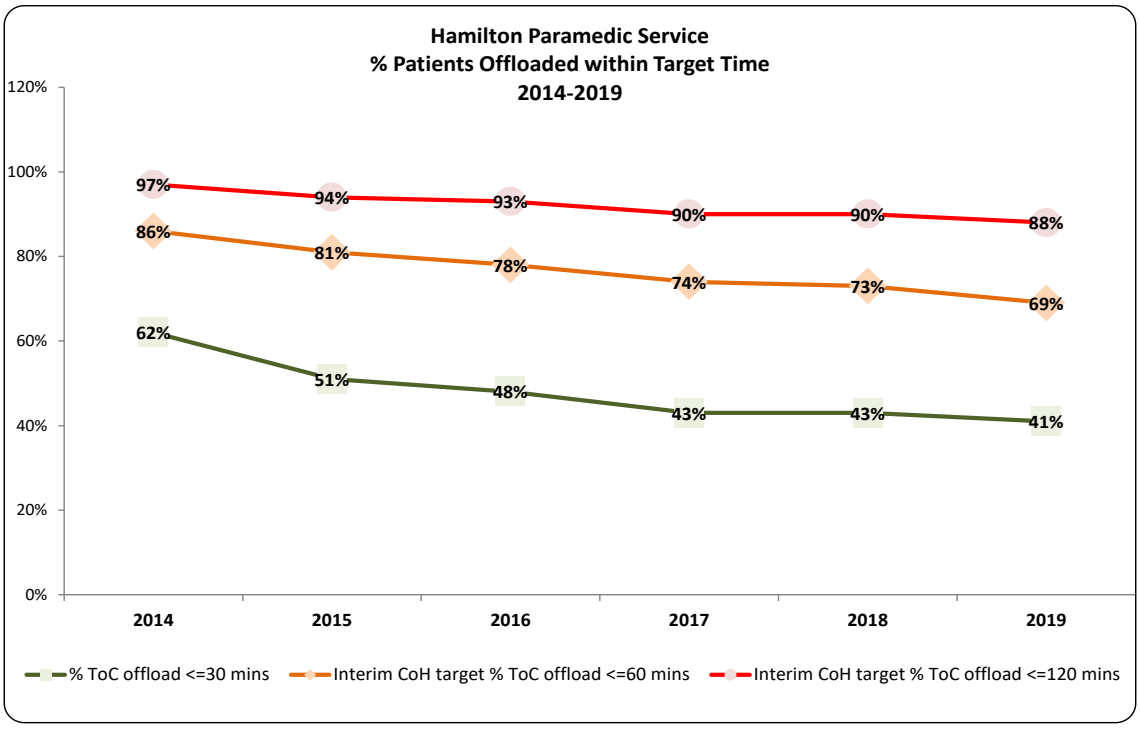


Off-Load Delay

An off-load delay occurs when the hospital does not accept responsibility for the care of the patient from paramedics within 30 minutes of their arrival to the Emergency Department. MOH recommends that transfer of care of patients occurs within 30 minutes 90% of the time. Paramedics are required to remain with and care for the patient until the hospital is ready to accept the responsibility.

As a result of a variety of system pressures, hospitals in Hamilton continue to struggle to meet the target of accepting the patient within 30 minutes of paramedic arrival. Thus, the City of Hamilton and hospitals have implemented interim targets of transfer of care to hospital within 60 minutes 90% of the time and within 120 minutes 100% of the time.

However, in 2019, only 41% of patients were transferred from paramedics to the hospital in 30 minutes or less. Transfer of care within 60 minutes occurred 69% of the time, falling short of the interim target of 90% of the time. Similarly, hospitals took over the care of patients from paramedics within 120 minutes 88% of the time, although the target is 100% of the time. The chart below shows the percentage of time patients were transferred to the care of hospitals within 30, 60 and 120 minutes for each year since 2014.



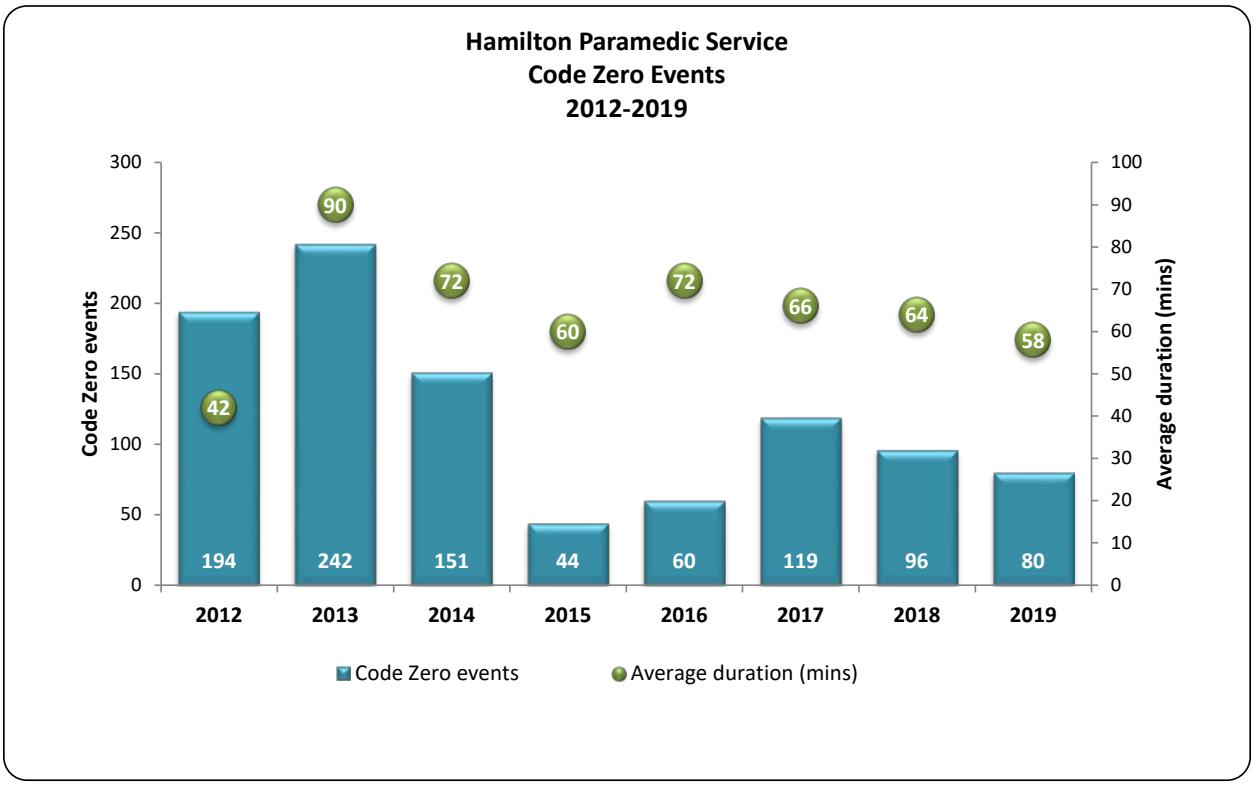
In 2019 paramedics spent **30,549** hours in excess of 30 minutes waiting in Emergency Departments to transfer care of their patient to the hospital

Photo Credit: CBC.ca
2018

Code Zero Events

Code Zero events occur when the number of ambulances available to respond to a call are limited to just one or none. Long off-load delays, particularly when there are 10 or more delays longer than 2 hours in one day, continue to be the major cause of code zero events. When a code zero event occurs, ambulances from neighboring municipalities are assigned to respond to emergency calls in Hamilton.

In 2019, there were a total of 80 code zero events that lasted almost an hour on average. The graph below shows the number of code zero events from 2012 to 2019 and the average length of time a code zero event lasted that year.



"The one paramedic helped my wife cut up some food for me…to try to get my sugar level up. I spilled some on the floor and the paramedic cleaned it up. Being seniors, we appreciated it. The paramedics stayed with us until my blood sugar level was fine.
Job well done!"

above & beyond

Community Paramedicine

HPS began the Community Paramedicine program in 2014. Through a range of approaches the program helps clients who have complex and chronic conditions by meeting their needs where they live and thereby reducing emergency department visits and hospital stays.

Hamilton's program is focused on three key areas:

NAVIGATE connecting clients to the resources they need
ADVOCATE ensuring clients have access to the resources they need
COLLABORATE working with community partners to ensure clients' needs are met

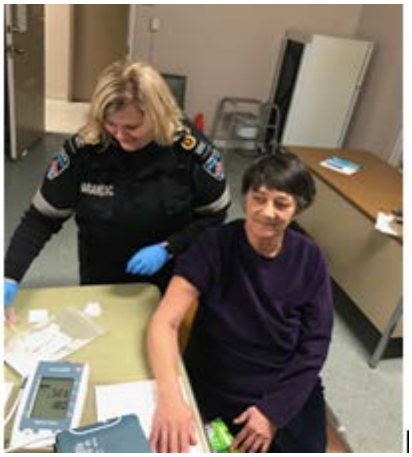
Home Visits

When someone has been identified as using 911 services regularly a specially trained Community Paramedic is notified who visits the client in their home and conducts an in-depth assessment. As part of a network of service providers the paramedic can quickly connect the client to the resources they require. In 2019, 653 clients were enrolled in the Home Visit Program with Community Paramedics making 347 visits resulting in a 50% reduction in calling an ambulance among these clients.

Clinics

Clinics are set up in selected buildings where vulnerable seniors reside. Community Paramedics' interventions are focused on health promotion and the prevention and monitoring of high blood pressure, diabetes, cardiovascular disease and social isolation.

In 2019, the Clinic Program operated in nine vulnerable seniors' buildings throughout the city with a total of 260 sessions and over 1,900 visits by residents.



Flu Clinics

In 2018, the Clinic Program expanded to include influenza immunization during the flu season. In November and December 2019, 50 clinics were held with 236 residents of vulnerable seniors' buildings receiving the flu shot. In a feedback survey, recipients said the convenience of having the shot available in their building prevented them from having to travel in inclement weather and ensured that they received the vaccination.

Remote Patient Monitoring

The Remote Patient Monitoring Program leverages technology to allow patients to stay in their homes while being monitored by Community Paramedics. Information about the patient's chronic condition is transmitted from a variety of devices to a database monitored by a paramedic. If a predetermined threshold is exceeded, a Community Paramedic promptly contacts the patient. In 2019, there were 51 new patients enrolled in the program bringing the total to 74 patients who are using remote technology to monitor their health. Analysis conducted by Queens University shows that this program results in a 26% reduction in both 911 calls and emergency department visits.

Social Navigator

The Social Navigator Program (SNP) is a collaboration with the Hamilton Police Service to support at-risk individuals and those with repeat police interactions by connecting them to health and social services they require. In 2019, there were 105 clients in the SNP although over 280 people were referred to the program. There was also contact made with an additional 301 individuals who needed brief assistance.

Social Navigators referred their clients to 241 various programs and services to provide support for housing/shelter, mental health, rehabilitation, primary care, income and employment as well as assisting in attending appointments and obtaining food and clothing.

The SNP has been successful in reducing the amount of times police were called for clients for adverse purposes.

Public Access Defibrillation

The Community Paramedic Program is responsible for the maintenance and tracking of Automated External Defibrillators (AEDs) throughout the city and advocate to increase in the number of AEDs in the community. Medical evidence shows that when an AED and CPR are administered immediately, often by a bystander, the chance of survival from sudden cardiac arrest is substantially improved by up to 75%.

In 2019, there were 439 AEDs in the city and three uses. In one instance a 9-year-old child was successfully resuscitated. AEDs are located throughout the city in public buildings, such as City of Hamilton office buildings, schools, libraries, local event arenas, fitness centres, recreational facilities, hockey arenas and seniors' centres.

Paramedic Palliative Outreach Support Team

The PPOST Program is a new Community Paramedic Program initiated in October 2019. A specially trained team of Community Paramedics are contacted when a patient's palliative care team is unavailable. Community Paramedics are able to support the patient through a palliative crisis in their home and avoid a transport to the emergency department. Since October, the team has supported five patients and averted four hospital visits. There are plans to expand the program to provide paramedic support to palliative care patients in 2020.

Flu Response for Emergency Department Diversion

The FREDD Program is a new Community Paramedic Program initiated in December 2019. It provides a mobile response unit to influenza-like illness calls at long-term care homes during the flu season. Paramedics treat long-term care residents in the home thereby decreasing the need to go to the hospital. This program continued until the end of March 2020.

Emergency Department Diversion to Withdrawal Management

The EDWIN Program is another new Community Paramedic Program that began in late December 2019. It enables paramedics to transport men with addiction-related issues to the Men's Addiction Service Hamilton (MASH) rather than to hospital emergency departments. In 2020, the program will be expanded to include transports to two additional facilities: Womankind Addiction Services and Youth Substance Use Prevention.

In her spare time, paramedic Mandie crochets hats for newborns. The hats are included in all paramedic obstetrical kits.

They are even in HPS colours.

The hats stay with the babies so Mandie is always busy crocheting.

above & beyond

Clinical Excellence

Clinical excellence is demonstrated by Hamilton paramedics through a commitment to continued growth and development. In 2019, paramedics underwent an aggregate total of 25,131 instructional hours. A variety of procedures were implemented in 2019 that expand the range of capabilities of paramedics so they can provide excellent clinical care to patients.

Intraosseous Infusion

Intraosseous infusion (IO) is used to directly access the marrow of bone to provide fluid and medication when intravenous access is not possible. In 2019, paramedics were trained on the utilization of the EZ-IO device to quickly and effectively gain vascular access in emergency situations. Since implementation in the fall, the EZ-IO device has been used 36 times.

