



THE REGIONAL MUNICIPALITY OF NIAGARA
PUBLIC HEALTH & SOCIAL SERVICES COMMITTEE
FINAL AGENDA

PHSSC 10-2021

Tuesday, November 9, 2021

1:00 p.m.

Meeting will be held by electronic participation only

This electronic meeting can be viewed on Niagara Region's Website at:

<https://www.niagararegion.ca/government/council/>

Due to efforts to contain the spread of COVID-19 and to protect all individuals, the Council Chamber at Regional Headquarters will not be open to the public to attend Committee meetings until further notice. To view live stream meeting proceedings, visit: niagararegion.ca/government/council

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1. <u>CALL TO ORDER</u>	
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4. <u>DELEGATIONS</u>	
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7. OTHER BUSINESS

8. NEXT MEETING

The next meeting will be held on Tuesday, December 7, 2021 at 1:00 p.m.

9. ADJOURNMENT

If you require any accommodations for a disability in order to attend or participate in meetings or events, please contact the Accessibility Advisor at 905-980-6000 ext. 3252 (office), 289-929-8376 (cellphone) or accessibility@niagararegion.ca (email).

Housing Services

Public Health & Social Services Committee

November 9, 2021

Donna Woiceshyn, Director, Housing Services / CEO

Jenny Shickluna, Manager, Housing Programs

Wendy Thompson, Manager, Community Resource Program

Cameron Banach, Manager Housing Operations

HOUSING SERVICES

COMMUNITY SERVICES

Donna Woiceshyn, Director, Housing Services / CEO NRH

Jenny Shickluna, Manager, Housing Programs

Wendy Thompson, Manager, Community Resource Program

Cameron Banach, Manager Housing Operations

Introduction

- History
- Alternative Service Delivery (ASD)
- Transition
- Niagara Regional Housing (Board of Directors)



The Role of the Service Manager

Maintaining Existing Community Housing Stock

(numbers at end of 2020)



2,850

NIAGARA REGIONAL
HOUSING OWNED UNITS



3,564

HOUSING PROVIDER UNITS

59 Non-Profit and
Cooperative
Housing Programs



1,668

RENT SUPPLEMENT
UNITS

Responsibilities within the Housing and Homelessness Action Plan (HHAP)

- Support Provider Capacity and Capital Repairs
- Address End of Operating/Mortgage Agreements
- Housing in Human Services Integration
- Centralized Housing Waitlist Policies
- Landlord Engagement and rent supports
- Renovation Program and Affordable ownership
- Community Housing Strategy and Data
- Engage local municipalities in planning for Community Housing
- Innovative Housing Solutions
- Sustainability Goals and Capital Retrofit Programs

Housing Services Portfolio

Levy Funded

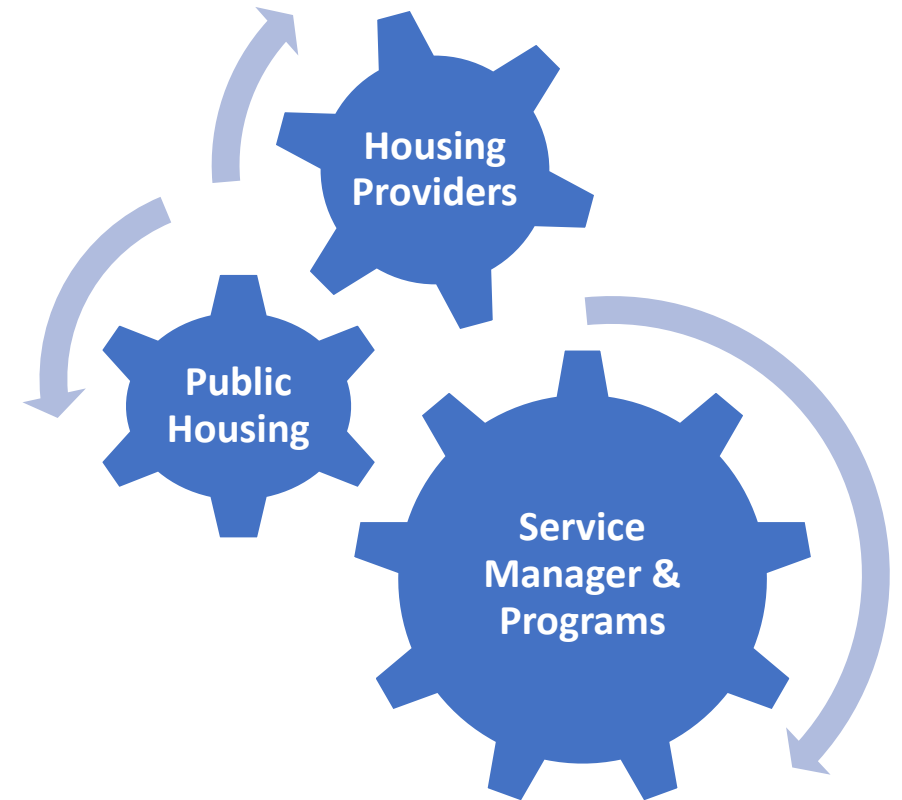
- Social Housing Provider Subsidies and Oversight
 - Rent Supplement and Housing Allowance
 - Centralized Waitlist Management
 - Community Resource Unit
- *Public Housing (NRH)

Ministry Funded

- Strong Communities – Rent Supplement Program
- COHB Program Application Process
- SIF/OPHI/COCHI
 - Rent Supplement
 - Housing Allowance
 - Housing First
 - Home Ownership Assistance
 - Niagara Renovates
 - New Development Funding – Capital
 - Support Services

Housing Services Support

- **Housing Services** support to non-profit and co-op housing providers
- ***NRH** is the Local Housing Corp (LHC) and the largest community housing provider in Niagara
 - Will have access to all of the same services from Housing Services as the other providers



