Toronto Seniors Housing Corporation

Quality and Tenant Engagement Committee (QTEC) Meeting Agenda

Date: Tuesday, September 30, 2025

Time: 3:00 pm to 5:00 pm

Location: WebEx and Livestream

Item	Time	Description	Action	Type of Item	Presenter
1.	3:00 pm 2 min	Chair's Remarks	Information	N/A	Chair
2.	3:02 pm 2 min	Land and African Ancestral Acknowledgements	N/A	N/A	Chair
3.	3:04 pm 1 min	Approval of Public Meeting Agenda	Approval	Agenda	Chair
4.	3:05 pm 1 min	Chair's Poll re: Conflict of Interest	Declaration	N/A	Chair
5.	3:06 pm 1 min	Approval of QTE Public Committee meeting minutes of July 14, 2025	Approval	Minutes	Chair
6.	3:07 pm 1 min	Action Items Review	Information	List	Chair
7.	3:08 pm 5 min	CEO Update	Information	Verbal Report	Tom Hunter
8.	3:13 pm 10 min	OCHE Bi-Annual Report Jan 1-June 30, 2025	Information	Report	Melanie Martin
9.	3:23 pm 10 min	Operational Dashboard	Information	Report	Brad Priggen
10.	3:33 pm 10 min	Strategic Directions Q2 2025 Progress Report	Information	Report	Grant Coffey

Item	Time	Description	Action	Type of Item	Presenter
11.	3:43 pm 25 min	Future Strategic Directions Project	Information	Report	Grant Coffey
12.	4:08 pm 5 min	Engagement, Partnerships and Communications Update	Information	Verbal	Deanna Veltri
13.	4:13 pm 15 min	Community Safety Unit Q2 Report	Information	Report	Allan Britton
14.	4:28 pm 30 min	Aging at Home Service Delivery Models	Information	Report	Deanna Veltri/ Tom Hunter/ Arlene Howells
15.	4:58 pm	Adjournment	Approval	N/A	Chair

Toronto Seniors Housing Corporation

Toronto Seniors Housing Corporation (TSHC)

Quality and Tenant Engagement Committee Meeting (QTEC)

Date: Monday, July 14, 2025
Time: 3:00pm to 5:00pm
Location: WebEx and Livestream

The Quality and Tenant Engagement Committee (QTEC) of the TSHC Board held its meeting on Monday, July 14, 2025, at 3:00pm via WebEx video conference. **This meeting was livestreamed and can be viewed here**.

Members in attendance:
Linda Jackson, Chair
Fareed Amin
Jim Meeks
Lawrence D'Souza
Councillor Crisanti

Guests:
Emily Gaus, Manager (A), Housing Stability Services City of Toronto

Deputant:
Arnold Margulis

TSHC staff present:
Tom Hunter, Chief Executive Officer
Grant Coffey, Director, Strategy and Business Management
Deanna Veltri, Director, Engagement, Partnership and Communications
Brad Priggen, Director, Operations
Carol Francis, Director, People & Culture
Wendy Dobson, Manager, Communications and External Affairs
Sandra Mageau-Marsh, Supervisor, Complex Tenancies
Thusany Puvanendran, Business Consultant
Karyn Bawden, EA and Board Secretary
Fatima Mahmood and Emma Francis, EAs

Item 1: Chair's remarks

The Chair, Linda Jackson, welcomed Committee members, Board, Staff and online participants to the Quality and Tenant Engagement Committee meeting of July

14, 2025. Ms. Jackson stated that the meeting was being live streamed on YouTube.

The Chair acknowledged that July 18, 2025 is Nelson Mandela International Day, a day that is observed to celebrate the life and legacy of Nelson Mandela, the former president of South Africa and global advocate for human rights.

The Chair noted there was full agenda, bringing forward the TSHC Translation and Interpretation Policy, the Operational Dashboard, a Local Housing Corporation Report Update and a TSHC Follow-up Support Initiative (Complex Tenancies). As well, the Chair noted there will be a verbal update on Engagement, Partnerships and Communications. She also state there were deputations on Item 8 - Translation and Interpretation Policy and Item 9 - Operational Dashboard and Item 11 - TSHC Follow-up Support Initiative.

The Chair then proceeded to the next agenda item.

Item 2: Land and African ancestral acknowledgements

The Chair began with Land and African ancestral acknowledgements.

Item 3: New Business and Approval of public meeting agenda

The Chair asked if there were any changes to the July 14, 2025 QTEC Public meeting Agenda, being none, she asked for a motion to approve the Public Agenda of July 14, 2025 as presented.

Moved: Jim Meeks
Seconded: Fareed Amin

With All in favour, it was resolved that the QTEC Public Agenda of July 14, 2025 was approved as presented .....**Carried**

Item 4: Chair's poll re: conflict of interest

The Chair asked the members of the Committee whether they were in conflict of interest with any agenda item. With no conflicts of interest being declared, the Chair continued to next Action Item.

Item 5: Approval of public minutes of QTEC meeting May 26, 2025

The Chair asked for a motion to approve the QTEC Public meeting Minutes of May 26, 2025

Moved: Jim Meeks
Seconded: Fareed Amin

With All in favour, it was resolved that the Amended QTEC Public meeting Minutes of May 26, 2025, were approved as presented ..... **Carried**

Item 6: Action items review

The Chair noted there were no outstanding Action Items and asked the Committee if there were any comments. With none, the Chair proceeded to the next agenda item.

Item 7: CEO Update

At the Chair's invitation, Tom Hunter went through his CEO update, highlighting:

- Updated Tenant Welcome Guide and a revised lease package
- City Talks
- Supporting Tenants during Heat Waves

- OCHE and TSHC present: Joint Arrears Case Conferencing and Tenancy Management Support
    - First session scheduled July 17, 2025

The Chair thanked Mr. Hunter and the Committee had a wholesome discussion, particularly around Air Conditioning for tenants. It was noted that although the mayor had offered up 500 air conditioning units, it is just not enough. It was recommended to reach out to private sector for donations. With that, the Chair proceeded to the next agenda item.

Item 8: Translation and Interpretation Policy

The Chair noted there was a deputation for this item and welcomed Mr. Margulis. Mr. Margulis thanked the Chair and Committee and highlighted a few areas of the policy being:

- Thanked staff and noted Translation is a necessity
- Code of Conduct to be multiple languages
- Seniors Speak to have links to other languages

The Chair thanked Mr. Margulis and then, through the invitation of the Chair, Deanna Veltri introduced Wendy Dobson, Manager, Communications and External Affairs and Thusany Puvanendran, Business Consultant. Ms. Dobson then went through the Translation and Interpretation Policy.

The Chair thanked Ms. Veltri, Ms. Dobson and staff and asked the Committee and Board if there were any comments or questions. There was a wholesome conversation among the Committee, with a few points from Fareed Amin, Board Chair, being: 1) Expand Translation past top 12, 2) Standardize Template for easy access for tenants and 3) Delegation (option to subscribe to newsletter).

The Chair thanked Mr. Amin and with comments noted, asked for a motion to approve the TSHC Translation and Interpretation Policy

Moved: Jim Meeks
Seconded: Fareed Amin

With All in favour, it was resolved that the TSHC Translation and Interpretation Policy was approved ..... **Carried**

The Chair then proceeded to the next Agenda Item.

Item 9: Operational Dashboard

The Chair noted there was a deputation for this item and welcomed Mr. Margulis. Mr. Margulis thanked the Chair and noted a few items, being:

- Ventilation and chemical contamination (pesticides) have decreased
- Official Investigations/inspection of unit
- TCHC Board Reports

The Chair thanked Mr. Margulis and then, at the invitation of the Chair, Brad Priggen went through the Operational Dashboard, highlighting:

- Monthly Summary
- Arrears
- Vacancies
- Maintenance Work Orders
- Administrative Requests (Tickets)
- Pest Management

The Chair thanked Mr. Priggen and then proceeded to the next Agenda Item.

Item 10: Local Housing Corporation (LHC) Report

At the invitation of the Chair, Brad Priggen went through the Local Housing Corporation (LHC) Report, highlighting:

- Housing Occupancy Rate
- Unit Turnover Days
- Tenant Move Out Rate
- Households in Good Financial Standing
- Rent Collection Performance
- Percentage No. of Tenant with Debt
- Average Amount of Arrears

The Chair thanked Mr. Priggen for the important information and then proceeded to the next Agenda Item.

Item 11: TSHC Follow-up Support (FUS) Initiative (Complex Tenancies)

The Chair noted there was another deputation from Mr. Margulis on this Item and welcomed him. Mr. Margulis thanked the Chair and noted a few items, being:

- Enterprise Management System
- Privacy
- Community Safety Units and what is shared
- Policy of sharing information (privacy policies)

The Chair thanked Mr. Margulis for his deputation and then at the invitation of the Chair, Brad Priggen welcomed Sandra Mageau-Marsh, Supervisor, Complex Tenancies and Emily Gaus, Manager (A), Housing Stability Services, City of Toronto. Ms. Mageau-Marsh went through the FUS Initiative, highlighting:

- Background/Overview
- How Tenants are Selected
- Referral Process
- Pilot Workplan

The Chair thanked Ms. Mageau-Marsh and there was a conversation around the Pilot Workplan. It was noted the Pilot came to fruition from the success from the RRH program and the Committee looks forward to the data from the pilot. With that, the Chair continued to the next Agenda Item.

Item 12: Engagement, Partnerships and Communications Update

At the invitation of the Chair, Deanna Veltri gave a verbal update on Engagement, Partnerships and Communications, highlighting:

- Socials (Mother's Day, Father's Day, Canada day)
- BBQs
- Regional Tenant meetings
- Seniors Speak Summer Issue

The Chair thanked Ms. Veltri and proceeded to the final agenda item.

Item 13: Adjournment

The Chair thanked the Committee members, Board, Staff, guests and the online attendees to the TSHC QTEC July 14, 2025, meeting and asked for a motion to adjourn the meeting.

Moved: Jim Meeks
Seconded: Fareed Amin

With All in favour, it was resolved that the TSHC QTEC July 14, 2025, meeting terminate ..... **Carried**

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Linda Jackson, Chair
Quality and Tenant Engagement Committee

Toronto Seniors Housing Corporation

Toronto Seniors Housing Corporation (TSHC)
Quality and Tenant Engagement Committee (QTEC)

Action Items List as of July 2025

Action items				
	Meeting Arising From	**Description**	**Resp**	**Status**
	No outstanding items as of July 14, 2025			

Completed Action items				
	Meeting arising from	**Description**	**Resp.**	**Status**
1.	March 24, 2025	Bring to Committee NORC Report	Deanna Veltri	Completed
2.	March 24, 2025	Bring to Committee Move-Out Report	Brad Priggen	Completed
3.	November 18, 2024	Tenant Work Orders Submitted	Brad Priggen	Completed
4.	November 18, 2024	Provide report of Rapid Re-housing bi-annually to QTE Committee	Tom Hunter/ Brad Priggen	Completed
5.	Sept 30, 2024	Provide stats on CCTV Cameras to Board	Brad Priggen	Completed

Toronto Seniors Housing Corporation

Quality and Tenant Engagement Committee (QTEC) Meeting

Meeting Date: September 30, 2025

Topic: OCHE Update – January 1 to June 30, 2025

Item Number: 08

To: Quality and Tenant Engagement Committee

From: Interim Commissioner of Housing Equity

Date of Report: September 30, 2025

Purpose:

To provide the TSHC Quality and Tenant Engagement ("QTE") Committee and the Board of Directors with the Office of the Commissioner of Housing Equity's ("OCHE") update for the period of January 1 to June 30, 2025.

Recommendation:

It is recommended that the QTE Committee review and receive this Report for information and forward it to the TSHC Board of Directors for information.

Reason for Recommendation:

This Report highlights the OCHE's case management, audit, and policy work through the period of January 1 to June 30, 2025, and focuses on the work metrics as outlined in the TCHC Board-approved 2025 OCHE Work Plan.

Data for the reporting period has been compared to the data reported on in 2024.

Introduction

In this period, the OCHE continued to support tenants to avoid evictions and reduce arrears. The results of the case management work and Arrears Collection Process ("ACP") audit findings are included in this report.

In addition to supporting tenants to remain housed, the OCHE is committed to supporting TSHC to lower the total arrears owing to the organization. The OCHE does this with the assistance of community partnerships described in Section 6.0 of this report. Through theses partnerships the OCHE has been able to reduce arrears owing to TSHC more quickly. In addition, the partnership the OCHE initiated with WoodGreen to access its Tax link program, has been expanded to Toronto Community Housing Corporation ("TCHC") and TSHC staff. This initiative is projected to stabilize over 1,000 tenancies in Year 1 and reverse over $5 million in arrears charged annually.

In Section 3.0 of this Report, the OCHE provides an update on the success of the monthly Dashboard Meetings. Through these meetings as well as discussions with TSHC senior management, it was determined that files where the service of the Ontario Public Guardian and Trustee ("OPGT") was needed, remain unresolved longer than usual as there is a delay until the OPGT becomes guardian. Section 8.0 provides a detailed account of the steps involved with an OPGT file and describes the reasons for the delay. Also included is a systemic Finding and Recommendation related to these unique files, which suggests they should be monitored separately from other arrears files.