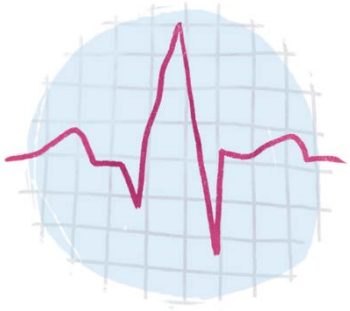
Autonomous Intravenous (AIV)

In 2019, for the first time Primary Care Paramedics were given the opportunity to utilize their certification acquired from other services to administer intravenous (IV) in Hamilton. In the past, this procedure was within the scope of practice of Advanced Care Paramedics only. Since September 2019, 19 paramedics have been certified in autonomous IV. In 2020, all Hamilton Primary Care Paramedics will be given the opportunity to be certified in AIV.

Neonatal Intensive Care Unit

In 2019, with funding from MOH, HPS acquired an ambulance dedicated to critically ill newborns. Paramedics will work with the McMaster Children's Hospital NICU transport team to transfer babies from referring hospitals to the Neonatal Intensive Care Unit at McMaster.

Paramedic Clinical Feedback



Once paramedics transfer the care of a patient to the hospital, they do not have access to information about the patient's outcome or how their actions impacted the outcome. A specialty program with the Hamilton General Hospital's Heart Investigation Unit (HIU) allows paramedics to transport heart attack patients directly to the HIU where a medical team is prepared to receive and treat the patient. In 2019, this program was enhanced to include feedback data from HIU to HPS related to the efficacy of paramedic procedures and results of HIU tests. This allows paramedics to build on strengths and identify and develop areas for improvement. The paramedic clinical feedback initiative will be expanded to include the specialty programs for trauma and stroke patients.

National Paramedic Competition

This annual competition is a one-day event that challenges paramedics on academic tests, practical scenarios using human actors and patient simulators. Paramedics and student paramedics from across the country compete to showcase clinical excellence. In 2019, Hamilton was represented by a Primary Care Paramedic team and an Advanced Care Paramedic team who won third place in their division. The 2020 competition is scheduled to be hosted by HPS in Hamilton.

PCP Division
Heidi Bergeron and Brian Mak

ACP Division
David Egier and Andrew Newlands

Continuous Improvement

A range of projects were undertaken in 2019 to improve processes, policies and services to ensure the HPS delivers optimal care to the community. Some of these projects are highlight below.

Tiered Response Agreement Review

The Tiered Response Agreement (TRA) between HPS and Hamilton Fire Department was established to ensure a timely response to medical emergencies in the community. In December 2019, a team of subject matter experts from paramedic, fire and dispatch services assembled for the first time to conduct a detailed review of the TRA and analysis of data to define its criteria. The project team will identify areas for improvement and efficiencies to the TRA and related processes. A report of their recommendations will be provided to Council for consideration in 2020.

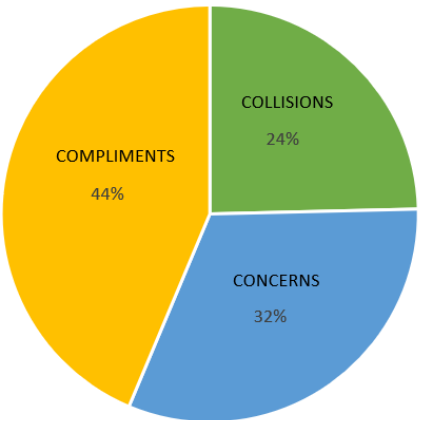
Stair Chair Upgrade

A stair chair is used by paramedics for alert patients who need to be transported down stairs or through narrow confined spaces. In 2019, paramedics identified the type of chair that best suits their needs and the needs of their patients. After participating in trials using a variety of stair chairs, paramedics completed a survey to indicate their preference. In 2019, the bariatric ambulance was equipped with the chair selected by most paramedics. In 2020, the preferred chair for all other ambulances will replace the current ones. The new chair is lighter weight, easier to handle and therefore will help to reduce the risk of injury due to lifting.

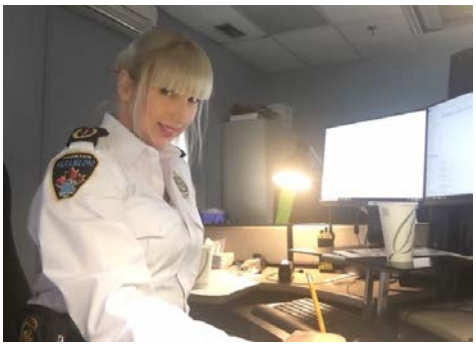
Quality Assurance

HPS has a robust quality assurance program that, among other activities, reviews and responds to feedback from both external and internal customers. Follow-up with paramedics is an integral part of the program to ensure the continuous improvement of HPS service delivery.

In 2019, 268 reviews were conducted to identify opportunities for improvement and employee recognition. Sixty-six were related to collisions, 85 were concerns about conduct and practice while 117 were compliments on paramedics' performance (not including social media posts).



Hamilton Paramedic Service Quality Reviews 2019


Liz Bates, Paramedic Supervisor

New Policy Manual

An extensive review of HPS policy and procedures was undertaken in 2018 by a Paramedic Supervisor with expertise. In the fall of 2019, a new manual was introduced to staff for feedback. The new manual has 42 policies reduced from 262 policies and procedures in the previous manual. Outdated and repetitive content was removed, and policies were rewritten in plain language with a clear purpose and includes links to related material such as legislation and training materials. Policies in the new manual represent the values of HPS, respect the knowledge and professionalism of staff and are not punitive referring only to discipline in the discipline policy. The new policy manual will go into full effect by early 2021.

Expanded Community Paramedicine Program

In the latter half of 2019, HPS expanded the Community Paramedicine Program in a continued effort to assist clients in the community and decrease the need for hospital visits. As described earlier, through the PPOST Program paramedics can assist palliative patients in their homes. The FREDD Program enables paramedics to treat long-term care residents with flu-like symptoms in the residence. The EDWIN Program allows for paramedics to transport clients with addiction-related issues to a facility rather than the hospital. In 2020, HPS will continue to expand existing Community Paramedicine Programs and explore new ones.

As well as adding new innovative programs to the Community Paramedicine Program, in 2019 Community Paramedics joined the Ontario Health Network enabling them to make virtual home visits.

Public Health Services Collaboration

Influenza Vaccines

In collaboration with Public Health Services, HPS was able to provide flu shots through the Community Paramedicine Program in 2019. Public Health Services supplied the vaccine, carried out inspections, supported the program and HPS provided Public Health Services with reports of progress.

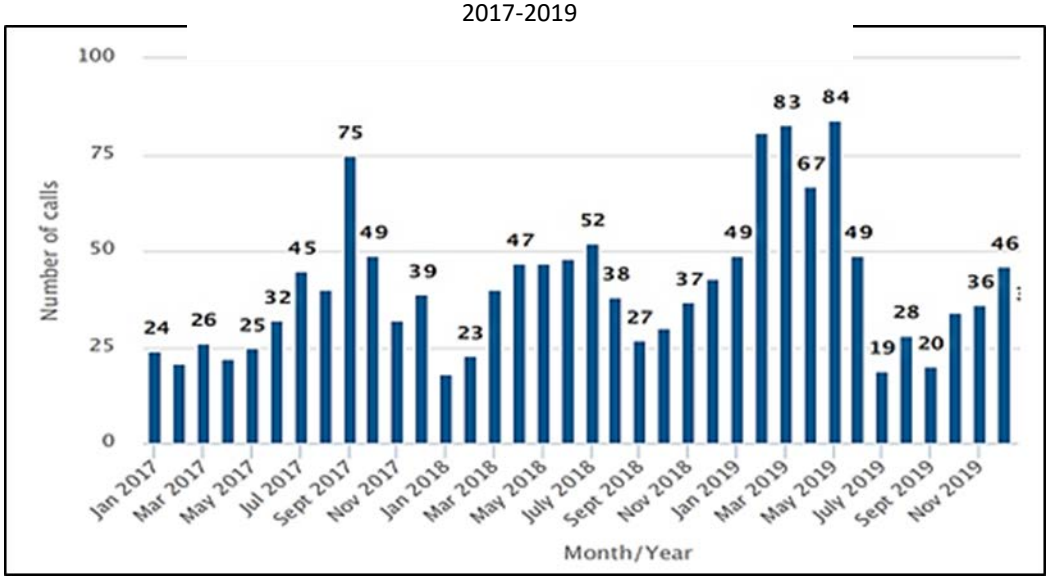
"From the time the paramedics arrived until they passed off my dad [to the care of the hospital], they were nothing but professional, and, in fact, went over and above their duties to be empathetic, caring, and very reassuring to my mother. My parents are both diabetic and they even made sure that they had a sandwich and a drink while they were waiting [in the emergency department]."

above& beyond

Opioid Information System

HPS continues to collaborate with Public Health Services to provide timely data on opioid-related emergencies to the public through the Hamilton Opioid Information System on the City's website. Tracking suspected opioid overdoses helps to inform mitigation efforts. In 2019, paramedics assisted approximately 596 people suspected of opioid overdose.

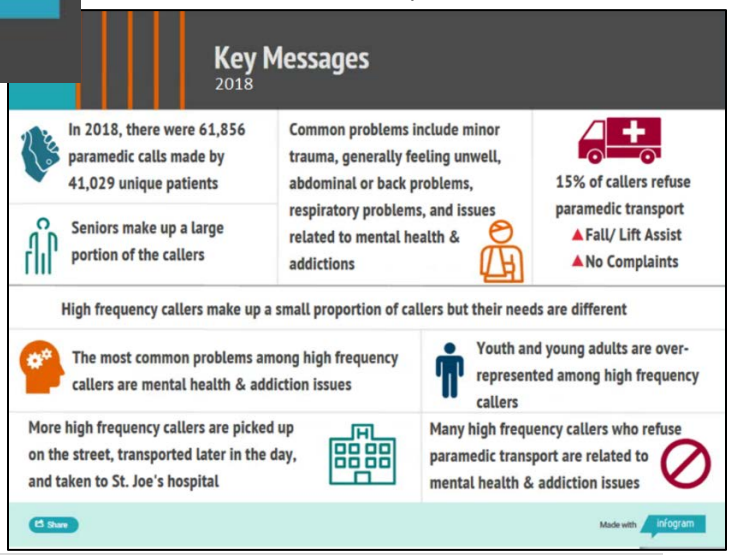
Monthly Opioid-Related Paramedic Incidents in Hamilton
2017-2019



Paramedic Services User Profile

In 2019, Public Health Services completed an analysis of 2018 paramedic patient call records to help HPS better understand the characteristics of people who access ambulance services multiple times.

The analysis generated a comprehensive report that is utilized for messaging to the community and stakeholders and informs HPS program planning as well as the ten-year Master Plan set to be released in 2020.



Community Connections

Community Events

Hamilton paramedics play an important role in the community not just because they provide quality care and emergency response but also because they provide information and support to various community groups. In 2019, HPS participated in over 30 community events of a wide variety including festivals, fairs, parades and fundraisers as well as educational, awareness-raising, appreciation and career development events.

HPS is able to support these events through utilizing paramedic volunteers, paramedics on modified duties and in special circumstances frontline staff or superintendents are able to attend these events. This ensures that no paramedics are taken away from their primary duty of being able to respond to emergency calls.

Media Presence

HPS had a strong media presence in 2019. Through over 60 spots in local television, newspaper and radio HPS shares important information relating to their work, raising awareness of key community issues and supporting community health, safety and well-being.

2019 Twitter Activity
@HPS_Paramedics
366 Tweets
14,000 Followers
2,295 Retweets
11,767 Likes
2.2 million Impressions

As well, through the HPS Twitter account, HPS was able to share timely news about emergency incidents, promote key community events and HPS charity work and celebrate the dedication of paramedics across the region. Social media also provided a platform to disseminate educational information related to drowning prevention, CPR, substance use and driving, when to call 911, rail track safety, stroke awareness and safety tips during inclement weather. In 2019, the HPS Twitter account had over 14,000 followers with a reach of over 2.2 million impressions or the number of times an HPS tweet appeared on users' timelines impressions.

Charity Support

Not only do Hamilton paramedics participate in community fundraisers such as Tim Horton's Camp and McHappy Day, they also help to lead various charitable causes. The following are just a few charitable endeavours that took place in 2019:

Tour de Paramedic Ride 2019

The Hamilton paramedics' cycling team Escarpment City Gears (ECGs) took part in the 2019 ride from Toronto to Ottawa with some starting in Hamilton and riding over 600 kilometers. The ride raised funds for the Canadian Paramedic Memorial Foundation for a monument to honour paramedics who have lost their lives in the line of duty. For four years, Hamilton paramedics have been involved in the ride and have raised close to $20,000.

Community Garden

The garden began six years ago by paramedics who continue to volunteer their time to tend the garden. The bulk of the produce is donated to Neighbour to Neighbour Centre. In 2019, Victory Gardens provided seeds and seedlings for the garden and the garden yielded over 1,835 pounds of produce for donation.

Sirens for Life

In 2019, Hamilton paramedics once again took part in the Canadian Blood Services challenge for local first responders to donate blood to ensure adequate blood inventory at hospitals. In 2019, there were 171 first responders in Hamilton contributing to the cause.

Food Drive

Hamilton paramedics partnered again with Neighbour to Neighbour, the Burlington Auxiliary O.P.P. and Fortinos for the 2019 annual food drive. This effort provides essential food to families in need during the holidays. In 2019, the drive raised over $26,000 in cash donations and approximately 12,300 pounds of food.

Toy Drive

The annual Paramedic Toy Drive for CityKidz ensures that children experiencing the challenges of poverty receive a personalized and meaningful gift at Christmas. In 2019, the toy drive raised almost $8,900 and 2,100 toys that filled two ambulances.

Awards of Achievement

A number of Hamilton paramedics were formally recognized in 2019 for their extraordinary achievements in serving the community and their peers.