Rent Subsidy Programs

Housing
Provider
Subsidies

Rent
Supplement

Housing
Allowance

In-Situ
Rent
Supplement

New
Development
Housing
Allowance

Canada
Ontario
Housing
Benefit*

Homeowner Programs

- Welcome Home Niagara
- Niagara Renovates
- Secondary Suites
- Multi Unit



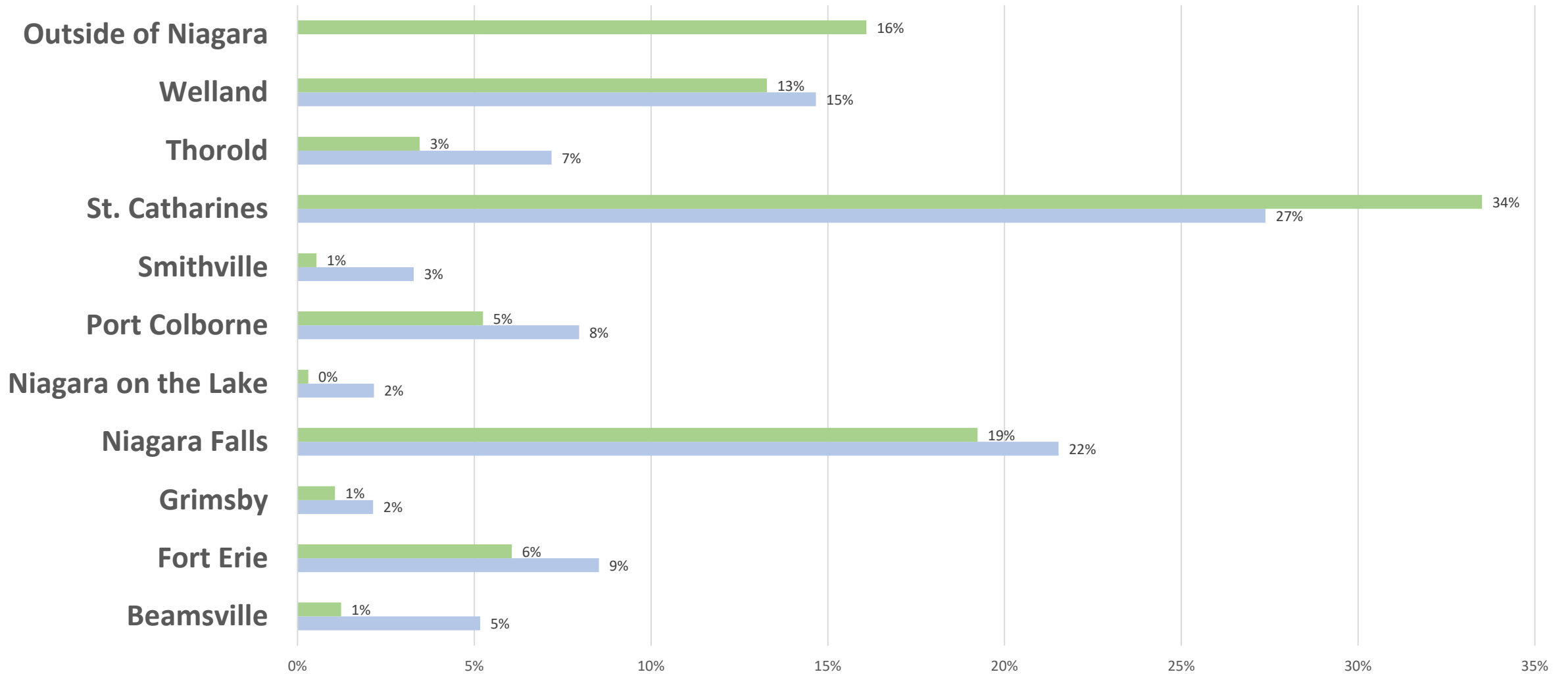
Niagara Renovates
before & after

Housing Access

- **Housing Access** is responsible for the administration and management of the Centralized Waiting List (made up of over 200 subsidiary wait lists)



■ Where applicants currently live ■ Where applicants have applied



Community Resource Unit

- Tenant support
- Eviction prevention
- Community Engagement
- Policy and communications development
- Housing initiatives (scholarships, students, special programs)



Niagara Regional Housing

Housing Operations

- Property Administration and day to day operations (Landlord) of **2,850 units**



Niagara Regional Housing

Capital Asset Management

- Capital Repairs to existing public housing units

New Development

- Public Housing New Development
- Housing Providers (non-profits , cooperatives and agencies)
- Supportive Housing partnership with Community Services



Questions



Subject: Niagara EMS – System Pressures Update

Report to: Public Health & Social Services Committee

Report date: Tuesday, November 9, 2021

Recommendations

1. That the Regional Chair **BE DIRECTED** to send correspondence to the Minister of Health to initiate immediate interventions to reduce the offload delay crisis occurring in many hospitals around the province including those in Niagara; and
2. That the Regional Chair **BE DIRECTED** to send correspondence to the Ministry of Health requesting approval of four additional ambulance dispatch staff.

Key Facts

1. Volumes of patients using 911, after fluctuating through the pandemic, has now not only returned to pre-pandemic levels, but has set record highs for the last four months.
2. Despite the increases in people accessing 911, the number of patients transported to local emergency departments has remained within pre-pandemic levels. This is likely a result of the system transformation changes put in place in 2019.
3. While there has not been a large increase in the number of patients transported to an emergency department, there has been a substantial increase in the time that paramedics are spending in the emergency departments waiting to transfer care of patients. Paramedics must frequently wait for several hours with their patients in hallways until the hospital can assume care of the patient. This is known as “offload delay”.
4. The current situation of offload delay has reached a critical state. In the past four months, offload delays have surpassed previous pre-pandemic records with incidents involving as many as 11 ambulances or more in offload at one hospital at the same time.
5. This increased demand on Niagara EMS has created considerable stress on EMS resources and in particular the Niagara EMS staff who continue to bear additional

responsibilities due to the pandemic (e.g. patient screening, enhanced PPE, cleaning, mobile vaccination).

6. Offload delays deplete resources to respond to other emergency calls, which, along with increased 911 volumes, impacts the workload and stress of emergency medical dispatchers (EMD's) to ensure appropriate emergency response and resource utilization.
7. The risks created as a result are significant. The depletion of available resources means that there are often not enough ambulances to provide emergency coverage for all of Niagara and ability to meet response times for critical patients.

Financial Considerations

The financial impact of offload delays include the cost of lost productivity/availability to provide service in the community and increased employee sick time and overtime.

Lost Productivity/Availability

Delays of paramedics caring for their patients in the emergency department while awaiting the hospital to assume care is currently 1.5 hours on average and 3.5 hours at the 90th percentile. Further, in the last seven months 349 patients remained on EMS stretchers between 4-6 hours, 53 were 6-8 hours and 10 patients remained under paramedic care for more than 8 hours in hospital. While in offload delay, paramedics are unable to be deployed into the community to maintain emergency coverage. The cost of this lost time is valued at \$113 per hour (non-overtime). In a recent week (October 18-24, 2021) Niagara EMS lost a total of 702 ambulance hours to offload delay. This equates to 4 twenty-four hour ambulances lost for the week. The cost of this lost time for this one-week period was \$79,326 in lost wages and does not include any backfill or vehicle costs. Year to date 2021 has seen a loss of over 15,000 hours (\$1.7M) of ambulance time to offload delay and at the current rate will see over 20,000 hours (\$2.26M) spent in hospital.

Sick Time & Overtime

While offload delays can not be specifically identified as a reason for staff sick time, the conditions staff are working in, which include prolonged periods in the hospital emergency department, continuously donning and doffing PPE (personal protective equipment), and their inability to do their work in the community as a paramedic, is a significant contributor to work absence. As offloads continue through the duration of a paramedic's shift, it is often difficult to relieve these staff at the end of their shift;

overtime is often required to continue caring for the patient until the hospital can assume care.

Niagara EMS Emergency Medical Dispatch (EMD) staff are also fatigued with the increase in 911 calls and the deterioration of available ambulances to respond to these calls, coupled with the stress of maintaining emergency coverage for Niagara communities with these resource limitations. These factors contribute to increased absences as staff have reached exhaustion. The result of increased sick time manifests to increased overtime where, it should be noted, it is becoming increasingly difficult to find paramedics and EMD's willing to work overtime within these conditions. This leads to increased efforts of administrative staff and managers to find staff to fill shifts.

Comparing 2020 to 2021 in the same period of April-August, sick time has increased 33% for paramedics and 30% for EMD's. This represents an increase of 1,719 hours or \$121,000 for paramedics and 104 hours for EMD's at a cost of \$6,500.

With respect to Recommendation #2 of Report PHD 11-2021, requesting support for the additional ambulance dispatch staff (EMD's), these positions receive 100% funding from the Province. Niagara EMS is unable to arbitrarily increase this staffing without Ministry of Health approval unless the liability for these positions is undertaken by the Region. Thus the reason to send correspondence to the Ministry urging them to approve this staff increase.