Lastly, in Section 7.0 of this Report, the OCHE provides an overview of a new initiative which is underway and showing positive results. Once per month, a Case Conference, co-hosted by TSHC and the OCHE is being held, where frontline staff and managers can attend to problem solve cases, ask questions about OCHE processes, and seek feedback to resolve arrears cases.

1.0 Referrals to the OCHE

The following chart shows the number of referrals to the OCHE. These numbers represent all regular referrals.

Region	January 1 to June 30, 2024	July 1 to December 31, 2024	January 1 to June 30, 2025
Total	170	125	138

1.1 Referrals Sent Back to TSHC

In this period, 58 files[1] were returned to TSHC, and most of these files were returned for reasons other than ACP compliance. This is a positive result as it demonstrates that TSHC is addressing arrears with tenants without the need for an OCHE intervention.

Of the 58 files which were sent back for any reason, only 9% (5/58) were re-referred to the OCHE for intervention. This indicates that the Sent Back process is working well to both build Senior Services Coordinator ("SSC") capacity and to use the OCHE as an office of last resort.

1.2 Arrears at the Time of Referral

From January 1 to June 30, 2025, the OCHE assigned 87 cases to Early Resolution Officers ("EROs") to address the arrears. These represented a total of $233,465.94 in arrears owing.

Of the files referred in this period, there were only three cases where the arrears exceeded $10,000.00 and all three had been previously reviewed by the OCHE. In these instances, the regions flagged these files as highly vulnerable and would benefit from a second intervention from the OCHE to stabilize the tenancies. It is

[1] Sent back – 13 of the 58 were received in a previous reporting period.

important to note that 67% (58/87) of the referrals to the OCHE were files where the arrears were under $3,000.00 at the time of referral. This demonstrates that arrears are being addressed by TSHC before they accumulate to an unmanageable level and that referrals are being made according to the timelines of the ACP.

The chart below breaks down the arrears at the time of referral to the OCHE:

Arrears owing at time of referral	Total of arrears		
	2024 Q1/Q2	**2024 Q3/Q4**	**2025 Q1/Q2**
$20k and over: # of Households:	-	$21,696.20 1	-
$10k – $19.9k: # of Households:	$41,424.00 3	-	$33,099.00 3
$5k – $9.9k: # of Households:	$73,439.93 10	$46,030.87 7	$24,946.00 4[2]
$2k – $4.9k: # of Households:	$118,949.96 38	$100,300.50 30	$128,717.03 38
$186.00 – $1.9k: # of Households:	$72,703.68 62	$67,258.32 60	$46,703.91 42
TOTAL VALUE TOTAL HOUSEHOLDS:	**$306,517.57 113**	**$235,285.89 98**	**$233,465.94 87**

2.0 Arrears Collection Process Compliance

While working with individual tenants to avoid eviction and identify underlying issues, the OCHE conducts an audit to ensure compliance with the ACP, the Eviction Prevention Policy and applicable legislation. At the conclusion of this

[2] 2 were Stage two files; 1 file was at a Loss of Subsidy at the time of referral.

work, the Commissioner issues a report containing recommendations to TSHC and the Tenant.

From January to June 30, 2025, the OCHE issued 85 reports with a total of 9 unique recommendations. It should be noted that in 11% (9/85) of cases, the ACP was followed perfectly. Additionally, in the OCHE's last Bi-Annual Report, it was noted that the finding for 'Documentation Standards' was addressed in the OCHE/TSHC Monthly Dashboard meetings and that this finding would improve going forward. The Chart below confirms that this was the case. This also demonstrates the value of the Monthly Dashboard meetings which are discussed in Section 3.0.

Of the 9 of unique recommendations made to TSHC, only 4 were significant. These are described in the chart below:

ACP Findings	January 1 to June 30, 2024	July 1 to December 31, 2024	January 1 to June 30, 2025
Make direct contact with the Tenant in the first month of arrears exceeding one month's rent plus $1.00 or $700.00 in arrears	38% (38/101)	34% (31/92)	44% (37/85)
Serve the Notice to Terminate the Tenancy in accordance with Arrears Collection Process timelines	41% (41/101) Avg arrears: $1,827.80	34% (31/92) Avg arrears: $1,749.77	42% (36/85) Avg arrears: $1,287.47
Documentation Standards not met: N4 Cover letter not sent or incomplete, Legal Card not updated as per ACP	79% (79/101)	74% (68/92)	29% (25/85)
Send the Notice to Terminate the Tenancy once /do not send multiple Notices to Terminate the Tenancy	16% (16/101)	10% (9/92)	15% (13/85)

3.0 Monthly Dashboard Meetings

In 2024, the OCHE began hosting Monthly Dashboard sessions with TSHC Supervisors and Managers. The goal for these meetings is to present the audit findings each month as recorded at the conclusion of each individual file closed in the previous month. In this way, TSHC can quickly course correct if necessary as emergent issues are identified. For example, as described in Section 2.0, when the audit findings revealed an increase in the number of files with findings around 'Documentation Standards,' it was immediately identified as being due to the letters that accompanied the N4. As evidenced in the audit findings presented in this report, this issue has been resolved. The importance of these meetings to pinpoint and correct issues, or to make amendments to the ACP if needed, has been acknowledged by TSHC.

4.0 OCHE Case Management Highlights

The OCHE captures data related to the EROs' engagement rate, as determined by the number of tenants who elected to work with the OCHE.

The chart below demonstrates the number of tenants willing to work with the EROs and the number of those tenants who were able to avoid a referral to the Landlord Tenant Board ("LTB") because of that work.

	July 1 to December 31, 2023	January 1 to June 30, 2024	July 1 to December 31, 2024	January 1 to June 30, 2025
Engagement Rate	99% (77/78)	98% (98/101)	100% (92/92)	98% (83/85)
Avoided the need for eviction	94% (73/78)	83% (84/101)	96% (88/92)	93% (79/85)

4.1 Arrears Managed by the OCHE

In this reporting period, the OCHE issued 85 reports, which accounted for $314,118.87 in arrears.

(a) Total arrears directly paid to TSHC totaled $239,688.83

- Direct payments totaled $183,470.35 from the following sources:
  - $8,864.00 directly from tenants/tenants' families (9 cases)
  - $1,207.00 Housing Stabilization Fund (HSF) (2 cases)
  - $173,399.35 Toronto Rent Bank (61 cases)
- Resolving Losses of Subsidy: $40,574.00 (9 cases)
- Completing Annual or an 'In Year' Reviews: $15,644.48 (6 cases)

(b) Arrears managed through Local Repayment Agreements (LRAs)

- $62,929.04 (24 cases) in arrears were managed through Local Repayment Agreements and will be paid back to TSHC over time (see Section 4.2) and have not yet been collected in full.

(c) Arrears approved to be forwarded to the Landlord and Tenant Board ("LTB")

- $11,501.00 (6 cases) in arrears were not resolved by the OCHE and it was instead recommended that TSHC file an L1 Application at the LTB, where the Tenant would have an opportunity to enter into a Mediated Agreement.

4.2 Arrears Managed Through Local Repayment Agreements

In this period, the OCHE brokered a total of 24 LRAs representing $62,929.04 in arrears owing. In considering tenants' income and expenses when brokering LRAs, the arrears repayment averaged $96.00 per month. The new partnership with the Toronto Rent Bank (see Section 6.0) has had a positive impact on the LRAs brokered, due to the LRA being avoided altogether or the length of the LRA decreasing due to the lump sum payments made by the Toronto Rent Bank. Of the

61 cases where funds were received from the Toronto Rent Bank, only 13[3] required an LRA to address the balance still owing.

The OCHE organized the size of the arrears at the time of brokering LRAs into categories based on the size of the balance owing. Below is a summary of the LRAs brokered by the OCHE based on these categories. These results are extremely positive:

Arrears owing	Total of arrears	Number of Cases	Average repayment amount	Average length of LRA (months)
$20k and over	-	-	-	-
$10k – $19.9k	$10,495.00	1	$300.00	35
$5k – $9.9k	$17,143.00	3	$112.00	51
$2k – $4.9k	$21,636.13	7	$91.00	36
$186.00 – $1.9k	$13,654.91	13	$79.00	14
TOTAL:	**$62,929.04**	**24**	**$145.50**	**34**

5.0 Breached OCHE Brokered Local Repayment Agreements

When the OCHE receives a Breach File, the EROs are tasked with determining whether exceptional circumstances existed warranting a new LRA. If there are no exceptional circumstances, the OCHE reports back to TSHC and recommends that they proceed to file an L1 Application at the LTB.

[3] The average length of the LRA was 33 months for households who accessed TRB funds and still required an LRA. Without the lump sum payments, the average length of the LRAs would have been 95 months.

The following chart describes the Breach referrals received:

Breach Files	January 1 to June 30, 2024	July 1 to December 31, 2024	January 1 to June 30, 2025
Total Breach Referrals	56	51	28
Sent back cases[4]	11	13	8
Breach cases reviewed:			
No Exceptional Circumstances	12	5	3
Unable to reach the Tenant to determine exceptional circumstances	9	4	2
Exceptional Circumstance - Report issued to TSHC	15	30	11

The total number of Breach files referred to the OCHE in this period has dropped significantly. This suggests that TSHC is catching missed payments quickly and getting tenants back on track, thereby avoiding an OCHE referral. It also confirms that due to the Toronto Rent Bank paying arrears balances in full, there are fewer LRAs being brokered, which is positive for tenants and for TSHC's total arrears balance.

[4] Sent back because ACP was not followed, LRA was in good standing, tenant passed away, arrears paid and sent to the OCHE in error

6.0 Community Partnerships

WoodGreen Community Services, Tax Link Service – Update

In 2025, the OCHE, in collaboration with WoodGreen, TCHC, and TSHC drafted a grant proposal to secure funding to expand access to WoodGreen's Tax Link Services to TCHC and TSHC staff. The Housing Secretariat (City of Toronto) approved funding for a one-year pilot program to support the WoodGreen Tax Link expansion to TCHC and TSHC. This expansion also includes extending Tax Link services to three Anchor Agencies under the Anchor Agency Services and Support pilot – COTA Health, Homes First Society, and Scarborough Centre for Healthy Communities, with at least one housing worker from each agency receiving training to support remote tax clinic services for TCHC and TSHC tenants in specific buildings.

As of August 13, 2025, TCHC's Community Servies Coordinators ("CSCs") and TSHC's SSCs were trained and given access to this important resource. The OCHE participated in the training roll-out for these staff members.

It is projected that by expanding access to this program to TCHC and TSHC the following benefits will be realized:

- Enable 38 TSHC SCCs and 45 CSCs to access Notices of Assessment ("NOA") and file taxes using Tax Link.
- Serve at least 1,000 tenants in Year 1, with potential to scale to 1,200 in subsequent years.
- Leverage additional tax preparer volunteers to support the model.

This initiative is projected to stabilize over 1,000 tenancies (at TCHC and TSHC) in Year 1 and reverse over $5 million in arrears charged annually. It should be noted that proactively assisting tenants in this way will decrease the need to process losses of subsidies due to non-return of the Annual Review, creating time

efficiencies for TSHC and reducing the need to refer files to the OCHE for this reason.

Resolving arrears includes reversing losses of subsidy and more important, preventing future losses of subsidy. It has become evident that the timely filing of income tax returns is crucial. With the expansion of the WoodGreen Pilot program to SSCs, it is expected that the total arrears owed to TSHC will decrease due to the faster processing of ARs.

In this period, the OCHE assisted tenants to file their taxes, or to access NOAs in 33 cases by using WoodGreen's Tax Link Service. This easy access to tax filing and NOA retrieval assists with the completion of the AR and preventing or reversing losses of subsidy. The NOA is also used by the OCHE to access funding from the Toronto Rent Bank.

The chart below describes the success realized through the partnership with WoodGreen's Tax Link Program:

Total households referred to Tax Link January 1 – June 30, 2025	# of Households avoided eviction	$ value of arrears reduced after processing rent reviews
33	100% (33/33)	$48,595.48

Toronto Rent Bank (TRB)– Update

The OCHE continues to be the administrator of the RGI Rent Bank Pilot and the only organization who can refer RGI tenants to the TRB for funding. The benefits of this funding to TSHC and to tenants is evidenced by the reduction in the length of LRAs and, in most cases, the elimination of tenants' arrears altogether. This not only supports TSHC to reduce its total arrears balance but also supports tenants to achieve successful tenancies and supports the City's mandate to ensure that individuals and families are able to stay in their homes and avoid homelessness.

In this period, the average length of the OCHE brokered LRAs was 37 months for households who accessed TRB funds and still required an LRA. Without the lump sum payments from the TRB, the average length of these LRAs would have been 100 months. Additionally, as the chart below indicates, of the 70 people who accessed the TRB in this period, only 16 required an LRA. Please note the numbers below include the cases referred to the OCHE as a Breached LRA file.