Gord Mooney a Community Paramedic dedicated to helping people in need through the Social Navigator Program earned the Paramedic Chiefs of Canada Award of Excellence for client centered initiatives.

Gord was also recognized for his achievement by Hamilton’s City Council.

Michael Giovinazzo was awarded the Governor General of Canada Emergency Medical Services Exemplary Service Second Bar for 40 years of dedicated service as a Primary Care Paramedic.

Traicee Chan was recognized for her innovation and commitment to her peers’ well-being through her work on the Peer Support Team. Traicee’s efforts help to strengthen the morale and cohesiveness of paramedics.

Primary Care Paramedics Dave Dean and Davina Shantz received the Hamilton Heath Sciences Centre for Paramedic Education and Research (CPER) Quality of Care Award. This award is for excellence in patient care and is peer-nominated.

Advanced Care Paramedics David Egier and Andrew Newland won third place in their division of the National Paramedic Competition.

In 2019, 35 recruits successfully completed the recruitment process and joined the HPS family prepared to deliver excellence in service to the Hamilton community. (Shown above, Recruit Class of June 2019)

Paramedics Stefan and Mandie organized 25 volunteers to help clean up Hamilton's Bayfront Park.

above & beyond

Hamilton

HAMILTON PARAMEDIC SERVICE 2019 ANNUAL REPORT

Emergency & Community Services Committee

July 13, 2020

Michael Sanderson
Chief, Hamilton Paramedic Service

HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Hamilton Paramedic Service

How Much Did We Do?

70,656 Events

194/day

87,037 Responses

238/day

53,248 Transports

146/day

How Much Did We Do?

Community Paramedicine

3 new programs

653 @Home clients

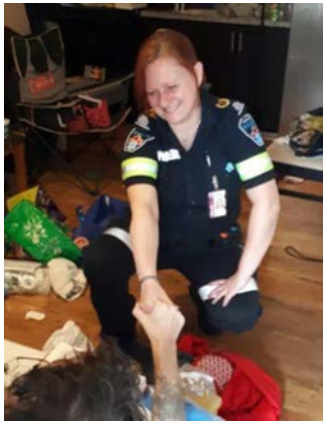
1,904 @Clinic visits

236 flu shots

51 new RPM patients

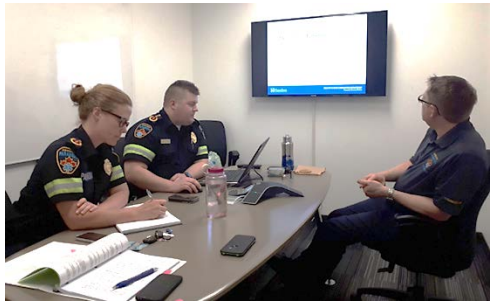
105 clients in SNP

439 AEDs



How Much Did We Do?

25,131 instructional hours



30+ community events

10+ charities

How Much Did We Do?

80 Code Zero events

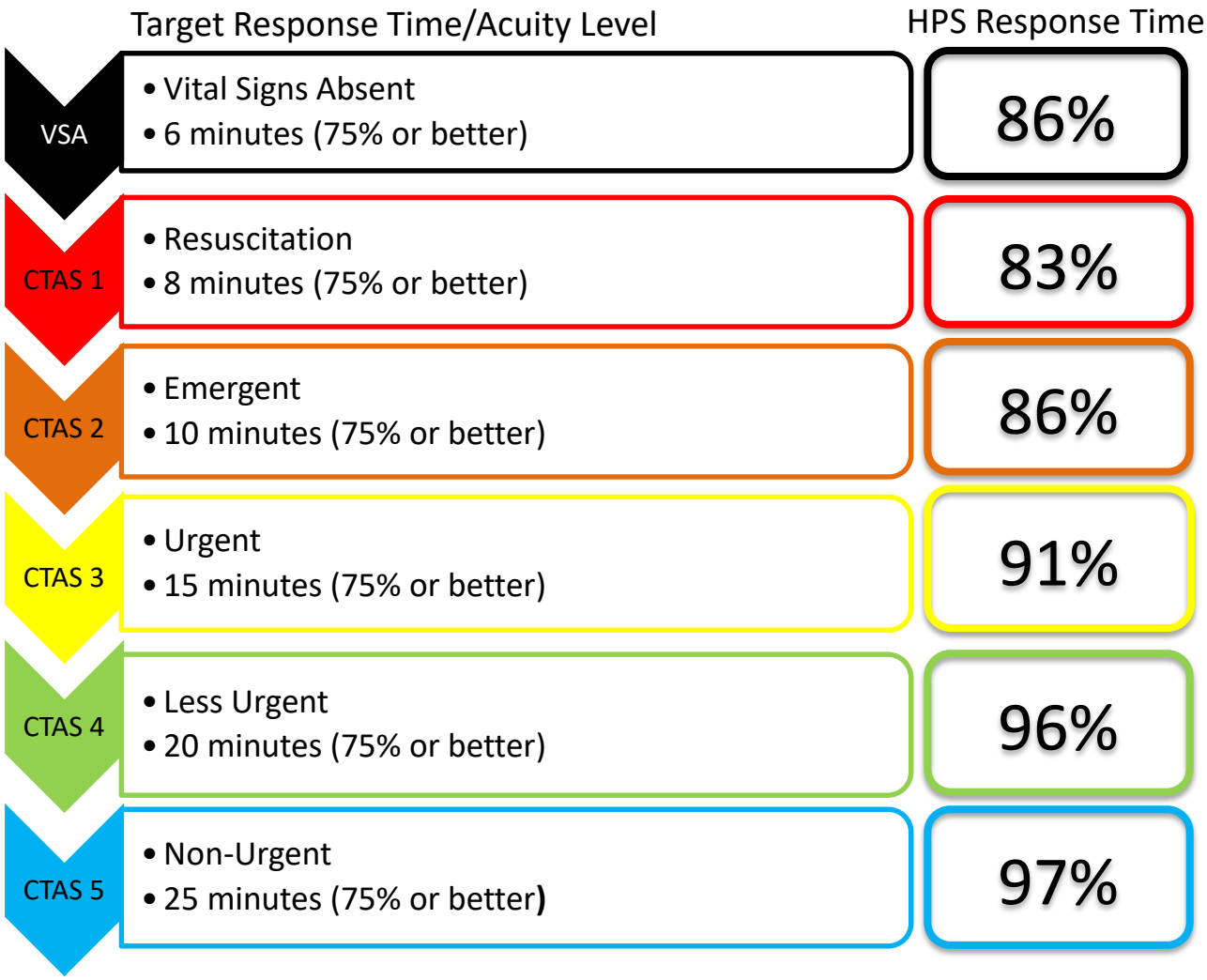
41% Transfer of Care ≤ 30 mins

30,549 hours in offload delay >30 mins

Photo: cbc.ca

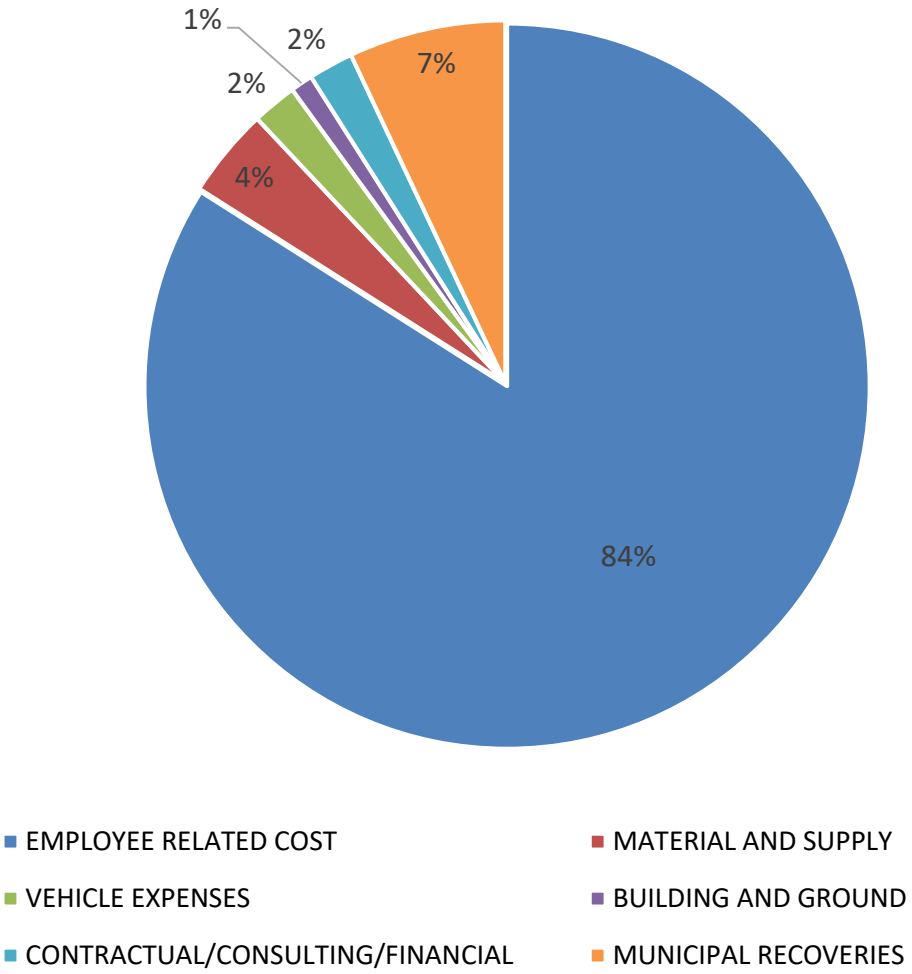
Photo: The Hamilton Spectator

How Well Did We Do?



How Well Did We Do?

Operating Budget



Materials & Supplies/Response

$23.44

Vehicle Cost/Kilometre

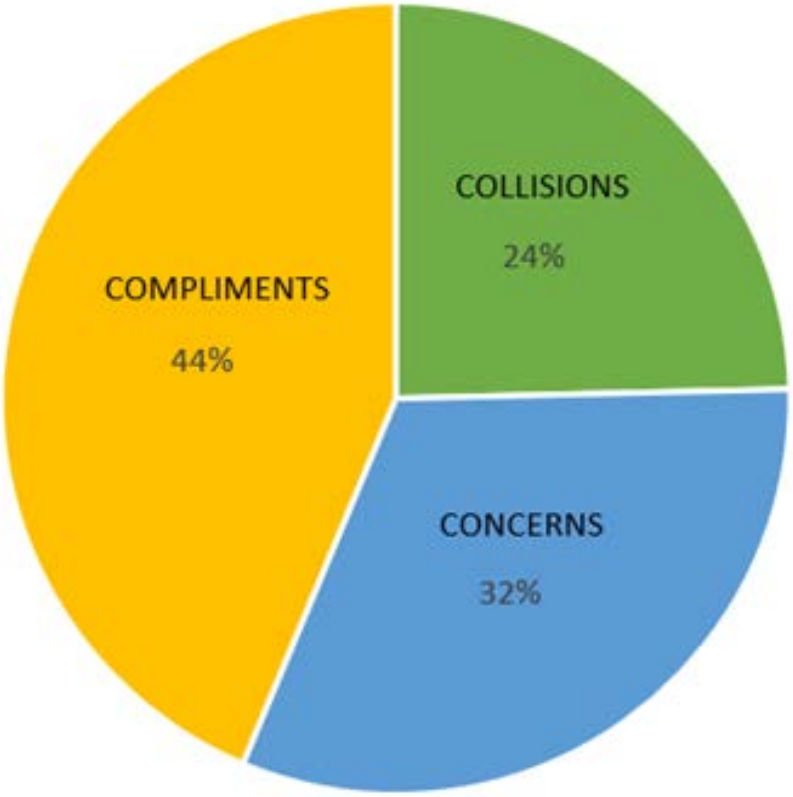
$0.67

Average Cost/Response

$587.28

How Well Did We Do?

Quality Assurance Reviews



They even made sure my parents had something to eat while waiting in the ED.

They arrived with smiles and support. They were my bright spot.

They took the best care of me and calmed down my husband.

They helped my wife cut up food for me. I spilled some and they cleaned it up.

They touched our lives and made the night easier.

How Well Did We Do?

Client Feedback

@Home

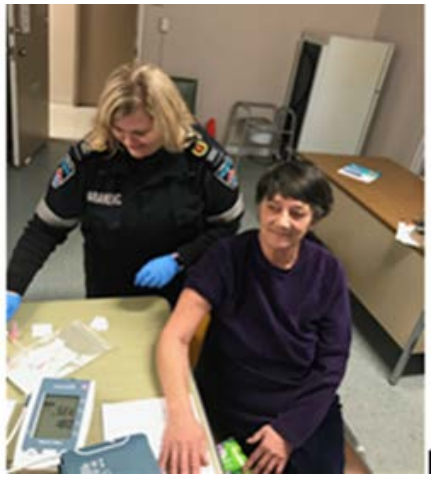
90% rated service as Excellent

@Clinic

97% rated service as Excellent

Flu Clinic

98% satisfaction rate

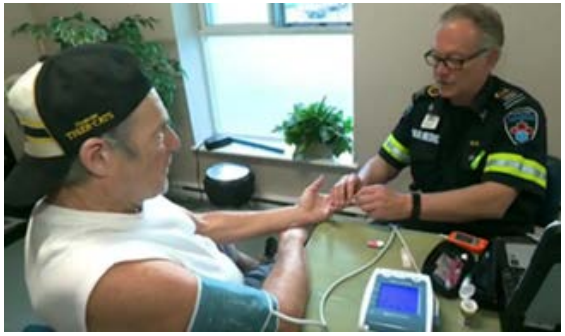


I got my flu shot this year because you are here.

The paramedic was nice and did a good job.

My pharmacy didn't have the seniors dose.

The paramedic was really fun.



How Well Did We Do?