Analysis

In follow up to CWCD 2021-182, memo to council regarding Niagara EMS offload delays, the intention of this communication is to provide PHSSC with additional information as to the current state of EMS call volume and ambulance offload delay pressures. These pressures are adversely affecting Niagara's paramedic service, and its ability to provide safe emergency medical response to Niagara's residents and visitors.

As that memo mentions, during the pandemic, volumes of patients seeking care at hospitals and using 911 has fluctuated. For Niagara EMS, the start of the pandemic in April 2020 saw a five-year low for both EMS call volumes and patient transports (Figure 1). At the same time, offload delay, which is the time beyond 30 minutes it takes to place a patient in a bed at the receiving emergency department, also reached a five-year record low. In fact, during the early pandemic period offload delay was almost completely absent.

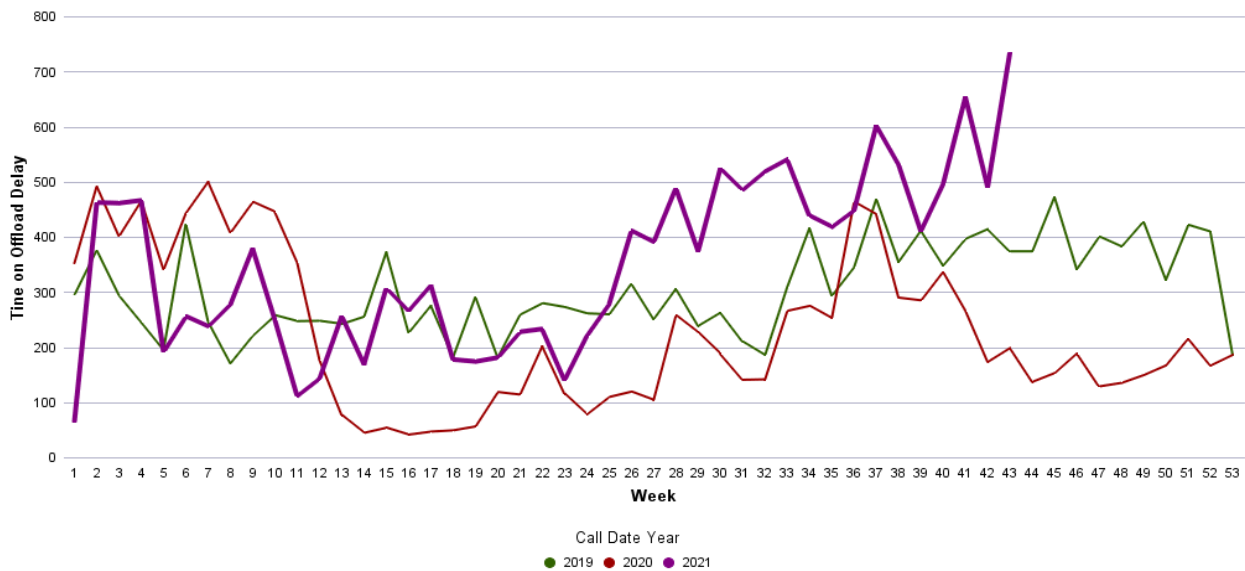


Figure 1: Compares the weekly hours spent in offload delay 2019-YTD 2021

However, since April of this year, both EMS call volume and offload delay have been sustained at a high level, setting new records. Factors which may be influencing call volume are discussed below, as well as historic and recent steps that Niagara EMS has taken to attempt to mitigate the impact.

EMS Call Volume Increase Factors

As CWCD 2021-182 discusses, for the past number of months Niagara EMS has experienced sustained call volume increases that have set new five year records. The increase in calls may be attributed to a number of factors:

- Seasonal variation (summers typically see call volume increases with increased outdoor activity, and trauma related calls also increase as a result);
- Post-lockdown increase in activity coinciding with seasonal variation, and;
- A significant rise in the number of opioid related calls for service.

Additionally, we have seen increases in the number and acuity of certain call types, such as chest pain and 'generally unwell' individuals with chronic illness, which could be associated with a cumulative impact of delayed routine care due to reluctance or increased challenges with accessing primary care during the pandemic. These increases can be seen in Figure 2 below.

Total Call Volume/Incident Trend

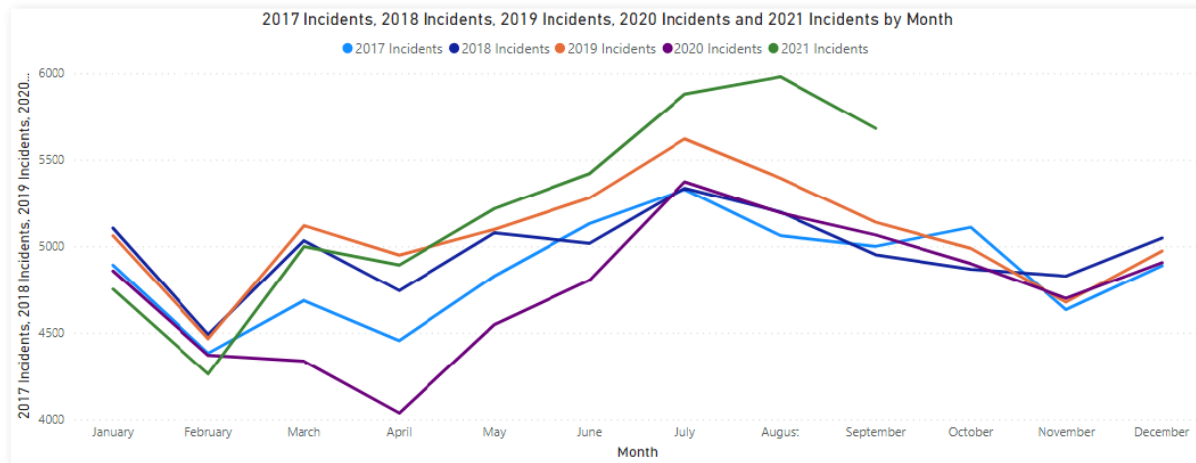


Figure 2: compares the number of monthly 911 incidents 2017-YTD 2021

Offload Delay Mitigation

Staff meet with Niagara Health representatives on a regular basis to discuss the issue of offload delay and review data to guide decision making and problem solving. Most recently, on October 20, staff including the CAO, Medical Officer of Health and Chief of EMS met with the Niagara Health President and other hospital leaders to discuss this issue and commit to implementing possible resolutions.

The issue of offload delay is not unique to Niagara and is a major issue in most provincial hospitals. A monthly report¹ issued by Ontario Health compares the offload performance of each Ontario hospital and unfortunately, Niagara Health's St. Catharines Site has placed 74th out of 74 for average offload times for the last 11 months. Niagara EMS has undertaken a number of initiatives, in many cases in collaboration with Niagara Health, to mitigate offload delays and help improve this performance with varying success.