Total files referred to Rent Bank	Total $ of arrears recovered	Number of Households paid in full	$ of arrears paid in full	Number of files which required LRA	Average length of LRA
70	$201,481.35	54	$121,481.35	16	37 months

7.0 New Initiatives

Case conferences:
In this period, the OCHE and TSHC set up monthly Case Conferencing sessions for TSHC staff where they were invited to discuss their cases with the OCHE staff. This achieves two important goals:

1. Improving relations between TSHC and the OCHE by offering transparency on case resolutions, files sent back and how files are screened and audited for ACP Compliance.
2. Identifying relevant topics for discussion or learning opportunities for future sessions.

Two case conferences have been held at the time of writing this report with an average attendance of 60 TSHC staff. Both were heralded by participants as helpful. Front-line TSHC staff shared their successes and frustrations in working with tenants and they not only benefited from hearing about how the OCHE handles similar situations, but also from each other. During both sessions participation was high, and feedback collected afterward was 100% positive. Based on the discussion from the first case conference, the OCHE presented a short

workshop at the second case conference on working with tenants on budgeting. By presenting information that has been identified by staff as having relevance, it was a productive exercise and the OCHE is enthusiastic about continuing in this way through to the end of 2025.

Also, from the case conferences and monthly meetings with TSHC senior management an issue was raised regarding cases referred to the Office of the Public Guardian and Trustee ("OPGT"). As a result, the OCHE completed an analysis of these cases and the results are provided below.

8.0 Files with referrals to the Ontario Public Guardian and Trustee

In some cases, TSHC tenants, lack the capacity to manage their finances and this impedes the OCHE from productively working with these tenants to reverse losses of subsidy and address arrears owing. When this occurs, the ERO forwards a referral to the OPGT requesting that they open an investigation. The OCHE advises the OPGT that the Tenant's capacity issues are creating a severe adverse effect on their finances, placing the Tenant at risk of losing their home due to the accumulation of arrears. As losing control over one's finances is serious, it should be noted, that the OCHE always attempts to resolve these files without the OPGT. First steps include: setting up Pre-Authorized Payments ("PAP"), recurring bill payments through the Tenant's bank, enlisting the services of a Voluntary Trustee, or involving family members are always considered first. However, the Voluntary Trustee will refuse service if they too, suspect a capacity issue and PAPs will be returned to due Non-Sufficient Funds ("NSF") if a tenant truly lacks the capacity to manage their finances. Additionally, the HoMES system is not set up to for flexibility in payments or to pay down arrears, via PAP.

When a referral is made to the OPGT, there are two ways it can be resolved. If the Tenant consents to a capacity assessment, it will be completed more quickly, and if the Tenant fails the assessment, the OPGT will gain control of the Tenant's finances. Obtaining this control can take several months as eliminating every other option, such as a family Power of Attorney, is required first. Additionally, it takes time to locate banking information, file taxes, and evaluate the Tenant's circumstances.

If a tenant refuses to consent to a capacity assessment, but clues exist to suggest capacity is lacking, the OPGT must open an investigation and in some cases obtain control through the courts. This takes significantly longer, and even the courts resist granting guardianship unless it is deemed truly necessary.

Once the OPGT gains control of a tenant's finances, it is likely the arrears can be addressed quickly and, in many cases, paid in full. The difficulty rests in the time it takes to get to this point. During the waiting period, it is concerning to TSHC to watch the arrears continue to grow, sometimes for more than one full year. The table below demonstrates the outcomes of the OCHEs OPGT referrals from 2023 – 2025:

Year of referral to OCHE	# of referrals made to OPGT	Average time of Hold at OCHE for OPGT investigation	Average time file is open from referral to close	Files closed as of August 2025
2023	16	7 months	14 months	15 files[5]
2024	16	8 months	9 months	5 files[6]
2025	2	4 months[7]	n/a	n/a

[5] 7 negotiated LRAs; 4 paid in full; 2 moved out; 2 proceeded to LTB
[6] 3 negotiated LRAs with TSHC; 2 paid in full
[7] As of August 2025.

As of August 31, 2025, the OCHE has a total of 9 files on hold pending an OPGT investigation. A breakdown of the files is as follows:

Metric	Value
Value of Arrears at OCHE referral:	$28,806.00
Value of arrears as of August 2025:	$127,223.50
Current time on hold as of August 2025:	14 months

The OCHE reviewed the outcomes of the OPGT files which were referred to the OCHE between 2023 and 2025. This review indicated that 48% (10/21) of files were resolved by negotiating an LRA between TSHC and OPGT, 33% (7/21) were resolved by the arrears being paid in full, 10% (2/21) moved into a long-term care facility and the remaining 10% (2/21) proceeded to the LTB as the OPGT declined the need for their service. In these cases, the Tenants were unwilling to address the arrears with the OCHE.

Finding 1: When tenants require the OPGT to manage their tenancies, it places TSHC at a disadvantage as no files can proceed to the LTB and arrears grow without a resolution for approximately 1 year. This negatively impacts TSHC's arrears and does not accurately reflect the work of front-line staff in their arrears reporting to the Board and Committee.

Recommendation 1: Given the amount of time it takes to resolve OPGT cases – it is recommended that those cases be reported separately to the Board and Committee to ensure an accurate reflection of tenant arrears, as these arrears will only grow and cannot be addressed until the OPGT completes its investigation.

Conclusion:

In this period, the OCHE managed the arrears for all 96 Stage 1 and Breached OCHE brokered LRA files representing $392,091.87 in arrears. Through its work the OCHE recovered $232,615.35 in arrears via direct payments, reversing losses of subsidy/completing Annual Reviews and an additional $82,513.04 by brokering

LRAs. The OCHE's success is driven by community partnerships and systemic improvements aimed at reducing arrears and preventing evictions.

The ERO's success rests on their flexibility to meet tenants in the community, and by leveraging the relationships with community partners, community service organizations offering case management, the OPGT, Voluntary Trusteeship Programs and our newer Pilots with WoodGreen and the Toronto Rent Bank. The OCHE wishes to extend its success to TSHC in all feasible ways, to support TSHC in using the OCHE only for the most difficult to resolve files.

The positive outcomes from the partnerships established with the Toronto Rent Bank and WoodGreen Tax Link Service, have encouraged the OCHE to seek further collaborations. The OCHE is currently working on a Pilot with Service Canada which would allow TSHC to access Service Canada with tenants or on behalf of their tenants in-person at the OCHE. The OCHE looks forward to providing an update on this partnership in our next Bi-Annual Report.

Implications and Risks:
The OCHE provides the Board with oversight of TSHC's operations related to evictions due to arrears of rent and ensures that tenants avoid eviction where possible. The OCHE reports regularly on its activities and TSHC's performance in the areas within OCHE's jurisdiction. This regular reporting by the OCHE ensures the Board is aware of the activities the OCHE has undertaken on behalf of TSHC and that these activities continue to align with the goals of the Board and TSHC.

Signature:
"Melanie Martin"

_____

Melanie Martin
Interim Commissioner of Housing Equity

Staff Contact:
Melanie Martin, Interim Commissioner of Housing Equity
437-997-3687
melanie.martin@oche.ca

APPENDIX 1: 2025 RECOMMENDATION SUMMARY

OCHE RECOMMENTATION	TSHC RESPONSE	EXPECTED COMPLETION DATE
Recommendation 1: Given the amount of time it takes to resolve OPGT cases – it is recommended that those cases be reported separately to the Board and Committee to ensure an accurate reflection of tenant arrears, as these arrears will only grow and cannot be addressed until the OPGT completes its investigation.	TSHC accepts this recommendation and will begin reporting separately the arrears of current tenants that awaiting the outcome of OPGT investigation.	Next reporting cycle

Toronto Seniors Housing Corporation

Quality Tenant Engagement Committee Meeting

Meeting Date: September 30, 2025

Topic: TSHC Operational Dashboard

Item Number: 09

To: Quality and Tenant Engagement Committee (QTEC)

From: Brad Priggen, Director of Operations

Date of Report: August 2025

Purpose: For information

Recommendation:

It is recommended that the Quality and Tenant Engagement Committee receive the TSHC August 2025 Operational Dashboard for information.

For note, an additional slide has been provided in the Dashboard: Annual Unit Inspections.

Brad Priggen
Director of Operations

List of Attachments:

09.1 - TSHC QTEC Report-August 2025 Ops Dashboard

Toronto Seniors
Housing Corporation

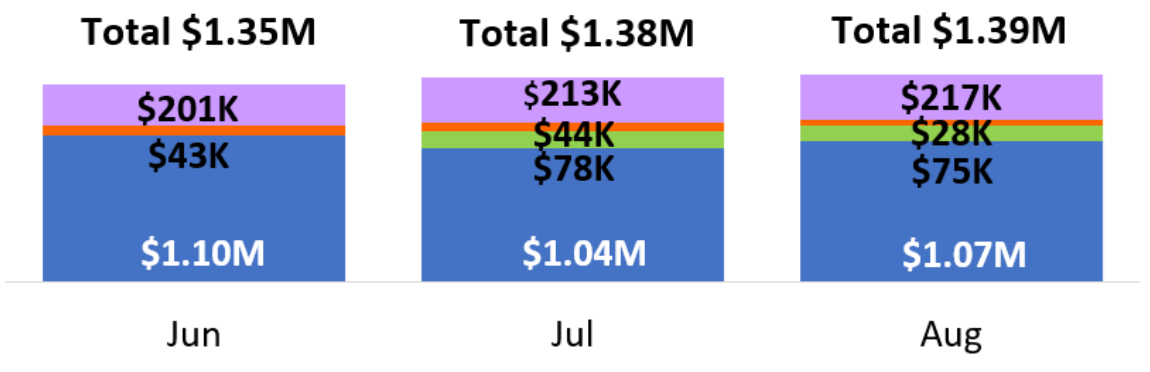
Operational Performance Monthly Dashboard
August 2025

Quality and Tenant Engagement Committee Meeting

Monthly Summary: TSHC

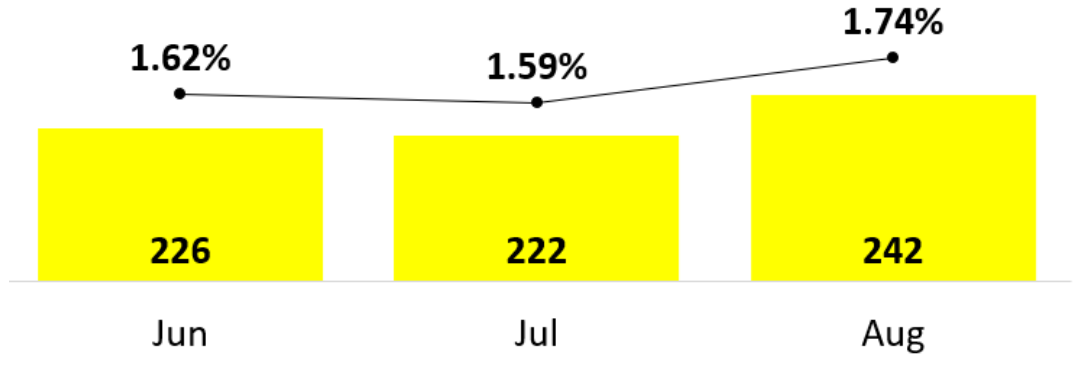
August 2025

ARREARS



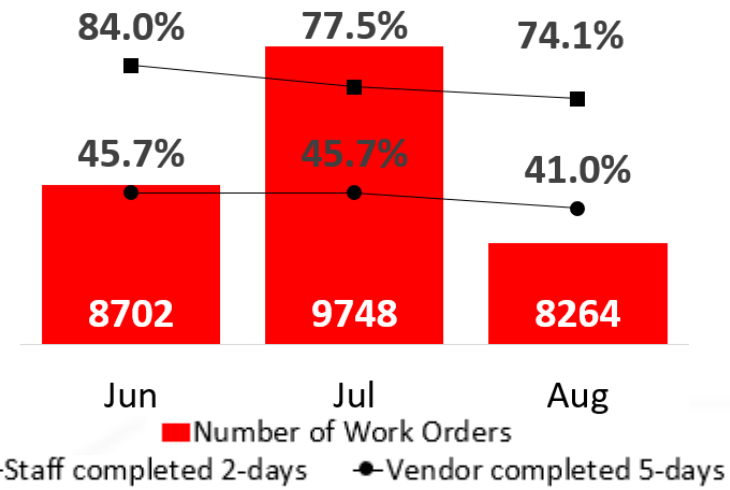
2024 Average Per Month: $1.52M

VACANCIES



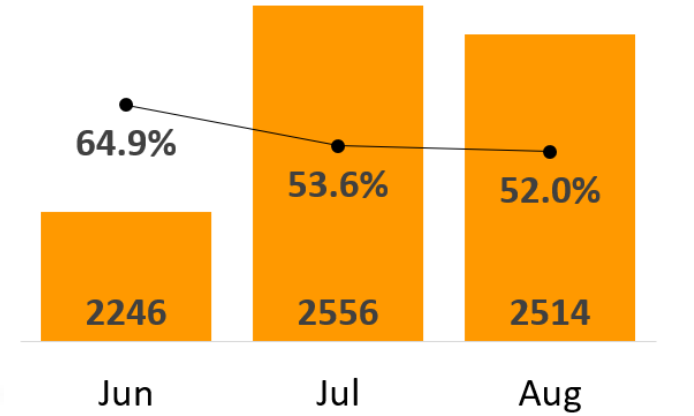
2024 Average Per Month: 1.57%

MAINTENANCE WORK ORDERS



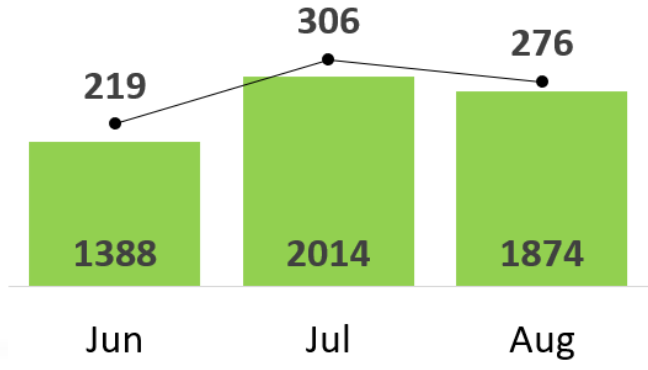
2024 Average/Month: 80.0% Staff; 37.3% Vendor