Client Feedback

Sarah James @bysarahjames · Oct 2, 2019

A huge shoutout to the @HPS_Paramedics for taking great care of my Dad. You folks are amazing. #HamOnt

Brandon Archer @2014_archer · May 27, 2019

@HPS_Paramedics Thanks for all you do the city wouldn't be the way it is without the dedicated team like you guys so Well Done And Congratulations

Steve Authier @steveauthier · Mar 17, 2019

@HPS_Paramedics Thanks for your great crew this morning in helping getting my wife to the hospital #Empathy & #Compassion make a big difference #HamOnt

Jeffrey Brinson, Ed.D. @JeffreyBrinson · Dec 30, 2019

Special thank you to the @HPS_Paramedics a small the doctors and nurses @mch_childrens @HamHealthSci for their care for my 10 year old earlier this month.

Show this thread

Is Anyone Better Off?

913 stroke responses

223 STEMI responses

351 patients resuscitated from suspected Sudden Cardiac Arrest (ROSC)

596 patients assisted with suspected opioid overdose

160,870 medical procedures

Is Anyone Better Off?

@Home

347 visits

50% reduction in 911 calls

Remote Patient Monitoring

~26% reduction in 911 calls

~26% reduction in ED visits

Social Navigator Program

241 services/programs provided to clients

Public Access Defibrillator

3 uses - 9 year old successfully resuscitated and recovered with no brain damage

Is Anyone Better Off?

Stephanie was 6 months pregnant with this little sweetheart when she had a stroke. Thanks to a swift response from her partner, Hamilton Paramedics and the stroke team at General Hospital they are both alive and well.

Is Anyone Better Off?

Food Drive

$26,015

12,264 lbs food

Toy Drive

$8,873

2,100 toys

Continuous Improvement

- Update of Policy and Procedure Manual
- Expanded Community Paramedicine Program
  - Paramedic Palliative Outreach Support
  - Flu Response for Emergency Department Diversion
  - Emergency Department Diversion to Withdrawal Management
- Advancement in Equipment (e.g., Stair Chair, IO drill)
- Review of the Tiered Response Agreement
- Educating on Naloxone awareness and use

Continuous Improvement

- Collaboration with Public Health Services
  - Opioid Information System
  - HPS User Profile
  - Flu shots
- Certified PCPs given opportunity to administer intravenous
- Feedback to paramedics from General Hospital's HIU
- Addition of NICU transport ambulance

Plans for 2020

✓ Obtain hybrid ambulances

- Participate on Hamilton Health Team
- Expand Community Paramedic Program
  - Transport to addiction management facilities for women and youth
  - Increase paramedic support for palliative care patients
- Update Tiered Response Agreement
- Finalize 10-Year Master Plan
- Reduce hospital offload delays
  - Expand Fit-2-Sit Program
  - Develop Alternate Destination Guidelines

COVID-19 Response

- Ensure health and safety of staff
  - Modify response plans
  - Establish Infectious Disease Paramedics team
  - Preserve, adapt, acquire PPE
  - Early screening of staff

- Facility evacuations

- Community testing
  - Hospices
  - Nursing homes
  - Retirement/seniors residences
  - Long-term care facilities
  - Residential care facilities
  - Shelters

Hamilton

QUESTIONS?

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Home for the Holidays Wrap Up (HSC20024) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Joshua Van Kampen (905) 546-2424 Ext. 4592
SUBMITTED BY: **SIGNATURE:**	Edward John Director, Housing Services Division Healthy and Safe Communities Department

Council Direction

On October 17, 2019, the Emergency and Community Services Committee approved the following:

> "That the General Manager of the Healthy and Safe Communities Department be authorized and directed to deliver and administer an emergency social housing repair program ("Home for the Holidays") in the form of unit occupation, with the intent of making as many units as possible available by December 24, 2019, with a program end date of March 31, 2020, at a maximum aggregate cost of $2,000,000 to be funded from the Unallocated Capital Levy Reserve (108020) or 2019 Year-End Corporate Surplus"; and,
>
> "That the General Manager of the Healthy and Safe Communities be directed to submit an Information Update to Council, reporting on the success of the program in the first quarter of 2020."

INFORMATION

At the end of 2019, CityHousing Hamilton (CHH) had a significant number of units they could not afford to "turn over" or prepare to be rented as their budget for the year had already been expended. CHH also had a number of units that were chronically vacant because they required costly repairs.

Home for the Holidays was initiated with the goal of bringing 250 rent-geared-to-income (RGI) units back on-line with as many of them as possible completed by December 25, 2019. The $2 M used for the Homes for the Holidays program was funded by the 2019 Year-End Corporate Surplus that was generated largely by unused RGI subsidy dollars being returned to Housing Services, as the Service Manager, from Social Housing Providers during the year-end reconciliation process in 2019.

From November 2019 through to March 2020, CHH repaired 300 units. Examples of repairs to the units include mould remediation, replacing flooring, replacing walls, and updating electrical and plumbing. Approximately 20% of the units had been vacant for a prolonged period of time. While units of every size were repaired, approximately half were bachelor or 1-bedroom units which would be appropriate for a single person or a couple, the households with the longest wait times on the Access to Housing (ATH) list.

The table below is a summary of how many unit sizes were repaired:

Unit Type – Bedroom Size	**# Repair Units**
Bachelor	44
1 Bedroom	133
2 Bedroom	31
3 Bedroom	89
4 Bedroom	10
5 Bedroom	2

Of the 300 units renovated under this program, 215 have been rented to households on the Access to Housing (ATH) waitlist, 13 have been rented as affordable market rent, while the other 72 are in the process of being rented out. It is estimated that CHH spent $2.1 M through this program. The remaining $100,000 will be covered through CHH's allocation from the Poverty Reduction Fund (Project ID 6731841611).

CHH has been working to address challenges with unit turnover and chronic vacancies. In April 2017, Council approved the Poverty Reduction Fund (BOH16034/CES16043) to address this issue. In combination with internal budgeting and process changes, CHH has largely cleared its backlog of vacant units. Home for the Holidays solidified a reset on unit turnovers. Aside from 18 remaining chronically vacant units, the remaining vacancies are due to redevelopment.

APPENDICES AND SCHEDULES ATTACHED

None

CITY OF HAMILTON
HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Provision of Conditional Grants for the Purposes of Paying Development Charges for Two Non-Profit Affordable Rental Housing Projects (HSC19060(a)) (Ward 3)
WARD(S) AFFECTED:	Ward 3
PREPARED BY:	Kirstin Maxwell (905) 546-2424 Ext. 3846 Jana Amos (905) 546-2424 Ext. 1554
SUBMITTED BY: **SIGNATURE:**	Edward John Director, Housing Services Division Healthy and Safe Communities Department

RECOMMENDATIONS

(a) That a conditional grant in the total amount of the development charges (DCs) for the 40 units of the 60-unit Hamilton East Kiwanis Non-Profit Homes Inc., 6 – 14 Acorn Street affordable rental housing development project that are not receiving funding under the Ontario Priorities Housing Initiative (OPHI) (“Kiwanis Project”), in the approximate amount of $1,000,903 be approved in accordance with the terms and conditions contained in the Conditional Grant Term Sheet attached as Appendix “A” to Report HSC19060(a);

(b) That a conditional grant in the total amount of the development charges (DCs) for the 43-unit building of the 95-unit Indwell Community Homes, 225 East Avenue North affordable rental housing development project that are not receiving funding under Ontario Priorities Housing Initiative (OPHI) (“Indwell Project”), in the approximate amount of $379,260 be approved in accordance with the terms and conditions contained in the Conditional Grant Term Sheet attached as Appendix “B” to Report HSC19060(a);

(c) That the conditional grants in the total amount of the development charges (DCs) payable for both projects in the approximate amount of $1,380,163 as well as the

deficit of approximately $43,227 in the Social Housing Stabilization Reserve (110041) once all 2020 commitments have been met, be funded from the Affordable Housing Property Reserve (112256), to the applicable DC Reserve;

(d) That the General Manager of the Healthy and Safe Communities Department or designate be directed and authorized to enter into a Conditional Grant Agreement respecting the Kiwanis Project with the terms and conditions contained in the Conditional Grant Term Sheet attached as Appendix “A” to Report HSC19060(a) in a form satisfactory to the City Solicitor, and that the General Manager of the Healthy and Safe Communities Department be authorized to execute any such agreements and ancillary documentation;

(e) That the General Manager of the Healthy and Safe Communities Department or designate be directed and authorized to enter into a Conditional Grant Agreement respecting the Indwell Project with the terms and conditions contained in the Conditional Grant Term Sheet attached as Appendix “B” to Report HSC19060(a) in a form satisfactory to the City Solicitor, and that the General Manager of the Healthy and Safe Communities Department be authorized to execute any such agreements and ancillary documentation;

(f) That the development charges payable for the Kiwanis Project be payable in 20 equal annual instalments without interest in accordance with the terms and conditions contained in the Payment Agreement Term Sheet attached as Appendix “C” to Report HSC19060(a);

(g) That the development charges payable for the Indwell Project be payable in 20 equal annual instalments without interest in accordance with the terms and conditions contained in the Payment Agreement Term Sheet attached as Appendix “D” to Report HSC19060(a);

(h) That the General Manager of the Finance and Corporate Services Department be directed and authorized to enter into a Development Charge Payment Agreement respecting the Kiwanis Project, under section 27 of the *Development Charges Act, 1997*, to require the payment of development charges otherwise payable under Development Charges By-law 19-142 and By-law 11-174, the earlier of the date of first occupancy or issuance of an occupancy permit, on such terms as the General Manager of the Finance and Corporate Services Department may require and including those on the Term Sheet attached as Appendix “C” to Report HSC19060(a), without interest, in a form satisfactory to the City Solicitor, and that the General Manager of the Finance and Corporate Services Department be directed and authorized to execute any such agreements and ancillary documentation; and,

(i) That the General Manager of the Finance and Corporate Services Department be directed and authorized to enter into a Development Charge Payment Agreement respecting each of the Indwell Project, under section 27 of the *Development Charges Act, 1997*, to require the payment of development charges otherwise payable under Development Charges By-law 19-142 and By-law 11-174, the earlier of the date of first occupancy or issuance of an occupancy permit, on such terms as the General Manager of the Finance and Corporate Services Department may require and including those on the Term Sheet attached as Appendix "D" to Report HSC19060(a), without interest, in a form satisfactory to the City Solicitor, and that the General Manager of the Finance and Corporate Services Department be authorized to execute any such agreements and ancillary documentation.

EXECUTIVE SUMMARY

Report HSC19060(a) seeks approval to provide conditional grants and development charges ("DCs") payment agreements for the payment of DCs for two affordable housing projects, one by East Hamilton Kiwanis Non-Profit Homes ("Kiwanis") and the other by Indwell Community Homes ("Indwell"). A portion of the units of each project have been approved for Ontario Priorities Housing Initiative (OPHI) funding (Report HSC19060) and meet the requirements for a DC exemption in the current by-law; however, both developments have additional affordable units that staff planned to recommend for DC relief when a new program was brought to Council.

When the 2019 Development Charges By-Law No. 19-142 was adopted there was a commitment to replace the by-law exemption for affordable housing with a program that provides greater control of the projects granted DC relief. As the report for the new affordable housing DC program was put on hold due to the COVID-19 crisis and the affordable units in the projects not funded by OPHI do not currently meet the by-law criteria, DC exemptions are not available.

Staff are recommending payment of the DCs in 20 annual instalments to enable the grant advances by the City to be spread over the affordability period of 20 years, thus securing the City's investment without the need for a mortgage registered on title and waiving the interest on the instalments to reduce the costs to the Housing Services Division.

The grants are to be offset by the Affordable Housing Property Reserve (112256).

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial:

Table 1: Total City Investment

Project	*Parkland Fee Relief	Total DC Relief OPHI Units	Total DC Relief Grant Non-OPHI Units	Total DC Relief for Affordability	Total City Capital Contribution
Kiwanis – Acorn St.	*$146,460	*$410,080 (20 units)	$1,000,903 (40 units)	$1,410,983	$1,557,443
Indwell – Royal Oaks	*$90,000	*$743,671 (52 units)	$379,260 (+$374,573 **CIPA) (43 units)	$1,122,931	$1,212,931
Total Housing	**$236,460**	**$1,153,751**	**$1,380,163** (+$374,573 CIPA)	**$2,533,914**	**$2,770,374**

*DC figures include City and Go Transit DCs after applying demolition credits

Report HSC19060 approved the use of approximately $1,238,791 from the Social Housing Stabilization Reserve (110041), which is dedicated to DC relief for qualifying affordable housing, to off-set the DCs for the OPHI-funded units of both projects (20 units of the Kiwanis development and up to all 95 units of the Indwell development. The figures in Table 1 differ from Report HSC19060 as the Indwell OPHI units no longer qualify for the Downtown Community Improvement Plan (CIPA) partial exemption.

The grants are to be offset by the Affordable Housing Property Reserve (112256) funded through the sale of properties that have been allocated for affordable housing purposes. The timing of the planned sale of properties may result in the Affordable Housing reserve to go into a deficit. Once the sales are finalized the deficit is expected to be eliminated as a consequence.

Staffing: N/A

Legal: Provision of the conditional grant and DC payment agreement conditions to Kiwanis and Indwell is not bonusing under the *Municipal Act* as both organizations are charitable non-profit corporations.

HISTORICAL BACKGROUND

The June 2019 changes to the *Development Charges Act, 1997 (DCs Act)* allow non-profit housing developers to pay DCs upon occupancy and in 21 equal annual instalments thereafter. Municipalities may choose whether or not to charge interest, and any DCs not paid may be added to properties' tax rolls and collected accordingly.

In July 2019, Council approved Report FCS19050 which adopted the 2019 Development Charges By-law No. 19-142. One of the changes in this by-law was to prohibit developments from benefiting from more than one DC exemption or partial exemption, including affordable housing projects.