As previously noted, the volume of patients transported to local emergency departments in the past six months has not significantly escalated beyond pre-COVID volumes; this

¹ Ontario Health. *ER Ambulance Offload Time Report: Provincial, LHIN and Site Level*. October 2020 to August 2021.

means that the volume of patients arriving at hospital is not the sole factor in offload delays. It should be highlighted that hospital offload delay is an issue of hospital throughput, and not solely an ED (Emergency Department) issue. It is impacted by such factors as hospital occupancy, elective procedures, and time to admit and discharge. Many of these issues are influenced by external factors such as alternate health resources and community-based alternate level care capacity. The pandemic and the surge of COVID-19 cases through multiple waves has impacted some of these factors (e.g. cancellation and backlogs of many procedures) for Niagara Health. Further, Niagara Health indicates that a staff shortage is impacting the offload performance. Therefore, EMS's ability to influence offload delay is somewhat limited. Nonetheless, significant efforts have been undertaken, and some of the activities to date include:

- Frequent and ongoing dialogue with Niagara Health leadership
- Parallel internal escalation processes between EMS and hospitals
- Annual Offload Nurse funding of \$817,662 from the Ministry of Health which funds nurses specifically to manage EMS offload patients in the hospital ED's so that paramedics can return to the road. This funding is not adequate to meet the actual challenges in the ED's and with the recent staffing challenges at Niagara Health, this resource is increasingly challenged to provide care to offload patients.
- Lean Six Sigma process improvement exercise (x2)
- Development of Vehicle Status Alert Algorithm (communicates low vehicle count status to EMS and NH staff, with expected actions associated with each level)
- Development of applications to track and communicate offload status in real time and in aggregate reporting (currently developing version 4)
- Geographical call distribution. This is the transport of patients to less crowded ED's when offloads become significant. This was less successful, as it was found to simply move the pressure to another site and result in a more significant issue.
- Transport of low acuity patients to Urgent Care Centers (UCC) in Port Colborne and Fort Erie
- Implementation of 'Fit2Sit' process to more quickly offload appropriate non-acute patients to the waiting room so that paramedics can return to the road
- EMS Superintendent monitoring exercise, with observation of offload process with recommendations for improvement
- Extensive media coverage.

Additional Recent Actions

- Procedures to increase paramedic to patient ratios where one paramedic crew provides care to multiple patients in order to free up other crews to return to the road for responses
- Placement of additional stretchers in the hospital to facilitate the lowering of stretchers in the ED and permit emergency clearing of crews based on acute triggers
- Procurement of extra cardiac monitors to facilitate increased patient observation in the ED
- Exploration of opportunities for paramedics to provide in-ED patient monitoring to free up staff.

Emergency Coverage

- Additional 12 hour ambulance added for the last quarter of the year proactively (rather than on-demand) within current funding
- Reassigned Bike Medic Unit paramedics to staff ambulance instead—continuing as funding permits
- Addition of CARE units (4) as part of the CPLTC program—target for November/December deployment
- Three temporary EMD's to assist with call volume in dispatch centre.

The combined impact of significant call volume increases and offload delay hours have led to increased staff overtime, missed meals, and operational stressors, which, combined with pandemic related stressors, are taking an increased toll on all staff.

Impact on Public Safety

The risks created by growing offload delays are significant. The depletion of available resources means that there are not enough ambulances to provide emergency coverage for all of Niagara. An Alert Status Algorithm was introduced several years ago to provide real-time situational awareness of the status of Niagara's EMS system. As noted in Table 1 below, each Alert Status Level is defined by the number of available ambulances in the system for a prolonged period of time. The number of occasions each Level was met is noted below.

Alert Status	Level 0 The number of calls waiting to be assigned an ambulance is greater than the number of available ambulances	Level 1 20% or less of normally staffed ambulances available in the region	Level 2 35% or less of normally staffed ambulances available in the region
2020	1	18	119
2021	6	77	349

Table 1: Frequency of Alert Status June 1 to October 25 2020-21 comparison

These periods of reduced emergency resources results in longer response times for those critically ill or injured and longer wait times for stable patients with lower acuity health needs. In response to the loss of resources, Niagara EMS attempts to maintain emergency coverage by up-staffing additional ambulances, which has resulted in increased operational expenses attributed to overtime costs as noted in the Finance section.

Impact on Staff

In addition to the increased costs and risks to the community, the burden of offload delays may be a further contributing factor to the decreased health and wellness of paramedic and dispatch staff in the form of unscheduled staff absences, missed meal breaks, and challenging interactions between EMS and hospital staff.

The ongoing demands of the pandemic combined with the increase in call volumes and offloads has created a workforce expressing exhaustion and frustration. Paramedics have been working through COVID-19 at the very front of health care, often in uncontrolled environments and uncertain situations posing threat to exposure to self and others. While these staff have demonstrated constant professionalism, they are experiencing first hand the effects of the increased workload and time on task that keeps them from serving the community as intended.

With the rise in call volumes, emergency medical dispatchers are faced with extreme stress as the 911 calls need to be answered and strained available paramedic

resources restrict their ability to assign a response sufficiently. This situation has placed increased pressures on a dispatch system that had been at peak capacity pre-COVID. Additional staff to meet the escalating demand has been requested of the Ministry of Health for the past 5 years without approval. As the MOH funds the ambulance dispatch operations, adding staff and receiving budget for this is at the sole discretion of the Ministry. Recommendation #2 of Report PHD 11-2021, is made to assist in elevating the request to obtain the much needed additional staff.

As the system pressures continue, the service endeavours to provide supports to staff to the extent possible, means to offset the demands of this stressful environment. New initiatives include the implementation of decompression time between calls and short period mental stress leave to protect the mental wellness of staff and prevent a longer-term absence.

Alternatives Reviewed

As noted earlier regarding offload delay mitigation strategies, success has varied. Staff continue to identify novel opportunities to further reduce the number of patients being transported to emergency departments with such initiatives as the Ministry-funded Community Paramedicine for Long Term Care program. Niagara EMS also remains committed to work with Niagara Health to implement changes to help better manage the patient flow from EMS to the care of the hospital.

From 2007-2016, Niagara was the municipality with the largest growth in EMS calls in Ontario, at 55.6%, almost double the Provincial growth of 30% (Ministry of Health and Long-Term Care (2018). Ontario's Emergency Health Services: Sector Overview. Health Analytics Branch, Health System Information Management Division). While the system transformation initiative helped address some of the unsustainable call growth, in the past five years the increase in call volume through the ambulance dispatch centre has grown another 5% resulting in a >60% increase over a 15 year period. Despite yearly business cases provided to the Ministry of Health for additional Emergency Medical Dispatch FTE's as a result of these year over year escalating call volumes, new staff have not been approved by the Province who funds 100% of the costs associated with the communications (dispatch) centre. Obtaining approval for these additional staff would address the large increase in workload, reduce stress, sick time, WSIB and overtime as well as mitigate against risk due to human error in the communications centre as a result of human exhaustion.

Relationship to Council Strategic Priorities

The issue of offload delays is directly related to the council priority of Healthy and Vibrant Community. Maintaining emergency coverage of ambulances in our communities leads to protecting the health of our residents and visitors. Engaging in alternate service delivery models that best meet the health and social needs of people calling 911 also reduce ED overcrowding and otherwise avoidable transports to hospital by ambulance.

Other Pertinent Reports

- CWCD 2021 - 182 Niagara EMS – Offload Delays Update
- PHD 05 - 2020 COVID-19 Impact on Niagara Emergency Medical Services
- PHD 10 - 2020 Niagara Emergency Medical Services System Transformation Update 3
- PHD 05 - 2018 Niagara EMS/Niagara Health Transfer of Care Improvement Strategy
- PHD 14 - 2017 Niagara EMS Hospital Offload Status Report

Prepared by:

Kevin Smith
Chief, Niagara Emergency Medical
Services & Director, Emergency
Services
Public Health & Emergency Services

Recommended by:

M. Mustafa Hirji, MD, MPH, FRCPC
Medical Officer of Health &
Commissioner (Acting)
Public Health & Emergency Services

Submitted by:

Ron Tripp, P.Eng.
Chief Administrative Officer

Subject: Emergency Social Services – Canadian Red Cross Contract / Agreement

Report to: Public Health and Social Services Committee

Report date: Tuesday, November 9, 2021

Recommendations

1. That the Regional Chair and Regional Clerk **BE AUTHORIZED** to execute an agreement with the Canadian Red Cross (CRC) for the provision of emergency social services for a term of three years, effective January 1, 2022 to December 31, 2024, in a form that is satisfactory to the Director of Legal Services.