ADMINISTRATIVE TICKETS



2024 Average/Month: 57.2%

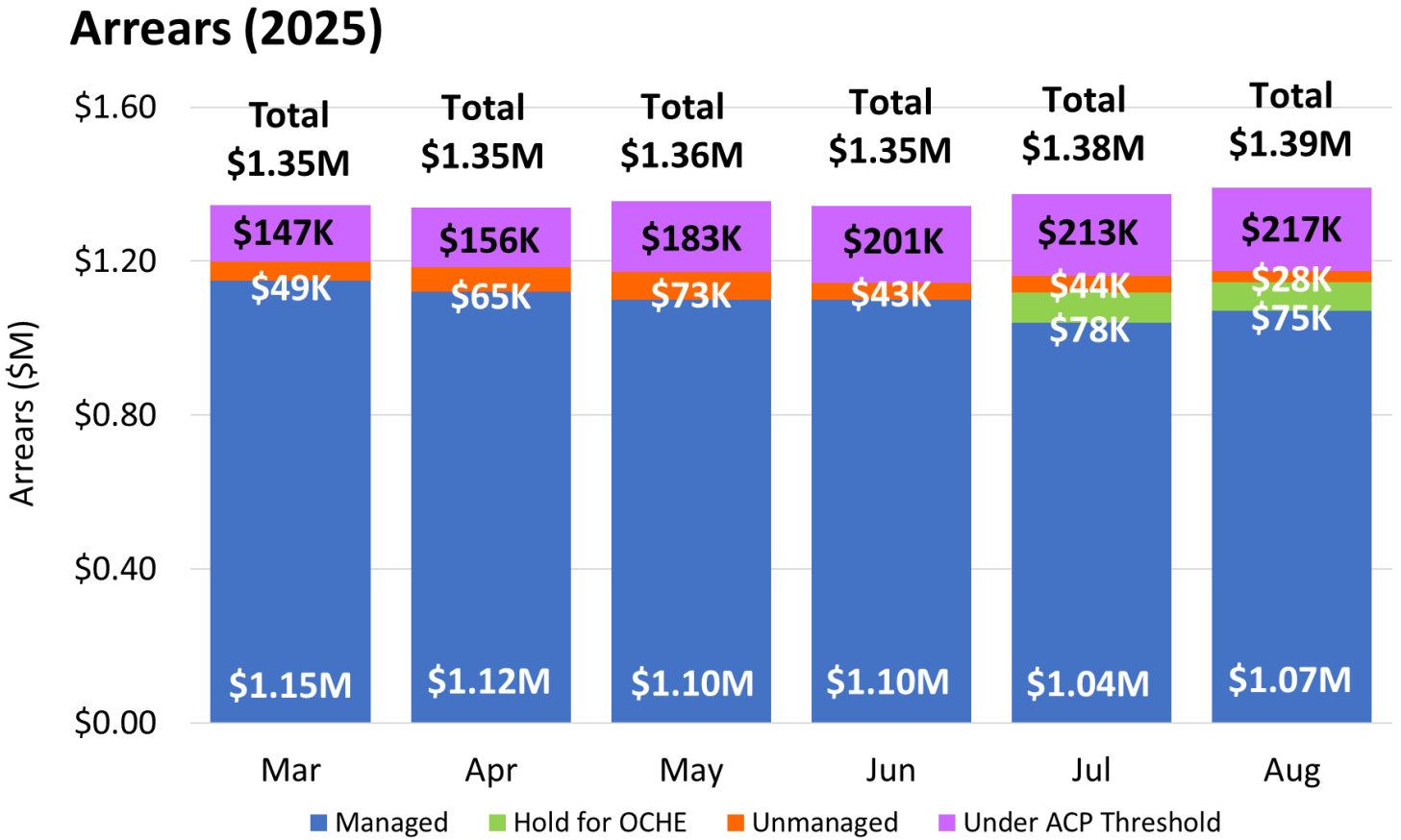
PEST MANAGEMENT



2024 Average/Month: 1,465 Units Treated

Arrears

August 2025



Arrears	Mar	Apr	May	Jun	Jul	Aug
Managed and Unmanaged	$1.20M	$1.19M	$1.18M	$1.14M	$1.09M	$1.10M
Hold for OCHE					$78K	$75K
Under Arrears Collection Policy threshold	$147K	$156K	$183K	$201K	$213K	$217K
Total	**$1.35M**	**$1.35M**	**$1.36M**	**$1.35M**	**$1.38M**	**$1.39M**

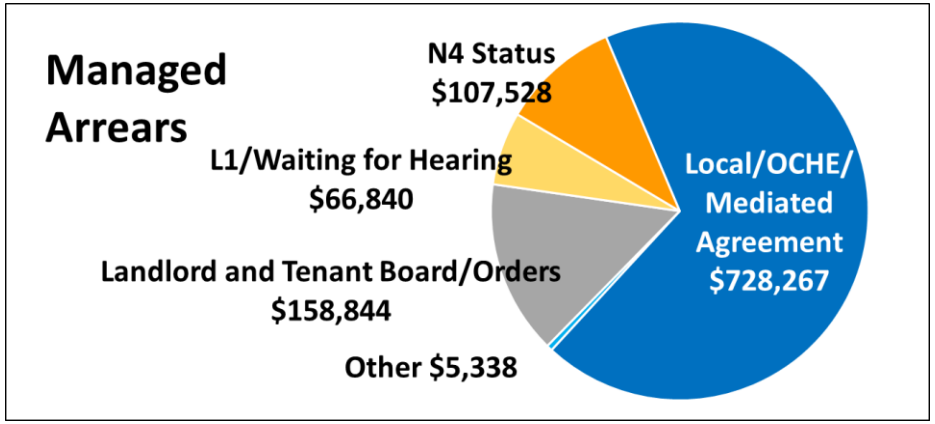
$11.4K increase in total arrears from July 2025

Managed arrears: $25.5K increase from July 2025

Hold for OCHE: $2.6K decrease from July 2025

Unmanaged arrears: $15.8K decrease from July 2025

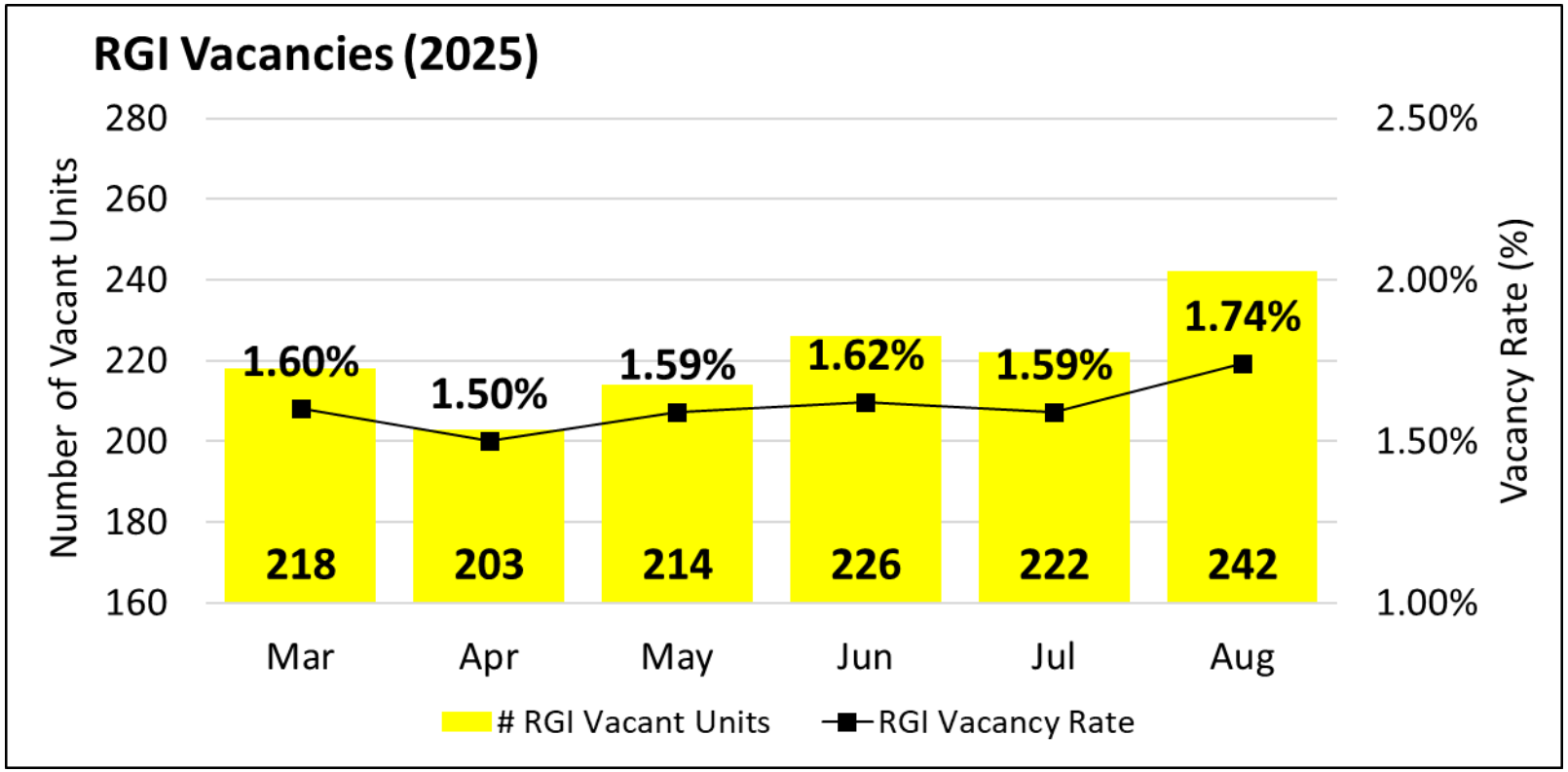
Under ACP threshold: $4.3K increase from July2025



Managed and Unmanaged Arrears	Total	Tenants
N4 Status	$107,528	73
L1/Waiting for Hearing	$66,840	10
Local/OCHE/Mediated Agreement	$728,267	285
Landlord & Tenant Board/Orders	$158,844	25
Other	$5,338	39
Total Managed	**$1,066,817**	**432**
Hold for OCHE	$75,413	6
Unmanaged	$28,641	33
Total Managed and Unmanaged	**$1,170,871**	**471**

Vacancies

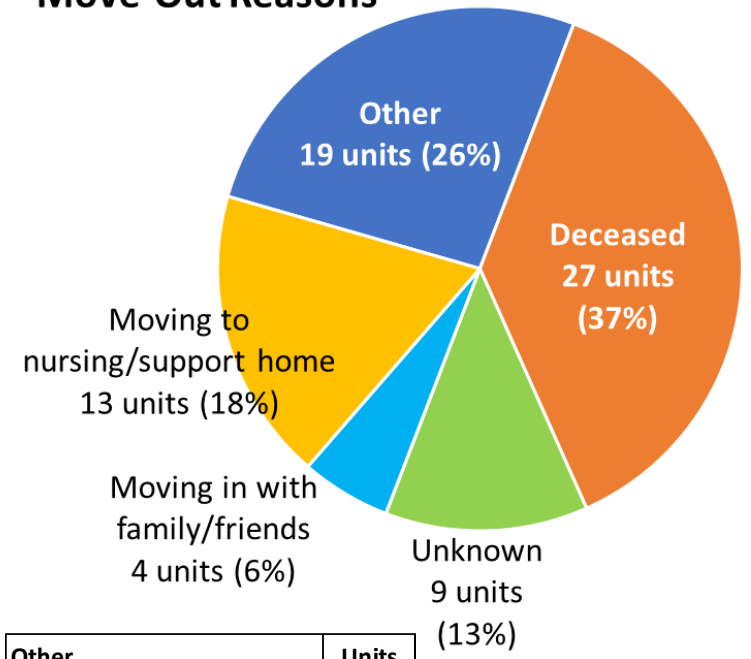
August 2025



1.74% RGI vacancy rate is below the Service Manager target of 2.00%

5.67% AFF (affordable housing) vacancy rate

76 move-ins and **72** move-outs



Other	Units
Relocating/Other	12
Transfer	4
Abandoned	2
Evicted for cause/legal	1

RGI Vacant Unit Status	Mar	Apr	May	Jun	Jul	Aug
Vacant and Ready	0	0	0	0	0	2
Central Wait List	95	56	69	75	71	80
Rapid ReHousing	40	47	52	44	31	48
Agency	0	0	0	0	0	1
Transfer	20	17	17	15	23	24
On Offer	7	32	13	14	9	9
Accepted	10	18	17	8	15	20
Maintenance	46	33	46	70	73	58
Total	**218**	**203**	**214**	**226**	**222**	**242**