On November 13, 2019, Council approved Report HSC19060 which recommended that the Province award Ontario Priorities Housing Initiative: Rental Housing Component funding to a portion of each of the Kiwanis-Acorn St. and Indwell-Royal Oaks affordable housing projects; 20 units of the 60 unit Kiwanis project, and 52 units of the 95 unit Indwell project. This approval qualified these units for DC exemptions under By-Law 19-142. Report HSC19060(a) pertains to the units in these projects that are not being funded through OPHI.

On May 27, 2020, Council approved Report FCS20028/PED20105 which authorized the charging of interest for DC instalments for non-profit housing development, as well as rental housing and institutional development.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Housing and Homelessness Action Plan

Hamilton does not have sufficient affordable rental housing units. In 2013, Council endorsed the 10-Year Housing and Homelessness Action Plan with the first outcome area to increase the supply of affordable housing. The City continues to fall below its targets for developing new units.

RELEVANT CONSULTATION

Corporate Services Department - Legal Services Division
Legal provided advice on the legal and financial mechanisms to offset the cost of DCs for the projects and the agreement terms and reviewed the final documents. Their input is reflected in the final report and appendices.

Corporate Service Department – Financial Planning, Administration, and Policy Division
Finance provided advice on the financial mechanisms to offset the cost of DCs for the

projects, including terms of the DC payment agreement, provided the financial numbers, and reviewed the documents. Their input is reflected in the final report and appendices.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

A. CMHC Co-Investment Fund/Leveraging Federal Funds

The provision of a conditional grant for the payment of DCs for the non-OPHI units in the Kiwanis and Indwell projects, in addition to the existing exemptions for the OPHI units, would help leverage more Federal funding for the projects. Both projects are applying to the CMHC Co-Investment Fund (CIF), which can provide both a forgivable loan and financing with low interest and other favourable conditions. The CIF has a complex scoring system that determines the strength of proposals, the amount of forgivable loan (if any), and the conditions of the CMHC financing. The amount of the required municipal contribution is a key factor in the scoring. Other factors include energy efficiency, accessibility, the number of larger units, long term financial sustainability, and more. The provision of conditional grants for the payment of DCs for the units not funded by OPHI will increase the scores of these projects, which will increase the amount of funding and improve the conditions of the financing.

Given the small amount of the typical CMHC grant and that CMHC primarily provides repayable loans, CMHC funds alone are not sufficient to make affordable development projects financially viable. The program is predicated on the concept of financial and other “partnerships.” Developer organizations must put together multiple funding sources to create a successful project, and municipalities are required to contribute in a monetarily meaningful way. This doesn’t necessarily mean direct capital, but the municipal contribution must be reported as a monetary contribution and direct capital contributions are valued. Financing affordable housing development is increasingly challenging given the exceptional construction cost increases of the past few years and the added uncertainty of the COVID-19 crisis.

B. Need for the City Investments

The need for affordable housing in Hamilton has been demonstrated in multiple previous reports. Report HSC20009 notes that significant changes to parts of Hamilton’s housing system are needed to increase its resilience to the challenges caused and amplified by COVID-19 and future epidemics.

To maximize peoples’ ability to become as self-sufficient as possible, most congregate living situations must be replaced with small, deeply affordable, low-barrier self-contained units where tenants’ self-sufficiency is fostered through access to appropriate supports.

In addition to the leveraging of more federal funds for a higher municipal contribution to the projects, the provision of these funds to these projects is important for the following reasons:

C. Affordable Housing Exemption in the DC By-Law

Council approval for the conditional grants for the payment of DCs and specific payment agreement conditions for DC payments for the non-funded units of the Kiwanis and Indwell Projects is needed as the units do not meet the criteria for DC exemption in the by-law. Council approval for the waiving of interest on DC instalment payments for these projects is necessary as this is a new requirement that would place additional costs on the Housing Services Division budget.

By-Law No. 19-142 Respecting Development Charges on Lands within the City of Hamilton exempts dwelling units within an affordable housing project that meet the following criteria from DCs:

1. The project must provide “housing and incidental facilities for persons of low and moderate income;”

2. The units must either have been approved to receive construction funding from the Federal or Provincial Governments under an affordable housing program or approved by the City of Hamilton through an affordable housing program; and,

3. The units must not be eligible for funding for DC liabilities from the Federal or Provincial Government.

The purpose of Criteria 1 and 2 are to ensure the units receiving City support are affordable and rented to those in need in both the short and long-term. The purpose of Criteria 3 is to ensure that the City does not provide funds that could instead be provided by either the Federal or Provincial Governments.

As CMHC has not yet committed the expected construction funding and financing for either project, the units not funded by OPHI do not currently meet Criteria 2 but will upon approval of CMHC funding.

Even with CMHC funding the units will not meet the wording of Criteria 3 but will meet the intent. CMHC requirements are project-wide and CMHC funding/financing is provided on a project-wide rather than unit specific basis. This open-ended use of funds means that DCs are included in the large list of eligible expenses; however, while the CMHC funds can be used for DCs, City conditional grants provided to offset the costs of

DCs will not replace federal funds. City funds leverage additional federal funds and are needed in addition to all other funding sources.

D. Terms of Conditional Grant Agreement and DC Payment Agreement

Both a conditional grant agreement and a DC payment agreement between the City and each of Kiwanis and Indwell will be required, subject to the terms as outlined in the Term Sheets attached as Appendices "A," "B," "C," and "D" to Report HSC19060(a). Both types of agreement will include provisions that a default, such as part of the development ceasing to be "non-profit housing," will require the DCs to become payable immediately. Outstanding DC payments to the City can be collected in the same manner as taxes.

Rather than the traditional approach of a forgivable loan with a mortgage registered on title to secure the City's interests, staff propose that the Grant be advanced annually at the time each instalment is due. The amount of any non-payment of an instalment can be added to the tax roll for the property. Not registering a mortgage on title and financially encumbering the property is beneficial to the developments' CMHC applications and the ability of the organisations to borrow funds for this and potential additional projects.

The conditional grant agreement terms are standard for affordable housing projects except for the higher potential maximum allowable rents. The final maximum allowable rents will be determined by the General Manager of the Healthy and Safe Communities Department ("GM") when project costing and budgets are more certain. Project costing is an iterative process in which costs and budgets become more detailed, specific, accurate, and certain with each iteration. The collective goal of staff, Kiwanis, and Indwell is for the rents to be as affordable as possible; however, flexibility is necessary in the current context of uncertainty resulting from the COVID-19 crisis. Many of these factors predate COVID-19 but have become significantly more unpredictable. These include:

- construction cost uncertainty including increased costs as a result of the physical distancing requirements for COVID-19;
- the financing challenges noted above;
- unknown future CMHC requirements, funding amounts, and financing conditions;
- unknown future requirements and financing conditions of other potential lenders/ financial contributors;
- unpredictable changes in the rental market; and,
- the reduced overall amount of government funding as a proportion of total project costs.

E. Implementation

DCs Act O.Reg.82/98 defines “non-profit housing development” as residential development by,

“(a) a corporation without share capital to which the Corporations Act applies, that is in good standing under that Act and whose primary object is to provide housing;
(b) a corporation without share capital to which the Canada Not-for-Profit Corporations Act applies, that is in good standing under that Act and whose primary object is to provide housing; or
(c) a non-profit housing co-operative that is in good standing under the Co-operative Corporations Act.”

The absence of an affordability requirement in this definition is not likely an oversight. The CMHC-Ontario Bi-Lateral Agreement lists mixed-income housing and the promotion of social inclusion through mixed-income housing principles for the agreement and all funding and action plans under it. The absence of a specific affordability requirement makes the administration of mixed-income affordable projects less complex. Mixed-income projects are preferred by many affordable housing advocates for a number of reasons, including the potential for cross-subsidization of rents by more expensive units to increase financial viability and facilitate deeper affordability of some units, social inclusion, and to create communities that meet a range of needs. CMHC’s Co-Investment Fund requires projects to include a mix of rent levels.

While it is possible to treat units within a single project differently according to the rents, doing so is administratively complex. Non-profit housing corporations and co-operatives are best able to determine the rents for their units and do so based on their affordable housing and non-profit mandates. Thus, provided the housing providers are non-profits or co-operatives, specific affordable rent requirements with complex administrative processes are not needed to ensure the rents will be and remain affordable. The *DCs Act* also enables for-profit rental projects to pay DCs in instalments, but over five rather than 20 years. The approach of not requiring specific levels of affordability by non-profit organisations could be considered by the City in the future but is not proposed at this time.

Municipalities are permitted to charge interest and recover any unpaid DCs by adding the principal and any interest “to the tax roll and collecting it in the same manner as taxes.” Through Report FCS20028/PED20105, Council approved the charging of interest for instalment payments of DCs for non-profit housing developments. Report HSC19060(a) recommends exempting the Kiwanis and Indwell Projects from the interest requirement.

It is City policy that the amount of the DCs is determined as of the date that the complete building permit application is received and accepted by the Chief Building Official as long as the building permit is issued within 6 months of the next rate increase. July 5, 2020 is the final day that complete applications can be made, and the 2019-2020 fee schedule applied in the DC calculation. The Downtown Hamilton CIPA exemption applies as of the date of permit issuance. For the purposes of this Report, staff has assumed that a complete building permit application will be made on or before July 5, 2020 and that the permit will be issued between July 6, 2020 and Jan 5, 2021.

DC Payment Agreement

The *DCs Act, 1997* permits a municipality to enter into payment agreements related to the timing of DCs. In order to advance the conditional grant concurrent with the required payment timing of the DC instalments it is recommended that a DC payment agreement be entered into in addition to the conditional grant agreement. This will allow the City to formally recognize that the amount of DCs due is fixed at the date of building permit issuance and align the due date with the terms of the conditional grant, being 20 annual payments commencing at the time the building is first occupied or approved for occupancy.

It may be noted that the DCs Act, 1997 was amended effective January 1, 2020 in part to delay the timing of DC payment for non-profit housing development to the time the building is first occupied, payable in 21 annual instalments. The timing of payments in the agreements is slightly different to align the DC instalment due dates with the advances of the conditional grants and various housing programs.

F. Changes in Affordable Housing Financing

Historically, government capital funding accounted for a much higher portion of project costs that currently (most recently 75% of total costs, but at times up to 100%) and were in the form of grants (forgivable loans). To enable the coordination of the multiple sets of requirements of the multiple sources of funds that are now needed to build a project, the reduced and less certain contributions need to be reflected in less onerous requirements and expectations. Development financing also must protect the long-term financial health of the non-profit housing providers, so they continue to serve vulnerable Hamiltonians long into the future.

Though more flexibility is needed at this time, it is important to recognize that both Kiwanis and Indwell have a legal mandate as charities to provide affordable housing to people in need. Both have a long history of successful partnership with the City and other levels of government to achieve this goal, and long-term ambitious strategic plans to not only continue their current service, but significantly increase the number of people

they serve. Kiwanis and Indwell each plan to build more than 1,000 units in Hamilton over the next five to eight years. Kiwanis currently operates 997 affordable units, while Indwell manages 425 with another 100 soon to be ready to receive new tenants. All of these units are in Hamilton, though Indwell has additional units in other municipalities. They both have a legal mandate and publicly stated commitment to keep their rents affordable for highly vulnerable tenants.

ALTERNATIVES FOR CONSIDERATION

None

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Economic Prosperity and Growth
Hamilton has a prosperous and diverse local economy where people have opportunities to grow and develop.

Healthy and Safe Communities
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

Built Environment and Infrastructure
Hamilton is supported by state of the art infrastructure, transportation options, buildings and public spaces that create a dynamic City.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC19060(a): Term Sheet: Conditional Grant to Hamilton East Kiwanis Non-Profit Homes Inc.

Appendix “B” to Report HSC19060(a): Term Sheet: Conditional Grant to Indwell Community Homes

Appendix “C” to Report HSC19060(a): Term Sheet: Development Charges Payment Agreement with Hamilton East Kiwanis Non-Profit Homes Inc.

Appendix “D” to Report HSC19060(a): Term Sheet: Development Charges Payment Agreement with Indwell Community Homes

Term Sheet for Conditional Grant Agreement

6 – 14 Acorn Street

Borrower: Hamilton East Kiwanis Non-Profit Homes ("Kiwanis")

Project: Kiwanis – the 40-units not funded under the Ontario Priorities Housing Initiative (OPHI) of the 60-unit affordable housing building currently under development by Kiwanis on the property municipally known as 8 and 14 Acorn Street, and legally defined as Part Lots 13 and 14 on Plan 46, designated as Parts 1 and 2 on Plan 62R-8132, in the city of Hamilton, province of Ontario and Lots 11 and 12, Plan 46, Part Lot 10, Plan 46, Part Lot 13, Plan 46, as in VM103496, in the city of Hamilton, province of Ontario hereinafter referred to as the “Project”

Lender: City of Hamilton ("City")

Type of Grant: Conditional grant to secure long-term affordable housing commitments as set out in this term sheet, Appendix “A” to Report HSC19060(a), below hereinafter referred to as the “Grant”

Grant Conditions

1. The Grant will be subject to the recipient entering into a conditional grant agreement (“CGA”) with the City containing such terms and conditions as set out in this term sheet, Appendix “A” to Report HSC19060(a).

2. The Grant will be subject to the recipient entering into a Development Charges (“DCs”) deferral agreement (“DCDA”) with the City, prior to the issuance of any building permits for works beyond the building foundation, on such terms as set out in Appendix “C” to Report HSC19060(a).

3. The amount of the Grant shall equal the municipal DCs owing for the 40 units of the 6 – 14 Acorn Street affordable housing development project that are not receiving Ontario Priorities Housing Initiative (OPHI) funding, for a term of 20 years from date of first occupancy.