Key Facts

- The purpose of this report is to seek Council’s approval to execute an agreement with the CRC that seeks to build capacity for the provision of emergency social services within the region and ensures that the desired level of service would be available in the event of an emergency.
- Niagara Region is legislated by the Emergency Management and Civil Protection Act 2.1 (1), as a municipality, to develop and implement an emergency management program that includes an Emergency Response Plan. The emergency plan shall include procedures to be taken for the safety or evacuation of persons in an emergency area.
- Niagara Region’s Community Services Department is responsible for leading the planning and delivery of the Region’s emergency social services plan to address how to respond in the event of a community disaster where residents are being displaced from their homes, ensuring agreements are developed and in place in collaboration with local area municipalities and external partners.
- Historically, the Region has held a contract/agreement with the CRC for emergency response disaster relief to support this mandate. CRC has made changes to its delivery model, funding and contract language. The costs associated with the response are in addition to the annual fee and since there is no way to predetermine the size and scope of an emergency a range for these costs cannot be provided. Thus, it was determined in partnership with Legal Services, that Council approval would be appropriate.

Financial Considerations

The annual contribution to the Canadian Red Cross under an agreement with the Region would be \$43,000 for each year of a three-year agreement. This figure is based on the Region's approximate population (481,727) and is the sum of \$0.09 per capita. This cost is similar to what other municipalities contribute for this emergency service. The annual fee of \$43,000 is included in the existing Community Services department base operating budget and is consistent with the prior year's fee.

In the event of an emergency response, services would be determined by the Region in partnership with the local municipality, where it is considered a municipal emergency. The costs associated with the response are in addition to the annual fee to ensure capacity to respond and the appropriate planning. These additional costs incurred during a response include lodging, food, supplies, out of town volunteer expenses and other direct costs of a Canadian Red Cross response. There is no way to predetermine the size and scope of an emergency, and as such, a range for these costs cannot be provided. Reporting of costs during an emergency would be managed in accordance with the Procurement By-Law Special Circumstances Purchases Section 17 (c) (ii) requiring "the Commissioner of Corporate Services/Treasurer, as soon as possible in the circumstances proceeds with identifying and approving or seeking approval of the funds required to pay for the special Circumstance", should funds not be available within the Region's operating budget.

Analysis

Emergency social services involve the coordination of essential services to individuals who are evacuated during an emergency, and are composed of six basic services:

1. **Registration and Inquiry:** The collection and management of evacuees' personal information, inquiries regarding evacuees' safety and family reunification.
2. **Emergency Feeding:** The provision of meals, snacks, and beverages to evacuees without food or food preparation facilities. This can be provided through a third party arrangement, such as the Salvation Army.
3. **Emergency Lodging:** The provision of safe and temporary lodging to evacuees, including overnight sleeping arrangements. This may include hotels or group lodging arrangements.
4. **Emergency Clothing:** The provision of clothing and footwear until regular sources of supply are available.

5. Personal Services: The provision of additional supports to evacuees that are more specialized (e.g. personal and hygiene products, baby supplies, mobility aids, etc.).
6. Management of Reception Centres where overnight accommodation is not required, however information sharing, registration and inquiry, emergency feeding and some personal services may be provided.

Niagara Region's Community Services Department is responsible for coordinating emergency social services in collaboration with local municipalities and external providers, such as non-profit groups and businesses that provide a specific service to evacuees during an emergency.

Historically, the CRC has been a key partner in the delivery of a range of emergency social services throughout Niagara region, and has responded to local events such as: 'White October', St. Catharines apartment fires, Grimsby downtown fire, Port Colborne water system failure.

The CRC has a reputation worldwide for providing emergency social services response during emergencies of all sizes and types. As such, the CRC has staff and volunteers available to respond as requested 24 hours a day, 365 days a year and can mobilize quickly in an emergency situation.

Under the Agreement, the CRC will collaborate and partner with the Region in preparedness activities including participation in emergency exercises, assessments of facilities for evacuation centres, training activities, recruitment of volunteers, pre-positioning of emergency sheltering supplies and the delivery of personal preparedness workshops to community groups upon request.

Municipalities with formalized agreements have priority in terms of receiving emergency response and this is pertinent, particularly for large-scale incidents impacting broader geographic areas. In order to ensure Niagara Region is equipped to respond to a local emergency, where coordination of essential services to individuals who are evacuated during an emergency is required, it is recommended that the Region enter into a formal agreement with the CRC.

Alternatives Reviewed

While Red Cross is the internationally recognized expert in emergency social services responses, the Region did consider the alternative of offering the program in-house. The requirements to be prepared to offer the breadth of emergency services including

family reunification, lodging, food and personal needs/supports would require: a significant investment in physical assets (e.g. cots, blankets, comfort kits); software and policies to address family reunification; one full time staff person to support oversight of this work at an estimated cost of \$77,000 to \$90,000; standby staffing and training to provide needed support during the emergency; and procurement support to establish preferred vendors to address hoteling, food supports and personal needs. Based on this analysis, the annual retainer with the Red Cross, of \$43,000, cost-effectively provides for the required capacity and expertise to ensure the best response in an emergency for the residents of Niagara. A contract with the Red Cross ensures that there is a standing ability to respond in a scalable fashion to address both a smaller emergency as well as a larger situation with a significant community impact. Staff therefore are recommending that Niagara Region execute an agreement with the Canadian Red Cross to provide emergency social services in partnership with Community Services in the event of an emergency impacting the residents of Niagara.

Relationship to Council Strategic Priorities

Not applicable.

Other Pertinent Reports

COM 05-2019 - Emergency Social Services Canadian Red Cross Contract Agreement

Prepared by:

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Community Services

Recommended by:

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Commissioner
Community Services

Submitted by:

Ron Tripp, P. Eng.
Chief Administrative Officer

This report was prepared in consultation with Jeffrey Mulligan, Manager Strategic Sourcing and Sterling Wood, Legal Counsel, Legal and Court Services, and was reviewed by Stephanie Muhic, Program Financial Specialist.

Subject: Long-Term Care Home Funding Policy Update

Report to: Public Health and Social Services Committee

Report date: Tuesday, November 9, 2021

Recommendations

1. That an adjustment to the previously adopted 2021 Regional Municipality of Niagara (Niagara Region) operating budget in the amount of \$1,360,741 to be fully funded through Ministry of Long-Term Care funding **BE APPROVED**.
2. That Regional Council **APPROVE** the addition of 112 permanent full-time equivalents (FTE)'s as per the recently announced Long-Term Care Home Funding Policy.