Annual Unit Inspections

August 2025

Start Date: July 14

End Date: November 30

Inspections Completed

Issues Identified

Life Safety Issues (ie. smoke detector, window screens)	143
Housekeeping Issues (ie. cleanliness, clutter)	352
Fire Safety Issues (ie. blocked pathways, flammable items)	220
Electrical Issues (ie. unauthorized lighting)	137
Pest Issues (ie. pest infestation)	462
Kitchen Repair/Replacement Items (ie. cupboards, counter)	385
Bathroom Repair/Replacement Items (ie. bathtub, toilet, fixtures)	272
Flooring Repair/Replacement	78
Doors, Walls, Stairs Repair	232
Balcony Issues (ie. clutter, BBQ)	89
Water Penetration Issues	128
Other Issues (ie. washer/dryer, renovations, electric bikes)	303
Total	**2801**

1,388

Work Orders Created

(work orders may have multiple items)

Items to be repaired by site site including life safety items, pest infestations

921

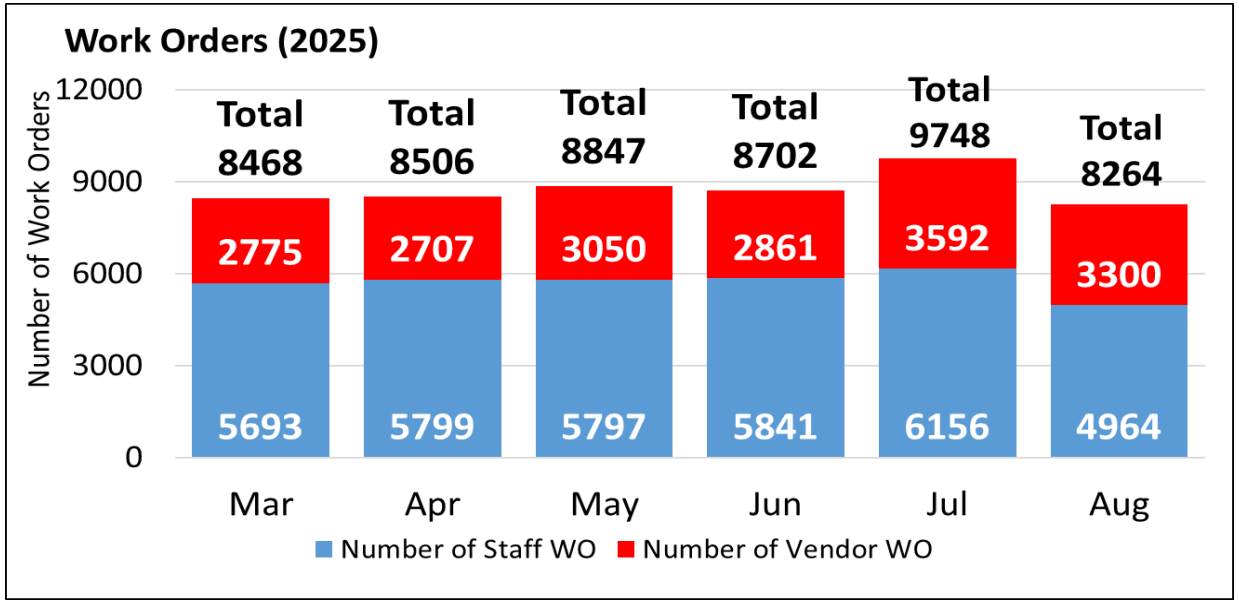
Violation Tickets Created

(one ticket per unit; may have multiple violations)

Clutter, cleanliness, hazardous conditions, unauthorized items and renovations, tenant damaged life safety items

Maintenance Work Orders (WO)

August 2025

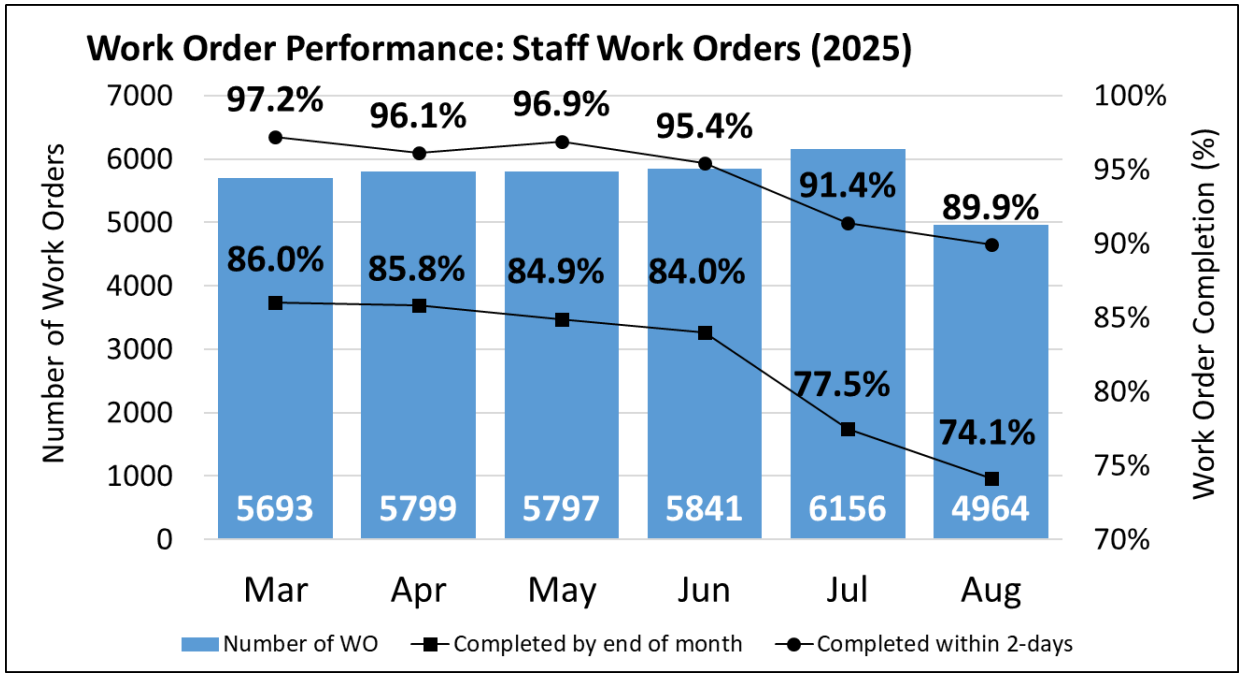


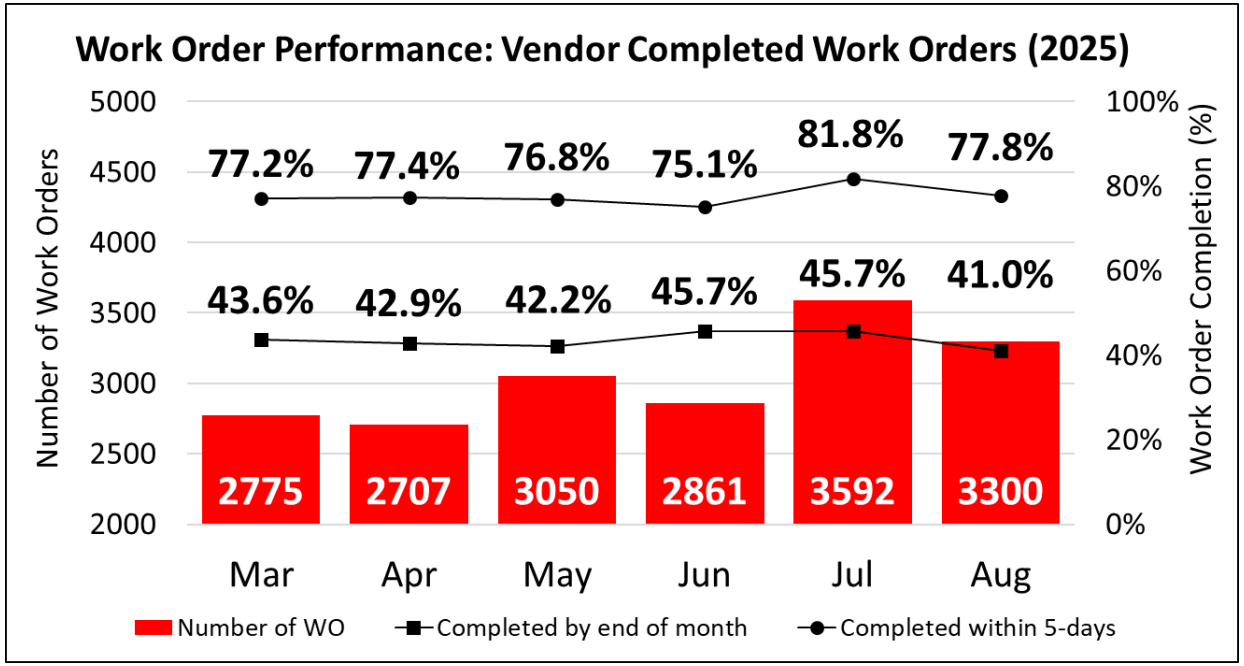
8,264 WO (work orders)

4,964 staff WO: (60%)	**74.1%** completed within 2 business days **89.9%** completed by end of the month
3,300 vendor WO: (40%)	**41.0%** completed within 5 business days **77.8%** completed by end of the month

Top 5 Staff Work Order Categories		
Alarm Monitoring	16%	**54% of WO**
Plumbing	12%	
Janitorial	11%	
Doors	8%	
Electrical	7%	

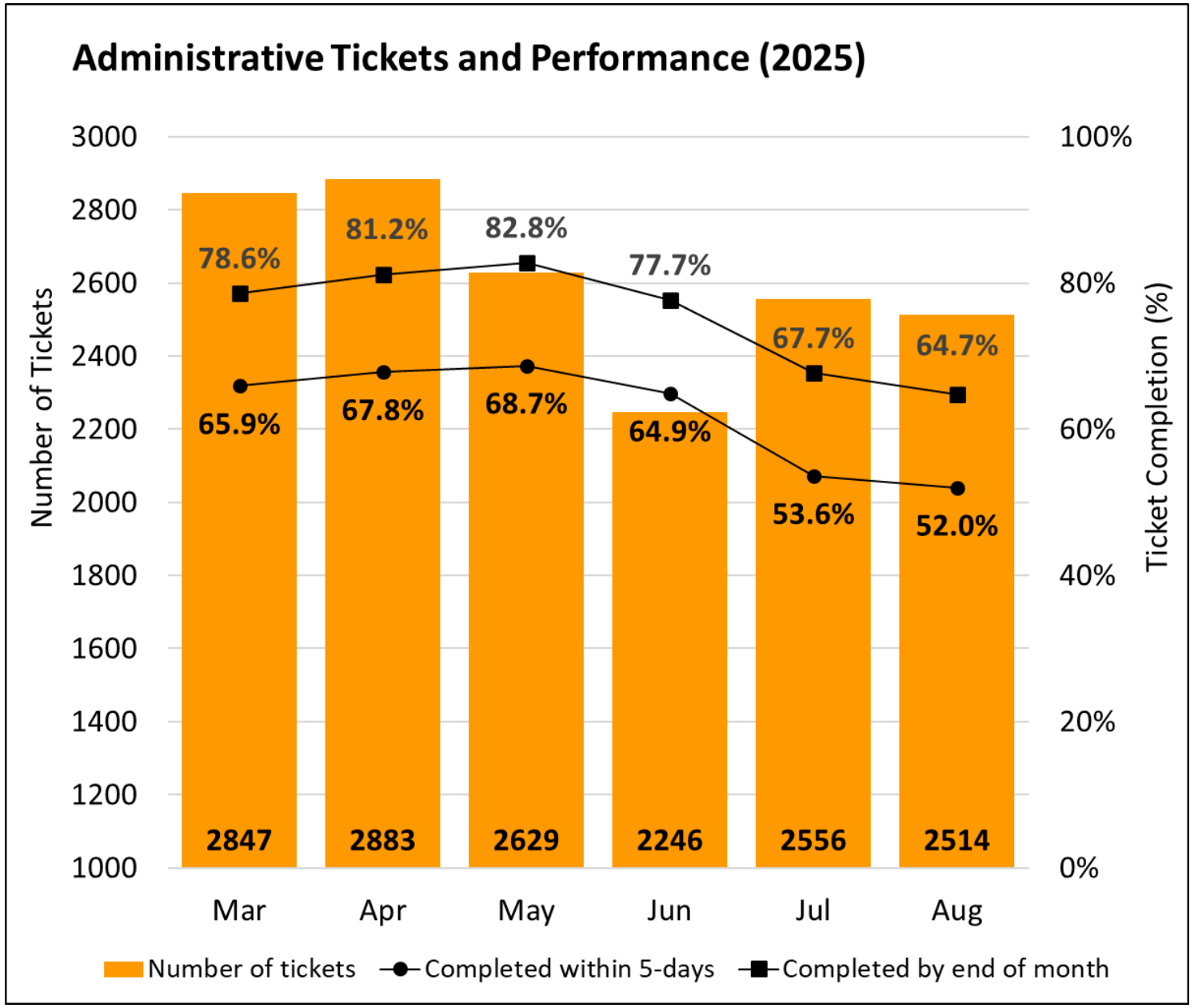
Top 5 Vendor Work Order Categories		
Pest Control	65%	**85% of WO**
Plumbing	8%	
Appliances	5%	
Doors	4%	
Elevators	3%	