4. The CGA will have a term of 20 years consistent with the period of affordability, commencing from the date any of the 40 affordable housing units in the Project are cleared for occupancy.

5. No assignment of the Grant, other than to the City, the CGA, or the DCDA will be permitted unless consented to by the General Manager of the Healthy and Safe

Communities Department ("GM") in his sole discretion and only in the following circumstances: (a) the property is sold to another provider of "non-profit housing" as defined in the DCDA who enters into an assignment agreement with the City and Kiwanis agreeing to be subject to all of the terms and conditions of the CGA and the DCDA for the remainder of the term of those agreements and such other terms and conditions as the GM and City Solicitor in their sole discretion deem appropriate; (b) the property is sold to another provider of "non-profit housing" as defined in the *Development Charges Act, 1997 ("DCs Act")* who enters into an assignment agreement with the City and Kiwanis agreeing to be subject to all of the terms and conditions of the CGA and the DCDA for the remainder of the term of those agreements and the assignee agrees to complete the Project in accordance with the Kiwanis plans approved by the City and such other terms and conditions as the GM and City Solicitor in their sole discretion deem appropriate.

6. Requirement to provide the City with original insurance certificates for "Property All Risks" insurance, Broad Form Boiler and Machinery insurance, and insurance against loss of Rent, rental value and other payments required to be paid or made by tenants, or business interruption and profits from the business, to the satisfaction of the Manager of Legal and Risk Management Services.

Rent Requirements & Maximum Allowable Rent

7. At all times during the term of the CGA the rents for these 40 units will at no time be above the maximum allowable rent level, stated in a percentage of CMHC Average or Median Market Rent for the City of Hamilton, to be determined by the GM in his sole discretion when the final construction and operating budgets are produced, but prior to signing of the construction contract. The maximum allowable rent level determined by the GM will be as affordable as possible given the financial conditions at the time of determination, and considering the reasonableness of the construction and operating budgets, the financial viability of the Project both during construction and throughout the affordability period, and the long-term financial viability of Kiwanis, but shall not be above 125% of CMHC Average or Median Market Rent for the unit type. The City shall provide Kiwanis with a conditional grant in the maximum principal amount of the municipal and Go Transit DCs payable by Kiwanis to the City for the development of the 40 units of the Acorn Street North affordable housing development project that are not receiving OPHI funding.

8. Units subject to the CGA may increase rents annually within a tenancy by the Provincial Guideline amount as specified annually by the Ontario Ministry of Municipal Affairs and Housing. Higher increases may be permitted at the sole discretion of the GM following submission of a business case justifying the

increase. At vacant possession, rents may be increased up to the maximum allowable rent level for the unit type as determine in accordance with Section 1.

Events of Default

9. Events of default shall include but not be limited to:
    a. Within the term of the Agreement the housing is no longer "non-profit housing" as defined under the *DC Act* O.Reg.82/98;
    b. Failure to observe any of the conditions for advance of a grant payment;
    c. Breach of any provision of the CGA or DCDA;
    d. If any part of the Project to which the Grant and DC deferral applies is changed so that it no longer consists of a non-profit housing;
    e. Any disposition of the property not consented to by the GM in his sole discretion which consent may include such conditions as the GM determines in his sole discretion;
    f. Failure to obtain an occupancy permit by December 2023;
    g. Failure to rent 95% of the units that are subject to the Agreement by July 2024;
    h. Failure to submit required documentation by 30 days past the March 1 deadline in this agreement;
    i. Failure to notify the City about any change in that could lead to failure of the Project either during or post construction; and,
    j. Failure to notify the City about any default of the agreement within 30 days.

10. Consequences of an event of default, unless permitted to be remedied in such time and manner as the GM determines in his sole discretion, shall include, but not be limited to: the payment of any unpaid DCs, no further deferral of unpaid DCs, no further Grant payments, and unpaid DCs shall be added to the tax roll.

Advance and Payment Provisions

11. The grant will be advanced in 20 payments ("Advance") yearly on [insert date and month] each equal to 1/20th of the DCs payable subject to all conditions for an Advance being met.

12. The grant will be assigned to the City and no Advance will be paid directly to Kiwanis. The grant will be irrevocably assigned to the City and at the time of each Advance will be transferred by the Housing Services Division to the appropriate DC reserve. The total amount of the Grant will equal the DCs payable.

13. The performance of the conditions for the Grant will be secured by the following: (a) the CGA, (b) the DCDA, (c) if permitted, registering restrictions on the sale of

the land without the consent of the City; and such other security as the GM determines appropriate.

Monitoring Provisions

14. During the term of the CGA and DCDA at and following initial occupancy, Kiwanis will monitor their respective Projects annually to ensure the obligations under the CGA and DCDA have been met for the previous year. During the term of the payment period Kiwanis will submit the following documents for the previous year to the Housing Services Division annually on or before March 1:

    a) Rent rolls for all of the units that are subject to the CGA and DCDA;
    b) Proof of income for any new tenants (entire household) of the units subject to the Agreement, generally in the form of a Notice of Assessment from the Canada Revenue Agency, or alternative documentation to the satisfaction of the City;
    c) Confirmation of insurance on the affordable units; and,
    d) By request only, annual financial statements (audited if available).

Other Provisions

15. Any out-of-pocket expenses incurred for the preparation of the CGA, over and above staff costs, are the responsibility of the proponent.

16. Any other terms deemed appropriate by the City Solicitor and GM.

Term Sheet for Conditional Grant Agreement

225 East Avenue North

Borrower: Indwell Community Homes ("Indwell")

Project: The 43-one-bedroom unit affordable housing building being developed by Indwell, which is the southernmost building of the two currently under development on the property municipally known as 223-227 East Avenue North, and legally defined as Lots 39, 40 and 41, Plan 286, Lots 88, 89, 90 and 91, Robert Land Survey, (aka OM1433), being on the west side of East Avenue, designated as Part 2 on Plan 62R-12181, in the city of Hamilton, province of Ontario hereinafter referred to as the “Project”

Lender: City of Hamilton ("City")

Type of Grant: Conditional grant to secure long-term affordable housing commitments as set out in this term sheet, Appendix “B” to Report HSC19060(a), below hereinafter referred to as the “Grant”

Grant Conditions

1. The Grant will be subject to the recipient entering into a conditional grant agreement (“CGA”) with the City containing such terms and conditions as set out in this term sheet, Appendix “B” to Report HSC19060(a).

2. The Grant will be subject to the recipient entering into a Development Charges (“DCs”) deferral agreement (“DCDA”) with the City, prior to the issuance of any building permits for works beyond the building foundation, on such terms as set out in Appendix “D” to Report HSC19060(a).

3. The amount of the Grant shall equal the municipal DCs owing for the 43 units of the 225 East Avenue North affordable housing development project that are not receiving Ontario Priorities Housing Initiative (OPHI) funding, for a term of 20 years from date of first occupancy.

4. The CGA will have a term of 20 years consistent with the period of affordability, commencing from the date any of the 43 affordable housing units in the Indwell Project are cleared for occupancy.

5. No assignment of the Grant, other than to the City, the CGA , or the DCDA will be permitted unless consented to by the General Manager of the Healthy and Safe

Communities Department ("GM") in his sole discretion and only in the following circumstances: (a) the property is sold to another provider of "non-profit housing" as defined in the DCDA who enters into an assignment agreement with the City and Indwell agreeing to be subject to all of the terms and conditions of the CGA and the DCDA for the remainder of the term of those agreements and such other terms and conditions as the GM and City Solicitor in their sole discretion deem appropriate; (b) the property is sold to another provider of "non-profit housing" as defined in the *Development Charges Act, 1997 ("DCs Act")* who enters into an assignment agreement with the City and Indwell agreeing to be subject to all of the terms and conditions of the CGA and the DCDA for the remainder of the term of those agreements and the assignee agrees to complete the Project in accordance with the Indwell plans approved by the City and such other terms and conditions as the GM and City Solicitor in their sole discretion deem appropriate.

6. Requirement to provide the City with original insurance certificates for "Property All Risks" insurance, Broad Form Boiler and Machinery insurance, and insurance against loss of Rent, rental value and other payments required to be paid or made by tenants, or business interruption and profits from the business, to the satisfaction of the Manager of Legal and Risk Management Services.

Rent Requirements & Maximum Allowable Rent

7. At all times during the term of the CGA the rents for these 43 units will at no time be above the maximum allowable rent level, stated in a percentage of CMHC Average or Median Market Rent for the City of Hamilton, to be determined by the GM in his sole discretion when the final construction and operating budgets are produced, but prior to the issuance of any building permits for works beyond the building foundation. The maximum allowable rent level determined by the GM will be as affordable as possible given the financial conditions at the time of determination, and considering the reasonableness of the construction and operating budgets, the financial viability of the Project both during construction and throughout the affordability period, and the long-term financial viability of Indwell, but shall not be above 125% of CMHC Average or Median Market Rent for the unit type. The City shall provide Indwell with a conditional grant in the maximum principal amount of the municipal and Go Transit DCs payable by Indwell to the City for the development of the 43 units of the 225 East Avenue North affordable housing development project that are not receiving OPHI funding.

8. Units subject to the CGA may increase rents annually within a tenancy by the Provincial Guideline amount as specified annually by the Ontario Ministry of Municipal Affairs and Housing. Higher increases may be permitted at the sole discretion of the GM following submission of a business case justifying the

increase. At vacant possession, rents may be increased up to the maximum allowable rent level for the unit type as determine in accordance with Section 1.

Events of Default

9. Events of default shall include but not be limited to:
    a. Within the term of the Agreement the housing is no longer "non-profit housing" as defined under the *DC Act* O.Reg.82/98;
    b. Failure to observe any of the conditions for advance of a grant payment;
    c. Breach of any provision of the CGA or DCDA;
    d. If any part of the Project to which the Grant and DC deferral applies is changed so that it no longer consists of a non-profit housing;
    e. Any disposition of the property not consented to by the GM in his sole discretion which consent may include such conditions as the GM determines in his sole discretion;
    f. Failure to obtain an occupancy permit by [insert date and month];
    g. Failure to rent 95% of the units that are subject to the Agreement by [insert date and month];
    h. Failure to submit required documentation by 30 days past the March 1 deadline in this agreement;
    i. Failure to notify the City about any change in that could lead to failure of the Project either during or post construction; and,
    j. Failure to notify the City about any default of the agreement within 30 days.

10. Consequences of an event of default, unless permitted to be remedied in such time and manner as the GM determines in his sole discretion, shall include, but not be limited to: the payment of any unpaid DCs, no further deferral of unpaid DCs, no further Grant payments, and unpaid DCs shall be added to the tax roll.

Advance and Payment Provisions

11. The grant will be advanced in 20 payments ("Advance") yearly on [insert date and month] each equal to 1/20th of the DCs payable subject to all conditions for an Advance being met.

12. The grant will be assigned to the City and no Advance will be paid directly to Indwell. The grant will be irrevocably assigned to the City and at the time of each Advance will be transferred by the Housing Services Division to the appropriate DC reserve. The total amount of the Grant will equal the DCs payable.

13. The performance of the conditions for the Grant will be secured by the following: (a) the CGA, (b) the DCDA, (c) if permitted, registering restrictions on the sale of

the land without the consent of the City; and such other security as the GM determines appropriate.

Monitoring Provisions

14. During the term of the CGA and DCDA at and following initial occupancy, Indwell will monitor their respective Projects annually to ensure the obligations under the CGA and DCDA have been met for the previous year. During the term of the payment period Indwell will submit the following documents for the previous year to the Housing Services Division annually on or before March 1:

    a) Rent rolls for all of the units that are subject to the CGA and DCDA;
    b) Proof of income for any new tenants (entire household) of the units subject to the Agreement, generally in the form of a Notice of Assessment from the Canada Revenue Agency, or alternative documentation to the satisfaction of the City;
    c) Confirmation of insurance on the affordable units; and,
    d) By request only, annual financial statements (audited if available).

Other Provisions

15. Any out-of-pocket expenses incurred for the preparation of the CGA, over and above staff costs, are the responsibility of the proponent.

16. Any other terms deemed appropriate by the City Solicitor and GM.

Term Sheet for Development Charges Payment Agreement

6 – 14 Acorn Street

Borrower: Hamilton East Kiwanis Non-Profit Homes ("Kiwanis")

Project: Kiwanis – the 40-units not funded under the Ontario Priorities Housing Initiative (OPHI) of the 60-unit affordable housing building currently under development by Kiwanis on the property municipally known as 8 and 14 Acorn Street, and legally defined as Part Lots 13 and 14 on Plan 46, designated as Parts 1 and 2 on Plan 62R-8132, in the city of Hamilton, province of Ontario and Lots 11 and 12, Plan 46, Part Lot 10, Plan 46, Part Lot 13, Plan 46, as in VM103496, in the city of Hamilton, province of Ontario hereinafter referred to as the “Project”

Lender: City of Hamilton ("City")

Type of Agreement: Development Charges Payment Agreement (“DCPA”) to require payment of Development Charges (“DCs”) payable for the Project as set out in this term sheet, Appendix “C” to Report HSC19060(a), below hereinafter referred to as the “Payment Arrangement”

Agreement Conditions

1. The Payment Arrangement will be subject to the recipient entering into a development charges payment agreement (“DCPA”) with the City containing such terms and conditions as set out in this term sheet, Appendix “C” to Report HSC19060(a).

2. The Payment Arrangement will be subject to the recipient entering into a conditional grant agreement (“CGA”) with the City, prior to the issuance of any building permits for works beyond the building foundation, on such terms as set out in Appendix “A” to Report HSC19060(a).

3. The DCPA will have a term of 20 years consistent with the period of affordability, commencing from the date any of the 40 affordable housing units in the Project are cleared for occupancy.