Key Facts

- The purpose of this report is to seek Council's approval of new FTE's to enable the use of new provincial funding for the eight Niagara Region long-term care homes and to undertake a gross budget adjustment in excess of \$1 million with Council approval per the Budget Control By-law Section 6.6A.
- The creation of new full-time permanent positions, resulting in an increase in FTE's, requires Regional Council approval under the Corporate Delegation of Authority Policy.
- The government released "A Better Place to Live, a Better Place to Work: Ontario's Long-Term Care Staffing Plan" (Staffing Plan) in December 2020 with a commitment to improve Ontario's long-term care (LTC) sector by increasing staffing levels.
- On October 15, 2021, the Ministry of Long-Term Care (ministry) released updates to the Long-Term Care Home Funding Policy detailing funding investments to support the staffing increases committed to in the Staffing Plan. Investments are issued in year-over-year increases from 2021-2022 to 2024-2025. The first wave of funding will be issued for a 5 month period (Nov. 1, 2021 – March 31, 2022).
- The new staffing funding, provided through a separate funding line, is restricted exclusively for increasing direct resident care staffing.
- LTC homes must report on use of this funding in the audited LTC Home Annual Report.
- The total confirmed increase in LTC staffing funding for Nov. 1, 2021 to March 31, 2022 for the eight Niagara Region LTC homes is \$3,401,854.

- This is new base funding and will fund the increase in staff with no levy impact and supports the addition of 112 permanent FTE's.
- Funding included in the 2022 budget will be estimated based on the 2021-22 ministry confirmed amounts. Once the ministry confirms the funding for the 2022-23 fiscal year, Seniors Services will bring a separate report to this committee outlining the confirmed funding and may request approval to adjust the 2022 budget as needed in accordance with the budget control by-law.

Financial Considerations

The Long-Term Care Staffing Increase Funding Policy outlines the terms and conditions of the funding that will be issued effective November 2021, up to the end of this fiscal year (March 31, 2022). Staffing funding will be allocated on a per bed per month basis based on the number of operational beds at the start of the program. The funding for the entire 2021-2022 fiscal period will be issued starting November 1, 2021, through fixed monthly installments.

As a one time exception, homes will be permitted to carry forward any unused funds in 2021 for use in the following January 2022 – March 2022 period.

To ensure that funding is used solely to increase resident care, the ministry is issuing the new funding through two new distinct protected lines that will be calculated as follows:

- RN, RPN, and PSW Staffing Supplement: \$599.49 per bed, per month
- Allied Health Professionals Staffing Supplement: \$112.94 per bed, per month

The table below details the 2021-2022 fiscal year staffing funding announced in the policy:

Funding Line	Nov - Dec 2021	Jan - Mar 2022	Total Confirmed Funding
RN, RPN, and PSW Staffing Supplement	\$1,145,026	\$1,717,539	\$2,862,565
Allied Health Staffing Supplement	215,715	323,573	539,288
Total Funding	\$1,360,741	\$2,041,112	\$3,401,853

Out-Year Notional Allocation Amounts

The government has further committed to an investment of \$7.7 million, \$12.9 million, and \$16.2 million for staffing increases in the 2022-23, 2023-24 and 2024-25 fiscal years, respectively. These amounts are subject to change and will be confirmed by the ministry each year. The ministry has provided a multi-year funding policy to enable ongoing planning of staffing strategies to support resident care.

Funding included in the 2022 budget will be estimated based on the 2021-22 ministry confirmed amounts. Once the ministry confirms the funding for the 2022-23 fiscal year, Seniors Services will bring a separate report to this committee outlining the confirmed funding and may request approval to adjust the 2022 budget as needed in accordance with the budget control by-law.

Analysis

Long-term care homes have been advocating for an increase in direct care staffing for many years. The need to increase LTC funding to 4.0 hours of care per day for LTC residents was originally recommended in the “People Caring for People Report” (2007). In 2017, the “Aging with Confidence: Ontario’s Action Plan for Seniors” (2017) revisited the recommendations of the “People Caring for People” report and committed to funding to increase the provincial average level of long-term care to 4.0 hours of direct care per resident per day.

To proactively plan for best use of anticipated increases in staffing funding, Seniors Services completed a staffing study in 2018. The study focused on determining the optimal PSW FTE’s per shift on a Resident Home Area to ensure resident focused quality care for the current profile of residents while maintaining a focus on operational efficiency.

Subsequently, the LTC sector was significantly impacted by the COVID-19 pandemic. The Long-Term Care COVID-19 Commission and the Auditor General each released reports outlining recommendations to strengthen the LTC sector.

In response to the reports the ministry is rolling out a plan that includes three pillars:

- I. staffing and care,
- II. accountability, enforcement and transparency and,
- III. building modern safe, comfortable homes for seniors.

In December 2020, the current government released “A Better Place to Live, a Better Place to Work: Ontario’s Long-Term Care Staffing Plan” (Staffing Plan) to operationalize the first pillar in the provincial plan. The staffing plan outlines a commitment to improve Ontario’s long-term care sector by increasing staffing levels. The ministry has now issued a Funding Policy that details the new funding investments to support increasing staffing levels. Consistent with this policy, the ministry has provided each of the Niagara Region long-term care homes with an allocation letter detailing the confirmed funding for Nov. 1, 2021 – March 31, 2022, as well as Out-Year Notional Allocation Amounts to support year-over –year increases from 2021 to 2025 to an estimated total of \$40.4 million.

The government has also introduced legislation to support improving the care of residents in long-term care homes. If passed, the *Providing More Care, Protecting Seniors, and Building More Beds Act, 2021* will repeal the current *Long-Term Care Homes Act, 2007* and create the *Fixing Long-Term Care Act, 2021*. The ministry will be monitoring for compliance through the new Proactive Inspection Program. The ministry is increasing staffing for inspectors to get to a level of one inspector for every two LTC homes in the province, and inspectors will be inspecting homes for compliance to the new requirements. The increases in LTC home staffing afforded through the Staffing Plan will support LTC homes to meet the enhanced requirements detailed in the updated legislation.

To optimize the value of the staffing funding at the bedside, Seniors Services has revisited the learnings of the staffing study and has initiated engagement with staff and residents in the development of new staffing schedules.

The Human Resources division is working closely with Seniors Services in the roll-out of a recruitment strategy aligned with the staffing funding announcement.

Alternatives Reviewed

Ministry of Long-Term Care restrictions on use of funding do not allow for alternative options.

Relationship to Council Strategic Priorities

The approval of 112 permanent full time equivalent positions for nursing/allied health staff supports Council Strategic Priorities of fostering Healthy and Vibrant Communities through the delivery of quality care to Niagara’s senior population.

Other Pertinent Reports

- COM 3-2021 Seniors Services Quality Improvement Report: Oct. – Dec. 2020
- COM 20-2020 Seniors Services Quality Improvement Report: July to Sept. 2020
- COM 02-2018 Direct Resident Care Staffing Levels in Long-Term Care

Prepared by:

Henri Koning, MHSc
Director
Community Services

Recommended by:

Adrienne Jugley, MSW, RSW, CHE
Commissioner
Community Services

Submitted by:

Ron Tripp, P. Eng.
Chief Administrative Officer

This report was prepared in consultation with Jordan Gamble, Program Financial Specialist; and reviewed by Manager; Helen Chamberlain, Director Financial Management & Planning/Deputy Treasurer.

MEMORANDUM

PHD-C 16-2021

Subject: Risk Management Activities in Public Health

Date: November 9, 2021

To: Public Health & Social Services Committee

From: M. Mustafa Hirji, Medical Officer of Health & Commissioner (Acting) & Sinead McElhone, Director Organizational & Foundational Standards (Acting)

A summary of risk management activities must be reported to the Ministry of Health as part of the third quarter Standards Activity Report due to the Ministry each year on or around October 31. It is a requirement of the *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* and *Public Health Funding and Accountability Agreement* to report the high risks in a standardized manner that are currently being managed at each board of health. Risk is defined as a future event that may impact the achievement of established objectives. Risks can be either positive or negative.