Administrative Requests (Tickets)

August 2025



2,514 administrative tickets

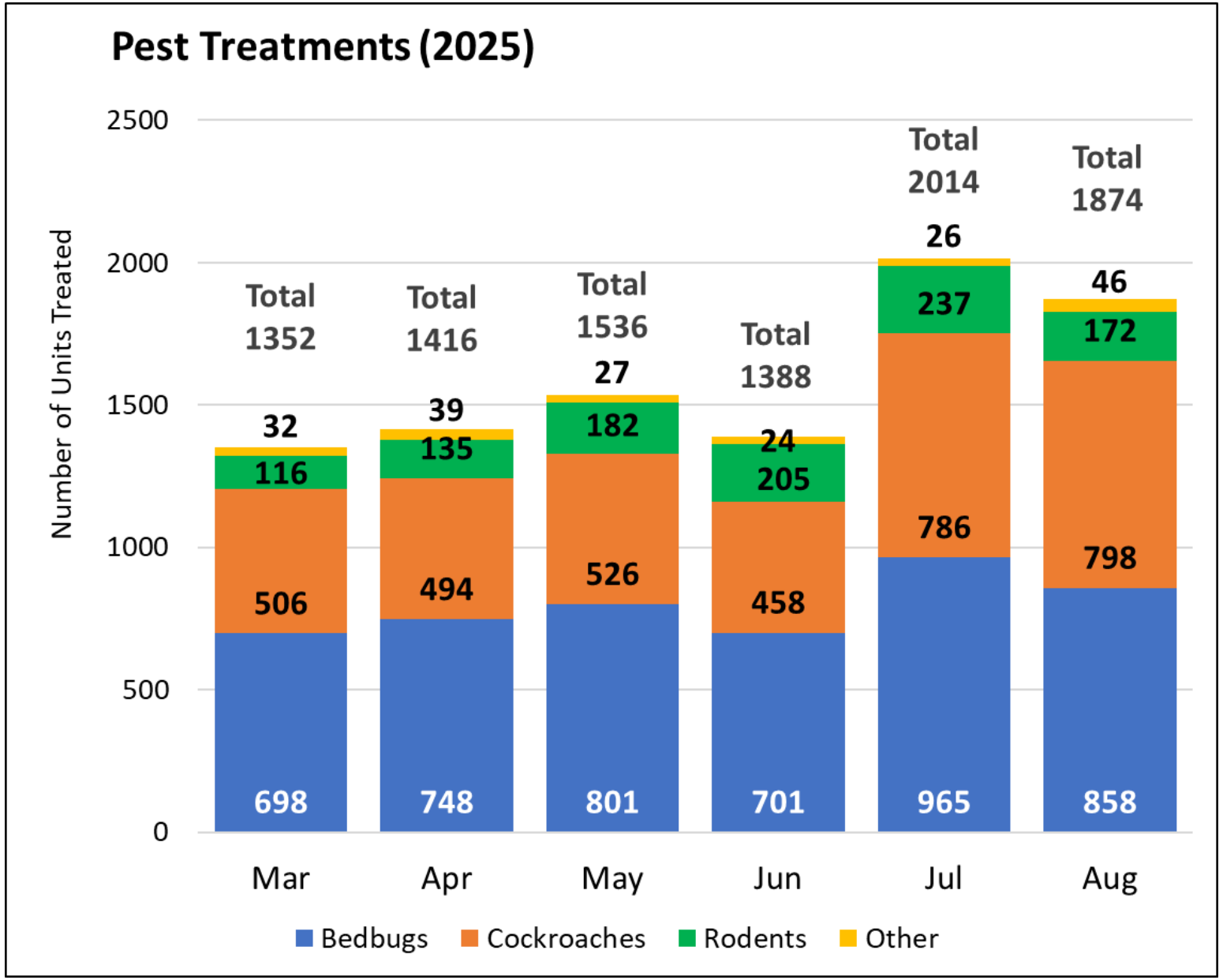
52.0% completed within 5 business days
64.7% completed by end of the month

Top 5 Administrative Ticket Categories		
Annual Rent Review	27%	**72% of Tickets**
Annual Unit Inspection	20%	
Document Requests/Support	15%	
Complaints	5%	
Arrears	5%	

Administrative Ticket Assignments	
Senior Services Coordinator	61%
Tenant Services Administrator	28%
Call Centre Agent	4%
Accessibility Group	1%
Other	6%

Pest Management

August 2025



1,874 units treated for bedbugs, cockroaches, rodents, other (flies, ants)

276 units declared pest-free

6 units received TSHC staff assistance with preparation and bed replacement

7 units received Toronto Public Health assistance (in collaboration with TSHC) with unit preparation for treatment

Glossary/Definitions

ARREARS

Arrears Collection Process (ACP): the process by which staff collect outstanding payments from tenants

Unmanaged arrears: arrears that are not in the collection process

Managed arrears: arrears that are in the collection process (N4 issued, repayment agreement, Order, etc.)

Under ACP threshold: arrears that are outside of the ACP

N4 issued: a legal notice to end tenancy for non-payment of rent

Repayment agreement: arrears for which an agreement has been negotiated for repayment; Local Agreements (negotiated by staff), OCHE Agreements (negotiated by OCHE) and Mediated Agreements (imposed by the Landlord and Tenant Board)

Order: an Order received from the Landlord and Tenant Board

VACANCIES

Vacancy rate: the percentage of rentable units that are vacant

Rapid ReHousing: an initiative to identify vacancies to be made available immediately to people experiencing homelessness in Toronto

Transfer: vacant unit to be used for overhoused or crisis transfers (household that is facing direct, immediate, elevated and acute risks to their health and/or safety)

On offer: vacant unit for which an offer has been made to an applicant

Offer accepted: vacant unit for which an applicant has accepted and is in the process of signing a lease

Maintenance required: vacant unit that requires minor maintenance

MAINTENANCE WORK ORDERS

Staff work orders: work orders assigned to staff and no vendor assigned

Staff work orders completed: work orders where staff have updated the status to “Work Completed”

Vendor work orders: work orders assigned to vendors (includes pest control vendors)

Vendor work orders completed: work orders where the vendor has updated the status to “Vendor Completed”

ADMINISTRATIVE REQUESTS (TICKETS)

Completed: tickets where staff have updated the status to “Completed“

PEST MANAGEMENT

Pest-free units: units are declared pest-free when no live activity (bedbugs/cockroaches) is observed by the technician or vendor following treatment

Toronto Seniors Housing Corporation

Quality and Tenant Engagement (QTEC) Meeting

Meeting Date: September 30, 2025

Item Number: 10

Report Name: Strategic Directions Progress Report – Q2 2025

To: Quality and Tenant Engagement Committee

From: Grant Coffey, Director, Strategy and Business Management

Date of Report: September 11, 2025

Purpose: For Information

Recommendation:

It is recommended that the Quality and Tenant Engagement Committee (QTEC) receive this report for information.

Reason for Recommendation:

At the Board of Directors meeting on February 26, 2025, the Board approved the updated 2023-2025 Strategic Directions (SD) Roadmap, to reflect revised timelines and activities, resource capacity, and build on progress and experience gained in 2023 and 2024. The updated Strategic Directions Roadmap outlines the key initiatives and milestones that will guide our progress until the end of 2025. This report provides highlights on the progress made on implementing the Strategic Directions in Q2 2025.

Key Performance Indicators Dashboard

As indicated in the Q2 2025 KPI Dashboard, the second quarter showed encouraging results across KPIs. For more comprehensive details, please refer to Attachment 1.

- **Arrears Management:** TSHC achieved a rent collection rate of 99.2 percent in Q2, this amount also includes arrears that have been collected in quarter.
- **Pest Management:** The Operations and Environmental Health Unit teams continue to work actively with tenants to address pest issues, resulting in 756 units being declared pest free in the second quarter.
- **Vacancy Management:** Housing Occupancy Rate exceeded target in Q2 and at 98.38% in June and the average unit turnover days in Q2 is 64 days, down from 66 days in Q1 2025.
- **Community Safety:** 2082 incidents (slightly up from 1949 in Q1 2025) and 516 proactive interventions (slightly down from 545 in Q1 2025) were reported in Q2 2025.
- **Tenant Engagement**
  - 117 Community Activities Fund (CAF) applications were approved in Q2, bringing the total number of applications approved mid-year to 160.
  - $36,754.31 in CAF funds have been distributed in Q2 to fund tenant activities.
- **Programs and Partnerships**
  - A total of 293 recurring programs led by tenants and service providers are currently being offered.
- **Employer of Choice**
  - One staff town hall was held virtually in Q2, with 127 attendees.
  - Meet and greet with the CEO for new hires, and orientation.
  - Lunch n'Learn sessions were held in Q2 to develop skills for: email, resume writing, interviews, and facilitation. 32 staff attended.

  - Action planning in follow up to the staff pulse survey results.
- **Organizational Excellence**
  - TSHC has worked with TCHC to finalize the year end Statement of Operations. TSHC's financial standing stays robust as of June 30, 2025.

Strategic Directions Roadmap

The SD Roadmap translates the Strategic Directions into a plan for delivery. The Q2 2025 Roadmap Tracker demonstrates progress across various strategic initiatives. In the second quarter of 2025, 20 projects/activities were planned, with six completed on time, and 14 with revised timelines, with two completed ahead of targets. Project teams are committed to completing activities according to the updated timelines. Attachment 2 provides highlights of the completed projects and outlines the details of those with revised timelines.

Review and Planning Sessions for Strategic Directions

An update on the development approach for future Strategic Directions will be brought to the September 30, 2025 Quality and Tenant Engagement Committee. To support ongoing reporting and management of the existing Strategic Directions, and further inform future approaches, planning sessions will also be held with Leadership and Extended Leadership Team later in the year.

Grant Coffey

Director, Strategy and Business Management

List of Attachments:

1. Attachment 1 – SD Key Performance Indicator Dashboard – Q2 2025
2. Attachment 2 – SD Roadmap Update – Q2 2025

Toronto Seniors Housing Corporation

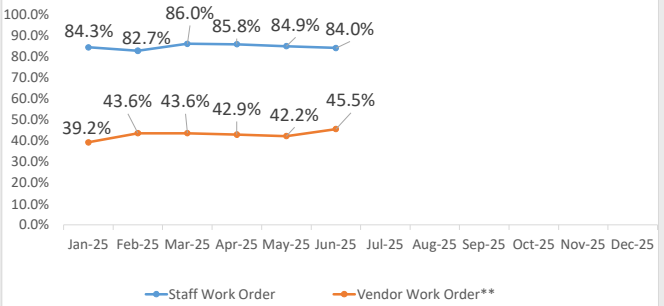
Toronto Seniors Housing Corporation (TSHC) Strategic Directions
Key Performance Indicator Dashboard - Q2 2025

Strategic Objective 1: To provide safe, clean and well-maintained buildings and to support stable tenancies

Highlights:

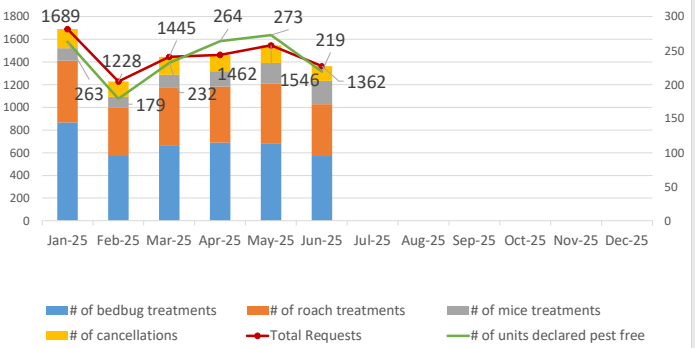
- Work Orders: the percentage of work orders completed within Service Standards, for staff the compliance rate was 84% and for vendors the rate was 45.5% in June.
- Pest Management: In Q2, a total of 756 units were declared pest free. Staff have assisted 18 tenants in preparation for treatment and coordinated the preparation of 26 units with Toronto Public Health.
- The housing occupancy rate at the end of June stood at 98.38%, exceeding the target of 98%. The average unit turnover days in Q2 was at 64 days, decreasing from 66 days in Q1.
- Arrears: TSHC achieved 99.2% rent collection rate in Q2. The arrears level has remained stable during Q2, with 95% of households maintaining good financial standing. A majority of households in arrears fell within the $1 - $2,000 range.