4. No assignment of the DCPA will be permitted unless consented to by the General Manager of the Healthy and Safe Communities Department and the General Manager of Corporate Services (“GMS”) in the GMS sole discretion and only in the following circumstances: (a) the property is sold to another provider of “non-profit housing” as defined in the DCPA who enters into an assignment agreement

with the City and Kiwanis agreeing to be subject to all of the terms and conditions of the CGA and the DCPA for the remainder of the term of those agreements and such other terms and conditions as the GMS and City Solicitor in their sole discretion deem appropriate; (b) the property is sold to another provider of "non-profit housing" as defined in the *Development Charges Act, 1997 ("DCs Act")* who enters into an assignment agreement with the City and Kiwanis agreeing to be subject to all of the terms and conditions of the CGA and the DCPA for the remainder of the term of those agreements and the assignee agrees to complete the Project in accordance with the Kiwanis plans approved by the City and such other terms and conditions as the GMS and City Solicitor in their sole discretion deem appropriate.

5. Requirement to provide the City with original insurance certificates for "Property All Risks" insurance, Broad Form Boiler and Machinery insurance, and insurance against loss of Rent, rental value and other payments required to be paid or made by tenants, or business interruption and profits from the business, to the satisfaction of the Manager of Legal and Risk Management Services.

Development Charge and PDCs

6. Kiwanis covenants to pay to the City, in respect of the Project, a total City development charge in the amount of $ **[insert # here]** or a revised amount as approved by the Council of the City (the "DCs"). Payment of $**0.00** shall be made prior to the issuance of the Building Permit. Payment of the balance of the DCs in the amount of $ **[insert # here],** the Payable Development Charges ("PDCs") shall be made in accordance with this Term Sheet.

Payment to Coincide with Conditional Grant Payments

7. The payment of the PDCs shall be made to the City annually, at commencement of, and concurrently with, the Conditional Grant Payments ("CGPs"). The required annual payment amount shall be the higher of:

   (a) the annual PDCs payment;
   (b) 1/20 of the approved conditional grant; or,
   (c) 1/20 of the PDCs;

   and if any portion of the PDCs remains unpaid on the date the last CGP payment occurs said unpaid portion shall be due and payable on the date the last CGP payment occurs except where, pursuant to the terms of this Term Sheet, the said payment is required and due in full prior to the said date (the aforesaid payment requirements shall be referred to as the "Payment Agreement").

Payable To

8. Payment will be made via assignment of the annual CGP until the PDCs are paid in full. Where the annual CGP is less than the required annual payment the difference shall be paid by Kiwanis within sixty (60) days from the date of the CGP payment. If the difference remains unpaid after sixty (60) days the difference shall be added to the Property Tax Roll.

Interest

9. Kiwanis shall not pay interest on any portion of the PDCs including any unpaid portion of the PDCs.

Events of Default

10. Events of default shall include but not be limited to:

    a. Within the term of the DCPA and CGA the housing is no longer "non-profit housing" as defined under the *DC Act* O.Reg.82/98;
    b. Failure to observe any of the conditions for advance of a grant payment;
    c. Breach of any provision of the CGA or DCPA;
    d. If any part of the Project to which the Grant and DCPA applies is changed so that it no longer consists of a non-profit housing;
    e. Any disposition of the property not consented to by the GM in the GM's sole discretion which consent may include such conditions as the GM determines in his sole discretion;
    f. Failure to notify the City about any default of the DCPA or CGA within 30 days.
    g. Where a mortgage, charge, lien, execution or other Encumbrance affecting the Property becomes enforceable against the Property; or
    h. Where Kiwanis becomes bankrupt, whether voluntary or involuntary, or becomes insolvent or a receiver/manager is appointed with respect to the Property; or
    i. Where Kiwanis certificate of incorporation is cancelled, or Kiwanis is otherwise wound up or dissolved as a corporation or there is any other change in the ownership or corporate status of Kiwanis not approved by the City in advance;
    j. Kiwanis:
        (i) decides to not receive the Grant;
        (ii) becomes ineligible for any reason to receive the Grant;
        (iii) does not enter into a CGA with the City prior to the issuance of a building permit for the Project;

(iv) the CGA, required to be entered into between the City and Kiwanis in order to obtain the Grant, is terminated for any reason prior to the PDCs being paid in full; and,

(v) Kiwanis fails to pay, on the date last Grant payment occurs, the portion of the PDCs that are not paid through the application of the Grant payments;

k. Such further events as the City Solicitor deems appropriate in her sole discretion.

11. Consequences of an event of default, unless permitted to be remedied in such time and manner as the GM determines in his sole discretion, shall include, but not be limited to: all future DC instalments becoming payable immediately and to be paid on demand, no further CGPs, and unpaid DCs shall be added to the tax roll.

Advance and Payment Provisions

12. The Payment Arrangement commences as of the date of initial issuance of the Building Permit (the "Commencement Date"), and the Payment Arrangement continues until the earlier of the date on which the final payment of the Grant occurs or, such earlier date payment in full is made of the PDCs, in accordance with the terms of the DCPA. The DCPA shall remain in force and effect until the PDCs are repaid and Kiwanis has performed all of its obligations under the DCPA.

The Development Charge

13. Kiwanis acknowledges and agrees that:
    a) the said amounts of the DCs and PDCs (or a revised amount as approved by the Council of the City) is the correct amount calculated and applied to the Kiwanis Application with the City for the Project.
    b) Kiwanis has not and will not file a complaint pursuant to the *DCs Act* with the City or in any other forum, with respect to the determination and application of the Development Charge By-laws, including the quantum of the charges;
    c) the PDCs referred to herein for payment by Kiwanis to the City may not be all of the DCs that may become applicable in respect of the Property as there may be further DCs applicable in respect of other development permitted on the Property such as the DCs imposed by a Board of Education, to which the DCPA does not apply.
    d) the Property is recorded under the following tax roll number(s) **[insert # here]** ("Tax Rolls") and that in the event the PDCs becomes payable and remains unpaid, in whole or in part, or, on its due date remains unpaid, then in addition to any other remedy available to the City at law or in the DCPA, the amount of unpaid PDCs may be added to the Tax Rolls and to any tax roll number which

the City may in its sole and unfettered discretion determine applies to the Property (“Additional Tax Roll”) and collected as realty taxes.

Other Provisions

14. Any out-of-pocket expenses incurred for the preparation of the DCPA, over and above staff costs, are the responsibility of the proponent.

15. Any other terms deemed appropriate by the City Solicitor and GM.

Term Sheet for Development Charges Payment Agreement

225 East Avenue North

Borrower: Indwell Community Homes ("Indwell")

Project: Indwell - the 43-one-bedroom unit affordable housing building being developed by Indwell, which is the southernmost building of the two currently under development on the property municipally known as 223-227 East Avenue North, and legally defined as Lots 39, 40 and 41, Plan 286, Lots 88, 89, 90 and 91, Robert Land Survey, (aka OM1433), being on the west side of East Avenue, designated as Part 2 on Plan 62R-12181, in the city of Hamilton, province of Ontario hereinafter referred to as the “Project”

Lender: City of Hamilton ("City")

Type of Agreement: Development Charges Payment Agreement (“DCPA”) to require payment of Development Charges (“DCs”) payable for the Project as set out in this term sheet, Appendix “D” to Report HSC19060(a), below hereinafter referred to as the “Payment Arrangement”

Agreement Conditions

1. The Payment Arrangement will be subject to the recipient entering into a development charges payment agreement (“DCPA”) with the City containing such terms and conditions as set out in this term sheet, Appendix “D” to Report HSC19060(a).

2. The Payment Arrangement will be subject to the recipient entering into a conditional grant agreement (“CGA”) with the City, prior to the issuance of any building permits for works beyond the building foundation, on such terms as set out in Appendix “B” to Report HSC19060(a).

3. The DCPA will have a term of 20 years consistent with the period of affordability, commencing from the date any of the 43 affordable housing units in the Project are cleared for occupancy.

4. No assignment of the DCPA will be permitted unless consented to by the General Manager of the Healthy and Safe Communities Department and the General Manager of Corporate Services (“GMS”) in the GMS sole discretion and only in the following circumstances: (a) the property is sold to another provider of “non-profit housing” as defined in the DCPA who enters into an assignment agreement

with the City and Indwell agreeing to be subject to all of the terms and conditions of the CGA and the DCPA for the remainder of the term of those agreements and such other terms and conditions as the GMS and City Solicitor in their sole discretion deem appropriate; (b) the property is sold to another provider of "non-profit housing" as defined in the *Development Charges Act, 1997 ("DCs Act")* who enters into an assignment agreement with the City and Indwell agreeing to be subject to all of the terms and conditions of the CGA and the DCPA for the remainder of the term of those agreements and the assignee agrees to complete the Project in accordance with the Indwell plans approved by the City and such other terms and conditions as the GMS and City Solicitor in their sole discretion deem appropriate.

5. Requirement to provide the City with original insurance certificates for "Property All Risks" insurance, Broad Form Boiler and Machinery insurance, and insurance against loss of Rent, rental value and other payments required to be paid or made by tenants, or business interruption and profits from the business, to the satisfaction of the Manager of Legal and Risk Management Services.

Development Charge and PDCs

6. Indwell covenants to pay to the City, in respect of the Project, a total City development charge in the amount of $ **[insert # here]** or a revised amount as approved by the Council of the City (the "DCs"). Payment of $**0.00** shall be made prior to the issuance of the Building Permit. Payment of the balance of the DCs in the amount of $ **[insert # here]** the Payable Development Charges ("PDCs") shall be made in accordance with this Term Sheet.

Payment to Coincide with Conditional Grant Payments

7. The payment of the PDCs shall be made to the City annually, at commencement of, and concurrently with, the Conditional Grant Payments ("CGPs"). The required annual payment amount shall be the higher of:

   (a) the annual PDCs payment;
   (b) 1/20 of the approved conditional grant; or,
   (c) 1/20 of the PDCs;

   and if any portion of the PDCs remains unpaid on the date the last CGP payment occurs said unpaid portion shall be due and payable on the date the last CGP payment occurs except where, pursuant to the terms of this Term Sheet, the said payment is required and due in full prior to the said date (the aforesaid payment requirements shall be referred to as the "Payment Agreement").

Payable To

8. Payment will be made via assignment of the annual CGP until the PDCs are paid in full. Where the annual CGP is less than the required annual payment the difference shall be paid by Indwell within sixty (60) days from the date of the CGP payment. If the difference remains unpaid after sixty (60) days the difference shall be added to the Property Tax Roll.

Interest

9. Indwell shall not pay interest on any portion of the PDCs including any unpaid portion of the PDCs.

Events of Default

10. Events of default shall include but not be limited to:
    a. Within the term of the DCPA and CGA the housing is no longer "non-profit housing" as defined under the *DC Act* O.Reg.82/98;
    b. Failure to observe any of the conditions for advance of a grant payment;
    c. Breach of any provision of the CGA or DCPA;
    d. If any part of the Project to which the Grant and DCPA applies is changed so that it no longer consists of a non-profit housing;
    e. Any disposition of the property not consented to by the GM in the GM's sole discretion which consent may include such conditions as the GM determines in his sole discretion;
    f. Failure to notify the City about any default of the DCPA or CGA within 30 days.
    g. Where a mortgage, charge, lien, execution or other Encumbrance affecting the Property becomes enforceable against the Property; or
    h. Where Indwell becomes bankrupt, whether voluntary or involuntary, or becomes insolvent or a receiver/manager is appointed with respect to the Property; or
    i. Where Indwell's certificate of incorporation is cancelled, or Indwell is otherwise wound up or dissolved as a corporation or the there is any other change in the ownership or corporate status of Indwell not approved by the City in advance;
    j. Indwell:
        (i) decides to not receive the Grant;
        (ii) becomes ineligible for any reason to receive the Grant;
        (iii) does not enter into a CGA with the City prior to the issuance of a building permit for the Project;

(iv) the CGA, required to be entered into between the City and Indwell in order to obtain the Grant, is terminated for any reason prior to the PDCs being paid in full; and,

(v) Indwell fails to pay, on the date last Grant payment occurs, the portion of the PDCs that are not paid through the application of the Grant payments;

k. Such further events as the City Solicitor deems appropriate in her sole discretion.

11. Consequences of an event of default, unless permitted to be remedied in such time and manner as the GM determines in his sole discretion, shall include, but not be limited to: all future DC instalments becoming payable immediately and to be paid on demand, no further CGPs, and unpaid DCs shall be added to the tax roll.

Advance and Payment Provisions

12. The Payment Arrangement commences as of the date of initial issuance of the Building Permit (the "Commencement Date"), and the Payment Arrangement continues until the earlier of the date on which the final payment of the Grant occurs or, such earlier date payment in full is made of the PDCs, in accordance with the terms of the DCPA. The DCPA shall remain in force and effect until the PDCs are repaid and Indwell has performed all of its obligations under the DCPA.

The Development Charge

13. Indwell acknowledges and agrees that:
    a) the said amounts of the DCs and PDCs (or a revised amount as approved by the Council of the City) is the correct amount calculated and applied to the Indwell's Application with the City for the Project.
    b) Indwell has not and will not file a complaint pursuant to the *DCs Act* with the City or in any other forum, with respect to the determination and application of the Development Charge By-laws, including the quantum of the charges;
    c) the PDCs referred to herein for payment by Indwell to the City may not be all of the DCs that may become applicable in respect of the Property as there may be further DCs applicable in respect of other development permitted on the Property such as the DCs imposed by a Board of Education, to which the DCPA does not apply.
    d) the Property is recorded under the following tax roll number(s) **[insert # here]** ("Tax Rolls") and that in the event the DCs becomes payable and remains unpaid, in whole or in part, or, on its due date remains unpaid, then in addition to any other remedy available to the City at law or in the DCPA, the amount of unpaid PDCs may be added to the Tax Rolls and to any tax roll number which

the City may in its sole and unfettered discretion determine applies to the Property (“Additional Tax Roll”) and collected as realty taxes.