The Ministry's standardized template includes the following:

1. Description of the risk
2. Selection of the category – there are 14 predefined categories, such as legal compliance, equity, financial, people/human resources, political, and privacy.
3. Assess the impact of the risk, if it occurred, on a scale of 1 (negligible impact) to 5 (threatens success of the objective)
4. Assess the likelihood of the risk occurring, on a scale of 1 (unlikely to occur) to 5 (is almost certain to occur)
5. Overall risk rating – this is automatically calculated based on the inputted values of impact and likelihood and describes the overall ranking of the risk in terms of high, medium, and low
6. Key risk mitigations – state the risk control methods and processes that are in place or will be implemented to minimize the risk.

Ten risks have been identified of which seven were identified as “high” risk, and subsequently are summarized in the following five categories:

1. People/Human Resources
2. Operational/Service Delivery
3. Financial
4. Governance/Organizational
5. Political.

People/Human Resources

(a) Leadership Stability – There have been departures of leadership due to retirement, burnout, and job uncertainty in 2020/2021. Since January 2018, the Medical Officer of Health has been working in an acting position and one of the permanent Associate Medical Officer of Health is on a long-term leave. Recently, a new permanent Associate Medical Officer of Health has been hired, but continue to have difficulties in attracting a temporary Associate Medical Officer of Health to support both COVID-19 and Business Continuity efforts. With the confirmation of the permanent CAO, the recruitment of a permanent Medical Officer hire is on the horizon in 2022 and the potential for a leadership change. Coupled with this, there are Acting Directors in place across Public Health as well as many Acting Managers. Having temporary positions in key leadership roles can have an impact on an organization and has the ability to destabilize teams.

From a risk mitigation perspective, a temporary Chief of Staff position was created to support the Medical Officer of Health and guide the Directors in their work. There has been intentional succession planning to backfill management positions and staff engagement is highlighted as one of the key areas of focus for the coming 18 – 24 months. New leaders are all encouraged to take part in core leadership training sessions (Leaders Edge, Crucial Conversations, and Coaching Leader) and other leadership training including mentorship opportunities. Focus group sessions have been held with Directors and Managers to obtain feedback on areas required for support. There continues to be regular communication with all Public Health staff to keep them engaged and informed e.g. Weekly email from Medical Officer of Health as well as a “pulse check” of staff through various methods such as surveys, confidential feedback, and through managers.

(b) Recruitment Challenges – A significant number of staff have been transferred to support COVID-19 and temporary positions have been difficult to recruit for with many sectors and neighbouring regions recruiting from the same pool. It has been difficult to hire and retain Public Health Nurses (PHNs), Public Health Inspectors (PHIs), and Data and Informatics staff in temporary or casual contracts, as Niagara Region is not able to offer competitive compensation for many positions due to the Region's salary grading processes. With the fluctuating COVID-19 cases (which increases the need for case and contact management, outbreak management, and call centre staffing) as well as vaccine delivery and non-pandemic Public Health programs needing to ramp up to support other serious issues within the community (e.g. opioids, mental health, sexually transmitted infections, family violence etc.), Niagara Region Public Health (NRPH) continues to be short-staffed in many areas. As of mid-October, 107.66 FTE remained unfilled during a time of intense work and need by Public Health.

In order to address the recruitment issues identified above, there has been significant effort to identify key roles and harder to fill positions by the Public Health Leadership Team (PHLT) and managers. There has been a conscious effort to hire longer duration temporary positions (as opposed to permanent) to manage the pandemic response. Some work has been outsourced to Public Health Ontario and medical students as appropriate. In addition, there has been some success attracting student placements (e.g. Environmental Health division) to support focused areas of work such as beach monitoring.

There is a need to explore cash incentives and other perks (i.e. work from home) as a recruitment strategy, as well as to consider non-traditional roles to fill staffing gaps (non PHN, non PHI) or broader/generic job descriptions to allow flexibility. PHLT continues to work closely with Human Resources and Finance to attract and retain appropriate staff to support both the Pandemic Response Division (PRD) and Business Continuity efforts through the use of social media and attraction branding (i.e. LinkedIn).

The PHLT has undertaken strategic planning to set priorities for October 2021-June 2023 and have been working to align resources and set realistic expectations. Bi-weekly redeployment and repatriation meetings take place to discuss staffing pressures and allocate staff to support business pressures in an agile manner. Finally, Public Health will continue to work with community partners and stakeholders to support vaccine delivery needs such as providing

training and support to the long term care homes and primary care from a COVax perspective and to reduce pressure on Public Health.

Operational/Service Delivery

- (a) **Pandemic Uncertainty** – There continues to be unknown expectations for vaccine administration (third doses, vaccine hesitant groups, and 5 - 11 year olds) and distribution responsibilities with multiple levels of government involved, and multiple siloed units within each level of government. There are also new demands on core Public Health work, such as the increases in opioid use, sexually transmitted infection rates, and mental health concerns that have increased due in part to the Pandemic. There are also some early indications that child mental health, violence in the home, and childhood overweight status and obesity have been exacerbated over the past 18 months.

In order to address the vaccine administration and distribution issues, NRPH has continued to work closely with internal and external partners and have modified the large mass immunization clinic sites to smaller sites. There are also significantly more pop-up clinics across Niagara, underpinned by the timely data and evidence, and outreach to reach those who are more vaccine hesitant. There continues to be close inspection of staffing required to maintain this level of operation and extensive communications required to support this more granular approach to vaccine administration. However, there continues to be unknown expectations from a vaccine perspective and most are beyond the control of NRPH.

The strategic planning priorities for 2021 - 2023 will also help to identify and hone resources to address both COVID-19 and Business Continuity related issues and identify priorities. Financial analyses based on gapping dollars has allowed PHLT to identify staffing needs to address both PRD and Business Continuity related priorities.

- (b) **Pandemic Recovery** – A major risk continues to be the impending post-pandemic right-sizing of the departmental budget and staffing after major scaling up for pandemic. There will be impacts on morale, loss of talent, retirements, etc.

In order to address this, PHLT has been keeping abreast of information related to the Annual Service Plan and Budget Submission and reporting, while the Medical Officer of Health (Acting) liaises with the Committee of Medical Officers of Health

(COMOH). The Ministry of Health has given an early signal that there will be opportunities for one time funding to support recovery efforts.

Significant work needs to be undertaken to ensure a smooth transition from having a Pandemic Response Division to disassembling this division and eventually having COVID-19 related work encompassed within the usual lines of Public Health business. This will require a large concerted effort of senior leadership, human resources, and finance to strategically plan and execute this over the coming 18 - 24 months. Significant communications will be required from both an internal staff and external perspective.

Finance

The cost sharing funding ratio remains at 70% Ministry of Health and 30% Regional Municipality of Niagara. Very few programs continue to be 100% funded (i.e. harm reduction funding, Seniors Dental program). While the Regional Municipality of Niagara operates on an annual budget cycle, the Ministry of Health operates on the province's fiscal calendar (April to March). This often contributes to a delayed announcement for formal budget approval well into the third quarter. This year, the Ministry has supported health units by disbursing partial funding quicker especially with the unprecedented spending due to COVID-19. However, full approval of the budget and release of funding remains pending at the time of writing this memo in late October, resulting in the funding source being approved by BOH as stabilization reserves. As well, there continues to be a risk of inconsistent funding and impact on equitable resources for clients across Public Health. While the Ministry included a one-time increase of \$455,000 in mitigation funding for 2021 and there are plans on maintaining this increase in 2022, this will not fully relieve the budget pressures for Business Continuity resources.