% of Maintenance Work Orders Completed within Service Standard*

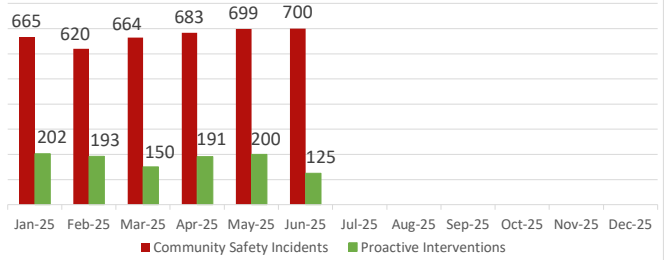


** The Service Standard for staff work orders is 2 days, while it is 5 days for vendor work orders.*
*** Vendor Work Order data does not include data on pest control*

Number of Pest Treatment Requests and Number of Units Declared Pest Free



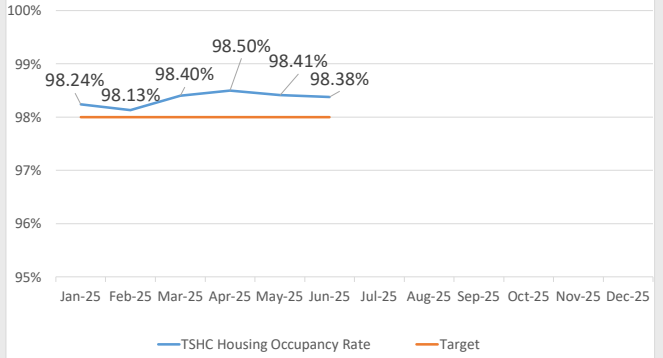
Community Safety



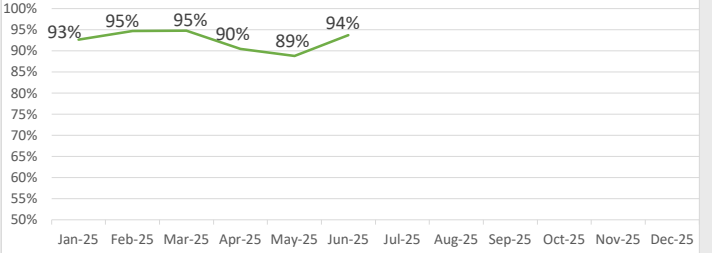
Community Safety Incidents include cause disturbance incidents, crimes against justice, crimes against property, crimes against persons, false fire alarms, fire incidents, medical incidents, mental health incidents, disputes, parking incidents, trespass incidents, sudden death, other incidents, etc.
Proactive Interventions include check welfare incidents, CSU patrols, and video requests.

Note: Incident categorization is reviewed on a regular basis and may be updated over time

Housing Occupancy Rate



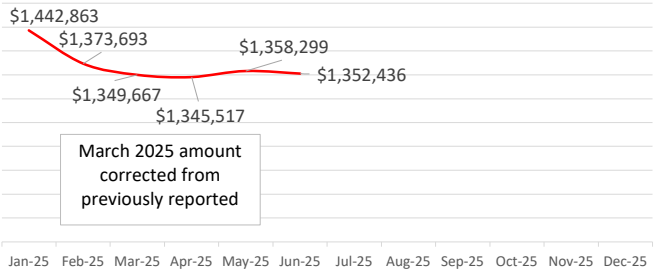
% of Units that Met the Unit Turnover Standard (60 days)



Average Unit Turnover Days
64 Days (▼ *from 66 days in Q1, 2025)*

Sector Average YTD
73.7 Days

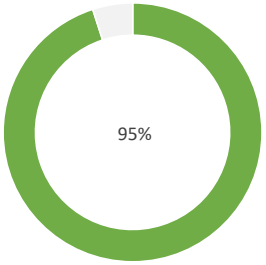
Monthly Rent and Parking Arrears



Rent Collection Rate
99.2% (▼ *from 100.2% in Q1, 2025)*

Sector Average YTD
91.8%

% of Households in Good Financial Standing



10 Evictions Enforced (15 evictions in Q1, 2025)

Households in Arrears

Rent and Parking Balance Range	No. of Tenant Accounts with Arrears
$1-$2,000	1305
$2,001-$4,000	79
$4,001-$6,000	35
$6,001-$8,000	23
$8,001-$10,000	12
$10,001 and above	19
Grand Total	**1473**

Toronto Seniors Housing Corporation

Toronto Seniors Housing Corporation (TSHC) Strategic Directions
Key Performance Indicator Dashboard - Q2 2025

Strategic Objective 2: To enhance tenant engagement and inclusion in their communities and provide opportunities for tenants to have a voice

Highlights:
- Staff collaborated with various City of Toronto partners to promote city initiatives to tenants across our portfolio including: TTC Advisory Committee on Accessible Transit member recruitment (City), TSHC Tenant Director recruitment (City/TSHC), and Ebike consultations (City/Toronto Community Housing Corporation (TCHC)).
- Senior Tenants Advisory Committee recruitment completed: 16 new members, 24 total members.
- During Volunteer week Tenant Volunteers received certificates, as well as t-shirts, lanyards, and cards.
- Seniors Speak included features on three tenants, Community Connect+, safety tips, reporting fraud, and thank you to volunteers.
- Video celebrating Seniors Month, National Indigenous History Month, Pride, Filipino Heritage, third anniversary of TSHC.

Community Activities Fund Distribution

$ Community Activities Fund Distributed in this quarter:

Q2: $36,754.31

$ Community Activities Fund Distributed in the same quarter last year:

$22,364 in Q2 2024

Number of Community Activities Fund Applications Approved:

117 in Q2

Communications with Tenants:

1 issue of Seniors Speak and **1** Community Letter with Video

15 new posters translated into top **8** languages and distributed

Tenant Engagement Activities

8 CEO Tours

2 Senior Tenants Advisory Committee Meeting

4 Regional Meetings

1 Community Connect+ Implementation Table Meetings

304 tenants participated (including tenants attending CEO Tours)

Online Engagement

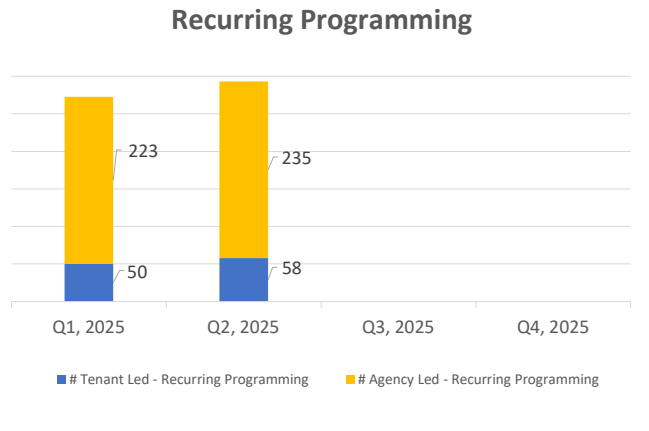
Website Users: **10,951**

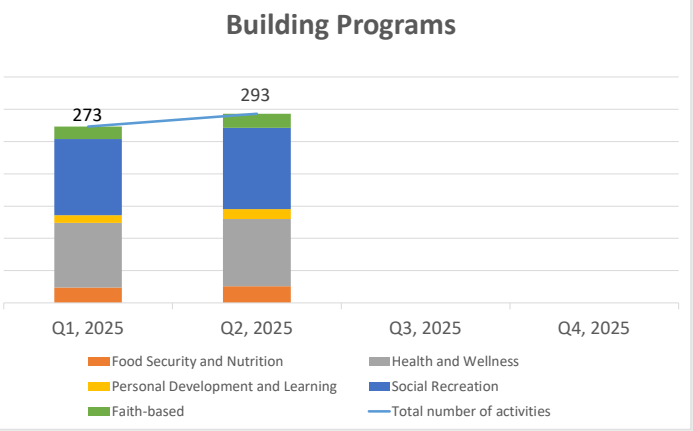
Social Media Audience: **2243**

Social Media Audience Growth: **99**

Strategic Objective 3: To facilitate access to services and programs that tenants need and want

Highlights:
- In Q2, continued to support Tenant Circle – initiated programming through the Community Action Fund (CAF), with a strong emphasis on seasonal and culturally relevant activities. Spring programming included:
  - 4 Dragon Boat Festival celebrations
  - 4 Easter events
  - 10 movie nights
  - and multiple Mother's Day and Father's Day celebrations.
- 117 Community Activities Fund applications were approved in Q2 with: 43 applications appoved for equipment and board games, 48 application approved that included food or meal provision components.
- Four Regional Tenant Volunteer meetings were held with 107 attendees. These meetings included presentations from Toronto Police Services and TCHC Energy Conservation Team.

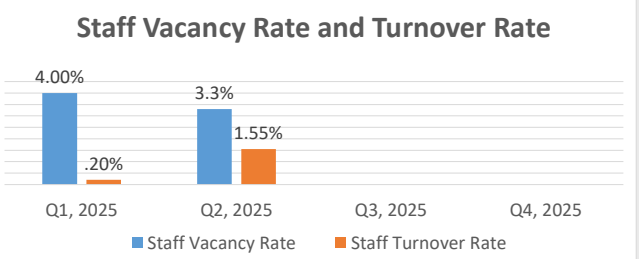




Strategic Objective 4: To promote innovation

No new innovations implemented across the organization in Q2.

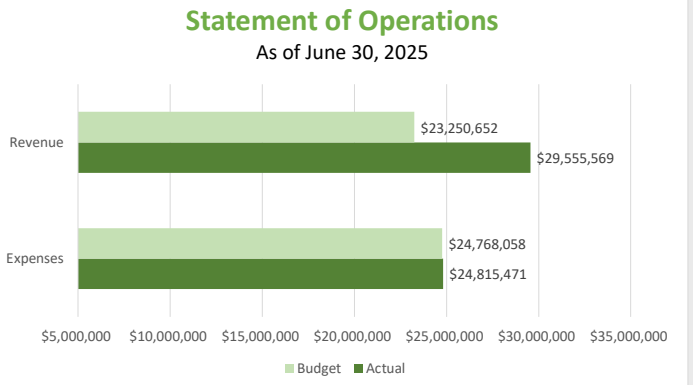
Enabler: Employer of Choice



Enabler: Employer of Choice

Highlights:
- Created and delivered three Staff Bulletins with 49 unique stories and three staff profiles. One staff newsletter on cybersecurity.
- One staff town hall was held virtually, with two staff and one TSHC Board Tenant Director presenters. 127 staff attended.
- Negotiated a new Collective agreement with Local 416.
- Joint Health and Safety Committee (JSHC) recognition event in partnership with Toronto Community Housing (TCHC) in May.
- Two Pride staff events in partnership with TCHC.
- Action planning in follow up to the staff pulse survey results.
- Meet and greet with the CEO for new hires, and orientation.
- Launch of 2025 Performance Management Process.
- Lunch n'Learn sessions held to develop skills for: email, resume writing, interviews, and facilitation. 32 staff attended.