Other Provisions

14. Any out-of-pocket expenses incurred for the preparation of the DCPA, over and above staff costs, are the responsibility of the proponent.

15. Any other terms deemed appropriate by the City Solicitor and GM.

CITY OF HAMILTON
HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	July 13, 2020
SUBJECT/REPORT NO:	Adaptation and Transformation of Services for People Experiencing Homelessness Update 1 (HSC20020(a)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Brian Kreps (905) 546-2424 Ext. 1782
SUBMITTED BY: **SIGNATURE:**	Edward John Director, Housing Services Division Healthy and Safe Communities Department

RECOMMENDATION(S)

(a) That Council approve:

(i) The authority of the General Manager of the Healthy and Safe Communities Department continue to enter into contracts necessary to secure access and purchase of service of the rental of hotel rooms for expanded temporary housing during the Coronavirus pandemic as well as cleaning, food and associated services from vendors and providers satisfactory to the General Manager of the Healthy and Safe Communities Department;

(ii) Conditional grants up to a maximum of $2.0 M in total to shelter providers for the provision of staffing and additional supports to homeless clients receiving emergency shelter in these hotel rooms;

(iii) A conditional grant in the maximum amount of $550 K to the Good Shepherd Centre Hamilton to renovate 378 Main Street East (the former Cathedral Boys School) into a temporary shelter for 45 men;

(iv) A conditional grant in the maximum amount of $700 K to the Good Shepherd Centre Hamilton to operate 378 Main Street East (the former Cathedral Boys School) as a temporary shelter for 45 men for the period of September 1, 2020 to June 30, 2021;

(v) A conditional grant in the maximum amount of $120 K to Mission Services of Hamilton Inc. to renovate their shelter at 325 James St. N. to allow for appropriate physical distancing and to return the shelter to an occupancy of 58 persons; and,

(vi) A conditional grant in the maximum amount of $930 K to Wesley Urban Ministries Inc. to operate its Isolation Centre for people experiencing homelessness for the period of July 6, 2020 to June 30, 2021;

(b) That all such purchases and grants outlined in Recommendation (a) that are approved by Council be funded from any available source jointly deemed appropriate by the General Manager of the Healthy and Safe Communities Department and the General Manager of the Finance and Corporate Services Department including, but not limited to, one or more of the following sources: Reaching Home, Community Homelessness Prevention Initiative, any available provincial or federal funding, or any available funds from the general levy;

(c) That the General Manager of the Healthy and Safe Communities Department be directed and authorized, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the purchases and grants outlined in Recommendation (a) on terms and conditions satisfactory to the General Manager of the Healthy and Safe Communities Department and in a form satisfactory to the City Solicitor; and,

EXECUTIVE SUMMARY

Housing Services created a framework outlining immediate, mid-term and long-term actions to guide a transition from emergency response to a focus on adaption and transformation of the services to prevent transmission of the COVID-19 virus. To improve physical distancing, the shelters serving men reduced occupancy so guests could spread out. The First Ontario Centre (FOC) temporary shelter for men enabled this reduced occupancy. A key part of the framework is to maintain existing shelter capacity while moving toward decommissioning the temporary shelter for men at FOC.

In line with this framework, Housing Services staff have negotiated agreements with three hotels to continue providing hotel rooms for people experiencing homelessness through to June 30, 2021. This includes 25 hotel rooms for families, 20 rooms for men and 20 rooms for women. The City has ensured food is provided for individuals at all hotels. Currently, Good Shepherd Centre Hamilton (Good Shepherd) manages the site for single women and Mission Services of Hamilton Inc. (Mission Services) manages the site for single men.

Good Shepherd has identified that the former Cathedral Boys School, which it owns, could be renovated to provide up to 45 beds of temporary emergency shelter for men.

These temporary beds would be in a congregate setting, but would incorporate appropriate physical distancing and, where possible, physical barriers. The renovation would be completed by the end of the summer to allow for the temporary shelter at FOC to be decommissioned.

With the investment of capital funding, Mission Services will be able to create partitions between beds in their dorms and create 10 rooms. This will allow them to operate at their original capacity of 58 beds.

Housing Services Division staff have negotiated with Wesley Urban Ministries Inc. (Wesley Urban Ministries) to operate the Isolation Centre for homeless individuals and families who test positive for the COVID-19 virus. Isolation Centre operations moved from Bennetto Recreation Centre to a new location in the downtown core on July 6, 2020. The capacity for individuals was reduced to 10 beds and the capacity for families remains at 5 units.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial:
The recommendations in Report HSC20020(a) represent new investments in operating expenditures in the shelter system. To date the City has received $6,880,800 in provincial and $2,619,966 in federal funding to assist with costs related to serving the homeless population during the pandemic.

Funding for the hotels includes food and damage costs in addition to the regular room charge. Contracts for Good Shepherd and Mission Services include the cost for managing the site, supporting clients, and some food charges. The City is also covering additional charges for security, increased cleaning/sanitation services, and laundry.

The funding for Good Shepherd is to design, renovate and operate the former Cathedral Boys School as a temporary emergency shelter.

The funding for Mission Services is to design and construct partitions, as well as private rooms and other improvements to allow for physical distancing and reduce infection transmission.

As of December 31, 2020, we are projecting COVID costs of $15.3 M that exceeds current funding by $5.8 M. Report HSC20020 included costs for 2020 of $2.3 M, and the recommendations in Report HSC20020(a) included costs of $4.89 M. The costs in Report HSC20020(a) are offset by the decommissioning of current facilities and revisions included in the projected costs by $6.15 M for a total deficit in 2020 of $6.85 M.

As of June 30, 2021, we project additional COVID costs of $9.06 M, Report HSC20020 costs of $1.30 M and Report HSC20020(a) projected costs of $4.22 M. The costs in Report HSC20020(a) are offset by the decommissioning of current facilities and revisions included in the projected costs by $4.15 M for a total deficit in 2021 of $10.43 M. Overall, the cumulative deficit projected is $17.28 M for 2020 to June 2021.

	Current COVID-19 Response	**HSC20020**	**HSC20020(a)**	**Total**
Prov/Fed Funding	$-9.5 M	$0.00	$0.00	$-9.5 M
Projected Costs to December 31, 2020	$15.3 M	$2.3 M	$4.9 M	$22.5 M
Revised Projected Costs to December 31, 2020			$-6.15	$-6.15
Deficit December 31, 2020	**$5.8 M**	**$2.3 M**	**$-1.25 M**	**$6.85 M**
Projected Costs to June 30 2021	$9.06 M	$1.3 M	$4.22 M	$14.58 M
Revised Projected Costs to June 30 2021			$-4.15	$-4.15
Deficit June 30, 2021	**$14.86 M**	**$3.6 M**	**$-1.19 M**	**$17.28 M**

Should no new resources be received from the provincial or federal government, the City of Hamilton would need to explore other financial options to support the on-going homelessness needs addressed in the recommendations above as well as future funding required to support the delivery of homeless services in a COVID-19 environment.

Staffing: N/A

Legal: N/A

HISTORICAL BACKGROUND

At its June 19 meeting, the Emergency and Community Services (ECS) Committee approved Report HSC20020 which authorized up to $3.4 M to fund day centres and drop-ins at Living Rock, Mission Services, Wesley Urban Ministries and the YWCA Hamilton. It also authorized up to $400 K to help Salvation Army Booth Centre create 30 individual rooms.

At the same meeting, the ECS Committee approved Report HSC20022 Canadian Medical Association Foundation COVID-19 Community Response for Vulnerable Populations Fund

authorizing the acceptance of $345,000 which will complement Hamilton's Reaching Home base funding.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

N/A

RELEVANT CONSULTATION

The Housing Services Division consulted with the sector planning tables including the Women's Housing Planning Collaborative, the Men's Emergency Services Coordination Committee, as well as an ad hoc sector group representing community partners in the health and housing sector. These groups have advised that shelter capacity must be maintained to address current needs and in anticipation of a potential rise in demand when evictions resume. There was also support for continuing and expanding responses that allow for maximizing physical distancing including the adaptation of existing congregate space to single rooms.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

The Housing Services Division has developed a framework to guide its transition from emergency response to adaption and transformation of its services. A key component of the framework is maintaining the appropriate number of emergency beds currently available. Contracting with hotels allows the City to ensure emergency beds are available for families, men, women and couples can be accommodated within existing shelter space. The Housing Services Division has negotiated agreements with three hotels for a total of 65 beds for the period of July 1, 2020 to June 30, 2021 which is the number of rooms regularly used through the pandemic. Given the specific needs of the single men and women staying in the hotels, it is necessary to contract with agencies to manage the sites and provide the supports.

Renovating a portion of the former Cathedral Boys School takes advantage of a site that is owned by a community partner. The estimated renovation costs of $550 K are an affordable way to quickly create additional spaces for single men allowing Good Shepherd to transfer their temporary shelter operations from FOC to the new site. In order to best support and manage the individuals, the facility would include:

- Meals and snacks for all of those accommodated;
- Lounge space;
- Recreational activities;
- Medical services through a nurse practitioner and the Shelter Health Network;
- Harm reduction supports;
- Case management and housing support services; and,

- Outreach services provided through other agencies including Ontario Works.

Providing capital funding to Mission Services will allow them to improve infection prevention and increase privacy by building partitions between beds in the dorms and building 10 private/separate rooms and return occupancy to 58.

Maintaining the capacity for people experiencing homelessness to isolate if they test positive for COVID-19 is another key element of the framework. Contracting with Wesley Urban Ministries to operate the isolation centre will allow the facility at Bennetto Recreation Centre to be decommissioned. Wesley will provide isolation service at a site it leases and operates currently with 10 beds to serve men and women and five family townhouse units to serve families. Family capacity will remain the same, but the number of beds for individuals will be reduced from 25 to 10. Given that the system has experienced an average of one positive test per month over the past three months, this is an appropriate capacity level.

The framework for adapting and transforming housing services to respond to the challenges of Covid-19, attached as Appendix "A" to Report HSC20020(a), outlines immediate, mid-term and long-term actions completed (noted with a check mark) or to be undertaken by the Housing Services Division.

ALTERNATIVES FOR CONSIDERATION

None

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Economic Prosperity and Growth
Hamilton has a prosperous and diverse local economy where people have opportunities to grow and develop.

Healthy and Safe Communities
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

Built Environment and Infrastructure
Hamilton is supported by state of the art infrastructure, transportation options, buildings and public spaces that create a dynamic City.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report HSC20020(a): Framework for Adapting and Transforming Services

Framework for Adapting and Transforming Services

Immediate Actions	Mid-Term Actions	Long Term Actions
Unsheltered ✓ Negotiate extensions to emergency funding for drop-ins and day centres to ensure continued access to hygiene and supports. **Shelters** • Strengthen shelter diversion and rapid rehousing initiatives ✓ Plan for decommissioning of First Ontario Centre as temporary shelter. ✓ Reconfigure space within existing shelters to maximise capacity and promote social distancing. ✓ Secure leases with hotels to ensure existing capacity is maintained. ✓ Determine need for alternative shelter sites. **Isolation Centre** ✓ Plan for decommissioning of Bennetto Recreation Centre. ✓ Identify sustainable model for isolation services and appropriate location. **Permanent Housing** • Maximise capacity of municipally-funded Intensive Case Management Programs to help house people from streets, shelters and hotels. • Coordinate available housing subsidies to support access to permanent housing.	**Shelters** • Decommission First Ontario Centre. • Implement plans to maintain current number of shelter beds. **Isolation** ✓ Decommission Bennetto Recreation Centre. • Implement new isolation service model. **Permanent Housing** • Explore opportunities to use any affordable housing projects under construction to serve this population.	**Shelters** • Assist with the planning and development approval process for those shelters looking to significantly and permanently establish facilities that are supportive and resilient to both the housing and health needs of the population. **Permanent Housing** • Maximise the amount and design of permanent low barrier supportive housing to significantly increase the availability and suitability of units. • Ensure the coordination and comprehensive integration of housing and health funding to promote effective, resilient and supportive housing forms.

10.1

CITY OF HAMILTON
N O T I C E O F M O T I O N

Emergency and Community Services: July 13, 2020

MOVED BY COUNCILLOR N. NANN
SECONDED BY COUNCILLOR ……..……

Signing of the AMO-OFIFC Declaration of Mutual Commitment and Friendship with Local Municipality and Friendship Centre Support

WHEREAS the City of Hamilton is working with the local Indigenous Friendship Centre, the Hamilton Regional Indian Centre;

WHEREAS the Indigenous Friendship Centre, the Hamilton Regional Indian Centre, has been an active contributor to the wellbeing of residents in the community;

WHEREAS the City of Hamilton has a good and ongoing relationship with the local Indigenous Friendship Centre, the Hamilton Regional Indian Centre, and wants to set a leading example in the area of Indigenous relations by demonstrating overlapping community interest and work;

WHEREAS the Association of Municipalities of Ontario (AMO) and the Ontario Federation of Indigenous Friendship Centres (OFIFC) Declaration of Mutual Commitment and Friendship reflects the municipality's understanding of and working relationship with Indigenous people in the community; and,

WHEREAS the local Indigenous Friendship Centre is contemplating the signing of this declaration and participation in related concurrent activities during the virtual AMO Conference in August of 2020;

THEREFORE, IT BE RESOLVED

(a) that the City of Hamilton Council authorizes the Mayor to sign in conjunction with the local Indigenous Friendship Centre, the Hamilton Regional Indian Centre, the joint AMO-OFIFC Declaration of Mutual Commitment and Friendship on behalf of the municipality and participate in related concurrent activities during the AMO 2020 Conference; and,

(b) That Council direct staff to work with AMO in order to coordinate the declaration signing and related concurrent activities in advance of the AMO 2020 Conference.