Uncertain provincial funding for extraordinary expenses and reduced service levels for core programs and services due to redirected resources continues to take place due to the Pandemic. Recovery efforts will be significant due to the lack of ability to provide core services during the pandemic and there is a need for sustainable long-term funding. In addition, with expiring union contracts, there is the potential for more difficult salary negotiations in 2022 and beyond. Staff have been leaving for remote working high paid positions within Ontario and NRPH is unable to compete with salaries for certain positions (PHNs, PHIs, Informatics and Analytics, Communications, etc.).

In order to address these risks, NRPH will work closely with the Finance team and the Ministry of Health to submit a realistic mandatory program budget taking into consideration the pandemic recovery efforts. PHLT will continue to examine gapping positions and permanent reductions may be needed to manage budget. Reallocation and prioritization of projects and resources will need to occur based on surveillance data. It is likely that there will be increased collaboration with stakeholders to deliver certain areas of programming and there of course will be the continual alignment of operational planning with budgets. COMOH discussions with the Ministry have been taking place re: funding for COVID-19 efforts and recovery and this group will continue to liaise with the Ministry. Finally, there is a need to re-examine pay scales relative to specialist positions to ensure competitive salaries for both union and non-union groups in order to recruit and retain a strong workforce.

Governance/Organizational

Organizational Uncertainty – Currently, the Region on Council's direction is seeking a consultant to review the existence of the Public Health Communications & Engagement team and potentially transferring responsibilities to the municipal government's Communications team. A Request for Proposal (RFP) is currently underway to identify the consultant to do this as well as develop the Niagara Region Communications Master Plan. The uncertainty of the team's ongoing existence at a time of already intense workload and criticism has led to staff anxiety due to feeling undervalued, fear of losing jobs and/or being transitioned to another team. Three employees, including two senior Public Health communications staff have already left as a consequence of the disengagement created from this review. This potential fusion continues to be a large risk from a Public Health perspective as health messaging has the potential to become politicised (e.g. Section 22s being issued etc.) or may compromise the MOH's autonomy to be able to communicate health risks to the public without pressure to sanitise messaging.

In order to address this, the Chief of Staff and the Director of Organizational and Foundational Standards are active participants in the RFP process and continue to have open dialogue with decision makers, and the Medical Officer of Health will continue to provide presentations to the board of health on this particular topic, communications to the public through media on health risks, and gathering insights from previous reports (e.g. post-SARS reports).

Political

Scrutiny of Decisions – Over the past 18 months, there has been heightened scrutiny with decisions to support COVID-19 (i.e. Section 22 orders, use of masks, vaccination policies, third doses, etc.), while existing community health issues (such as opioids, mental health, sexually transmitted infections, and poor diet and sedentary behaviours) continue to be exacerbated by COVID-19 and receive sporadic media and political attention.

NRPH continues to build, retain, and sustain productive relationships with government stakeholders at all levels and engage in pilot projects with the Ministry of Health to lead change. NRPH also provides regular correspondence, presentations and education for councillors (i.e. memos, info-graphics, presentations) to keep them apprised of COVID-19 and other health topics.

Throughout the Pandemic, the MOH has hosted sessions for local politicians on COVID-19 response and worked collaboratively with partners. Public Health provides stakeholders with daily COVID data and other conditions when data are available. NRPH continues to prioritize high-risk programming to support vulnerable populations and to advocate for the Public Health voice to be engaged in vaccination decision making.

Risks have the ability to impact the achievement of established objectives in a positive or negative way. Developing plans to mitigate the risks, should they arise, is a proactive way to mitigate threats and take advantage of opportunities while meeting objectives and improving outcomes. NRPH will continue to monitor and reassess risks as part of good management practices to effectively manage risk.

Respectfully submitted and signed by

M. Mustafa Hirji, MD MPH FRCPC
Medical Officer of Health & Commissioner (Acting)
Public Health & Emergency Services

Sinéad McElhone, BSc DPhil
Director, Organizational & Foundational Standards (Acting)
Public Health & Emergency Services

MEMORANDUM

COM-C 34-2021

Subject: Shelter Diversion Pilot Update
Date: November 9, 2021
To: Public Health & Social Services Committee
From: Adrienne Jugley, Commissioner, Community Services

This memo is in response to a request from a member of the Public Health and Social Services Committee to provide an update on the shelter diversion pilot.

Building on The RAFT's successful youth shelter diversion pilot program, Niagara Region funded the pilot expansion of the shelter diversion program to two additional emergency shelters: Southridge Community Church Shelter in late 2019 and Nightlight Youth Services (Boys and Girls Club of Niagara) in 2020. The goal was to expand and test a centralized diversion approach with adults, as well as youth, experiencing homelessness and to support individuals presenting to different emergency shelter sites to access alternate housing arrangements where possible, rather than a shelter stay.

Diversion utilizes a number of approaches such as:

- offering financial, utility, and/or rental assistance;
- short-term support or support coordination with other involved service providers;
- conflict mediation;
- connection to social/ family support, services and/or benefits; and
- housing search support.

In the current model, individuals seeking to access emergency shelter are connected with a diversion worker, whose goal is to learn more about the individual's current housing situation, and what they need, so that it is possible to identify and explore safe, alternate housing arrangements.

In the most recent 12 months of available data (July 2020 to June 2021), the pilot has reported 117 successful diversions for 104 unique youth (age 16-24 years), representing 36% of possible shelter intakes in that period. In the same period, there have been 138 successful diversions for 124 unique adults (age 25+), representing 11%

of possible shelter intakes. The following table contains information on the diversion rates.

Successful Diversion	Youth new to shelter system	All youth presenting at shelter including those that are new	Adults new to shelter system	All adults presenting at shelter including those that are new
No	48.5%	64.3%	76.3%	89.4%
Yes	51.5%	35.7%	23.7%	10.6%
Total	100.0%	100.0%	100.0%	100.0%

Niagara Region has been working closely with The RAFT, Southridge Community Church, and Nightlight Youth Services on the development of system-wide training program and standardized diversion assessment questions that can be implemented across key access points into the homelessness system, starting with emergency shelters and the Niagara Assertive Street Outreach team. This will achieve a consistent approach to diversion across the homelessness system as we work together to create a Coordinated Access System in Niagara.

In addition, Niagara Region, alongside its community partners, will engage a third party evaluator to review the current shelter diversion program. This will include an updated scan of promising practices/literature, comparison with other models, review of successes, opportunities for improvement of the current model, and the provision of recommendations for a proposed diversion approach to possibly expand across key access points into the homelessness serving system.

Made possible through COVID-19 funding, Niagara Region took the opportunity to enhance diversion as part of the broader pandemic response, to support shelter capacity within the system by diverting individuals where possible to alternate housing arrangements. Provincial and federal COVID funding comes to an end as of March 31, 2022, but it is hoped that learnings of the pilot, and recommendations of the third party evaluation, will assist with homeless system planning and the determination of a possible return on investment to assist with future budget deliberations. Staff have submitted a one time budget request for 2022 to support an extension of the diversion pilot, along with other critical programs, currently supported with emergency COVID funding as it is anticipated that pandemic-related pressures will exist in the homelessness system beyond March 31, 2022.

Respectfully submitted and signed by

Adrienne Jugley, MSW, RSW, CHE
Commissioner