Enabler: Organizational Excellence



SD Roadmap Update Q2 2025

Objective/Enabler	Accountabilities	Initiatives	Actions	Time-limited Activities	Current Timeline	Updated Timeline	Status	Highlights/Comments
Tenant engagement To enhance tenant engagement and inclusion in their communities and provide opportunities for tenants to have a voice	Director, Engagement, Partnerships and Communications	Communicate effectively with our tenants and other stakeholders	Develop communications strategy, including multiple channels and tools, translation, accessibility legislation (Accessibility for Ontarians with Disabilities Act) compliance and consistent messaging	Intranet upgrade	~~Q2 2025~~ Q3 2025 (TCHC dependent)	Q3 2025 (TCHC dependent)	Revised Timeline	TCHC continues to lead the development and implementation of the intranet system, with TSHC as an active partner and participant. Content development remains underway. Go-live dates are currently planned for Fall 2025.
Tenant engagement To enhance tenant engagement and inclusion in their communities and provide opportunities for tenants to have a voice	Director, Engagement, Partnerships and Communications	Communicate effectively with our tenants and other stakeholders	Develop communications strategy, including multiple channels and tools, translation, accessibility legislation (Accessibility for Ontarians with Disabilities Act) compliance and consistent messaging	Annual Report	Q2 2025	Q2 2025	Completed	The 2024 Annual Report has received Committee and Board approval and will go before City Council at Executive Committee in July.
Partnership To facilitate access to services and programs that tenants need and want	Director, Engagement, Partnerships and Communications	Facilitate access to priority health and community support services	Maintain and create new partnerships to help senior tenants access the support and services they need and want	Develop and implement a tenant participation satisfaction survey	~~Q2 2025~~ Q1 2026	Q1 2026	Revised Timeline	Currently investigating digital and in-person methods for tenant participation satisfaction surveying. Revised Timeline for implementation is Q1 2026.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Implement elements of good governance practices	Enhance governance practices in the areas of: governance foundations, principles and structures; board responsibilities and oversight; governance processes; and board effectiveness	Skills matrix for Board members	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	Timeline has been revised to Q4 2025. A Governance Workshop with Board Members is targeted for Q4 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Implement elements of good governance practices	Enhance governance practices in the areas of: governance foundations, principles and structures; board responsibilities and oversight; governance processes; and board effectiveness	Assess agenda and materials and review committee processes	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	Committee Terms of References have been reviewed. Further processes related to Committees will be discussed at a Board Goverernance workshop in Q4.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Implement elements of good governance practices	Enhance governance practices in the areas of: governance foundations, principles and structures; board responsibilities and oversight; governance processes; and board effectiveness	Review the Committee's Terms of Reference (TOR)	~~Q4 2025~~ Q2 2025	Q2 2025	Completed	Each Board Committee Terms of Reference was reviewed and approved through Board in June 2025. These will be further discussed in Q4 2025 as part of a Board Governance workshop for potential future considerations.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Meet the requirements of the Shareholder Direction and the City as housing manager	Ensure regular and annual reporting requirements are met	Annual Report and Annual General Meeting Requirements	Q2 2025	Q2 2025	Completed	The 2025 Annual General Meeting requirements were approved through Board in April 2025 and have been forwarded to the City for consideration at Executive Committee and Council in July 2025.

SD Roadmap Update Q2 2025

Objective/Enabler	Accountabilities	Initiatives	Actions	Time-limited Activities	Current Timeline	Updated Timeline	Status	Highlights/Comments
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Collaborate with TCHC	Develop relationship management agreements to support a positive working relationship	Clarify future legal relationship	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	Initial Business Terms positions developed for future legal agreement consideration. Discussions continue to refine positions. Revised timing to Q4 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Collaborate with TCHC	Develop relationship management agreements to support a positive working relationship	Update financial arrangement with TCHC	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	TSHC has established a separate budget from TCHC and is currently working on a review of the Future Legal agreement terms, Cost Allocation Model and Financial processes collaboratively with TCHC. This work is now targeted for completion by Q4 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Identify and reduce risk	Develop a TSHC risk and mitigation plan	Conduct a comprehensive risk assessment and implement mitigation plan	Q2 2025	Q2 2025	Completed	Enterprise Risk Management Framework was approved at the Board in February 2025, along with a Risk Dashboard and Risk Register. The Risk Register contains a comprehensive risk assessment that will be presented to the Board twice a year, which includes a mitigation plan for each risk.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Develop clear, plain language policies	Review priority policies to reflect TSHC values and principles	Post-transition Policy clean up	Q2 2025	Q2 2025	Completed	Completed with ongoing regular follow-up as part of policy review cycles.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Develop clear, plain language policies	Review priority policies to reflect TSHC values and principles	Review and update the tenant Human Rights Complaint Procedure	Q2 2025	Q2 2025	Completed	Tenant Human Rights Procedure has been completed with training being implemented in Q3-Q4 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Engagement, Partnerships and Communications	Develop clear, plain language policies	Review priority policies to reflect TSHC values and principles	Review and update the Translation and Interpretation Policy	~~Q2 2025~~ Q3 2025	Q3 2025	Revised Timeline	The Translation and Interpretation Policy has been drafted and presented to the Leadership Team for endorsement. Due to the timing of the Board and Committee meetings, the Policy will be submitted to the QTEC on July 14, 2025 QTEC for endorsement, followed by the Board of Directors meeting on July 31, 2025 for final approval.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Use technology effectively	Make best use of processes and data in HoMES system	Current SharePoint clean up/management	~~Q2 2025~~ Q3 2025	Q3 2025	Revised Timeline	The SharePoint Reorganization Initiative is nearing completion, consolidating 67 legacy sites into 10 function-based sites. Most sites are built, with some undergoing final reconfiguration. Content migration, testing, and pilot reviews are in progress. Governance and training materials are being finalized, with training scheduled. Full implementation planned for early-mid Q3 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Use technology effectively	Make best use of processes and data in HoMES system	Participate in intranet solution refresh	~~Q2 2025~~ Q3 2025	Q3 2025	Revised Timeline	Timing under review, targeted to start Q3 2025.
Organizational excellence To strive for organizational excellence for effective and efficient delivery of our mandate	Director, Strategy and Business Management	Use technology effectively	Make best use of processes and data in HoMES system	Identify TSHC technology opportunities	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	TSHC has been engaged with TCHC HoMEs Stability efforts, however still further work required on clarifying TSHC engagement and HoMES improvement requirements. Expect to revise to Q4 2025.
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Develop and implement a talent strategy	Identify, attract, recruit, and keep top talent	Review of employment offer letters	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	With legal for final review. Revised Timeline is Q4 2025.
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Develop and implement a talent strategy	Provide opportunities for growth and development to support staff in reaching their desired career goals	Launch and implement succession planning program	Q2 2025	Q2 2025	Completed	Launched succession planning program. Currently working on individual development plans. Work will be ongoing.

SD Roadmap Update Q2 2025

Objective/Enabler	Accountabilities	Initiatives	Actions	Time-limited Activities	Current Timeline	Updated Timeline	Status	Highlights/Comments
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Foster continuous learning and improvement	Develop, implement, and continuously improve onboarding, orientation and training programs that focus on enhancing skills to deliver seniors-focused services	Support the creation of job specific orientation programs	~~Q3 2025~~ Q2 2025	Q2 2025	Completed	Job specific orientation program for Cleaners has been developed and the orientation has been presented to CGHRC.
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Innovation to respond to a changing workplace	Review health, safety and wellness policies and programs to create a heightened “safety first” and “wellness” culture	Review and update of Health and Safety policies	~~Q2 2025~~ Q4 2025	Q4 2025	Revised Timeline	Work is underway, with four Health and Safety policies are targeted to be updated by end of Q4 2025 (two of these policies are reviewed annually). Review will be conducted to identify if there are additional Health and Safety policies to be developed.
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Innovation to respond to a changing workplace	Develop and implement programs and initiatives to support employee health and well-being	Psychological safety and mental wellness program	~~Q2 2025~~ Q1 2026	Q1 2026	Revised Timeline	The Psychological Health and Safety Policy is under review and targeting an updated policy by the end of Q4 2025. Once the policy is updated, scoping will begin to develop and implement the Psychological safety and mental wellness program. Staff will work with Employee Family Assistance Provided (EFAP) to identify program areas to support staff. Revised timeline is Q1 2026.
Employer of choice To be an employer of choice by fostering a culture of innovation that engages, empowers, and supports staff	Director, People and Culture	Innovation to respond to a changing workplace	Develop and implement programs and initiatives to support employee health and well-being	Review of respectful workplace policies	~~Q2 2025~~ Q1 2026	Q1 2026	Revised Timeline	Work is in progress to review workplace policies. Revised timeline is Q1 2026. Targeting three policies for review in Q3 2025, six policies for review in Q4 2025, and one policy for review in Q1 2026.

Toronto Seniors Housing Corporation

Quality and Tenant Engagement Committee (QTEC) Meeting

Meeting Date: September 30, 2025

Item Number: 11

Report Name: Approach to Developing Future Strategic Directions

To: Quality and Tenant Engagement Committee

From: Grant Coffey, Director, Strategy and Business Management

Date of Report: September 22, 2025

Purpose: For approval

Recommendation: It is recommended that the Quality and Tenant Engagement Committee approve the recommended development approach for TSHC's future Strategic Directions to bring forward to the Board of Directors.

Reason for Recommendation: TSHC 2023-2025 Strategic Directions require review going into 2026 and future years for renewal. To update and develop new, viable Strategic Directions, the initiative will require consultations with tenants and other stakeholders as well as research and analysis, and comprehensive updates to the Strategic Directions, Roadmap and Key Performance Indicators (KPI's). The recommended development approach offers a manageable way to fulfill this by leveraging a combination of staff and consultant expertise and an effective stakeholder engagement model.

2023-2025 Current Strategic Directions

The 2023-2025 Strategic Directions was first developed on an interim basis after TSHC became operational and fulfilled a need for the Corporation to establish measurable goals and a roadmap of activities post transition and establishment in 2022. A significant portion of the initiative was undertaken by a third-party consultant as TSHC was still building its staff capacity. TSHC staff, however, did play a role in managing and participating in consultations, and in later developing aspects of the final deliverables, such as the KPI's and ensuring oversight. Tenant input was primarily channeled through the Seniors Tenant Advisory Committee (STAC) as at the time other inputs from broader tenant consultations aligned to establishing TSHC were available.

TSHC has been reporting progress on the 2023-2025 Strategic Directions quarterly to Committee and Board since Q3 2023 and the majority of initiatives are slated to be completed by the end of 2025. The framework for the current Strategic Directions will shape the new strategic planning process.

Looking Ahead

Developing the new Strategic Directions will look different from the original process in a variety of ways. The perspective of tenants, who have now lived at TSHC managed properties for longer, need to be more meaningfully engaged to develop the new strategy. More staff have institutional knowledge that can be better leveraged to inform the strategy. TSHC also has more in-house capability to take on more portions of the strategic planning process. There is also new data, such as TSHC's own tenant and employee surveys to inform the strategy. Partnerships have been developed and the Board has indicated an interest to continue expanding innovation and drawing on leading

practices to inform TSHC's future directions and support achieving improved outcomes for tenants. TSHC has experienced much success in alignment to the current Strategic Directions, however there is a requirement to review and renew and ensure an effective strategy for TSHC.

Strategic Directions Development Approach

The recommended approach involves a collaboration between TSHC staff and a consultant and expanded stakeholder consultation, in particular with tenants. TSHC staff will utilize their capabilities to manage the initiative and drive the initial research and final strategy development process. The consultant will be brought on to help address TSHC's capacity to run more extensive consultations, a crucial requirement to develop a viable strategy. The consultant would also be expected to add value by making the engagements meaningful for the stakeholders in a way that they feel like they have a sense of ownership in the updated Strategic Directions. The consultant would also be expected to synthesize their interactions into digestible insights that can be incorporated into the final strategy.

While TSHC staff are expected to integrate the variety of inputs that have come from both the research and consultation stages, the consultant may be retained to help develop the final strategy if staff are constrained for capacity at the time.

Taken together, the recommended implementation model will help ensure that data, research, and tenant, staff and other stakeholder input is adequately incorporated to develop a clear, measurable and outcome-oriented strategy for TSHC for the next three to five years. The project to complete this work is anticipated to start in Q4 2025 and conclude by Q3 2026.

Key Project Functions

Main functions to develop the new Strategic Directions will include:

- Project planning to set up the overall parameters and timelines of the initiative.
- Initial research and review of data such as surveys and reports to understand the organization's status, challenges and opportunities.
- More extensive consultations with tenants, staff, partners, the Board and others to complement the research and understand emerging priorities for tenants, staff and the Board.
- Synthesis and analysis of these information gathering steps to set up the development of the strategy.
- The development of the final strategy will result in the following deliverables:
    - An updated Strategic Directions framework.
    - An accompanying Roadmap with a breakdown of initiatives
    - An updated set of KPI's.

The approach would retain the existing framework/template of the current Strategic Directions to inform the future strategy. Immediate next steps will include:

- An RFP for a consultant will be issued in October 2025.
- A consultant will be selected and onboarded in November 2025.

Please see Attachment 1 for an overview of the planned approach.

Grant Coffey, Director, Strategy and Business Management

List of Attachments:

1. Future TSHC Strategic Directions Development Approach

Toronto Seniors Housing Corporation

Future TSHC Strategic Directions Development Approach

Presentation to Quality and Tenant Engagement Committee – September 30, 2025

Objective

- Align on the next Strategic Directions development approach

Background

- Most commitments in the 2023-2025 Strategic Directions are set to be completed in 2025 (See Appendix).
- TSHC Leadership Team and Extended Leadership Team reviewed, reflected and updated the Strategic Directions on a periodic basis.
- On July 10, 2025, TSHC's Board of Direction provided initial thoughts on substantive elements of the next Strategic Directions:
    - We require a clear vision.
    - What is our mandate – stay the same or expand?
    - Consider the increasing complexity of our tenants.

Previous Approach to Developing Current 2023-2025 Strategic Directions

Toronto Seniors Housing Corporation

Item	Description
Implementation Model	- Consultant conducted Analysis and developed strategy - TSHC/Consultant ran consultations - TSHC developed the communications and KPI's
Stakeholders Engaged	- STAC members - Partner agencies - LT and staff that were present from August 2022 to April 2023 - Board
Sample documents/ references reviewed	Health commons report, Integrated Service model, Listening tour, 2021 Survey
Timeline to develop strategy	7 months
Cost to develop strategy	Approx $75K

Considerations for Developing Next Strategy

- TSHC is now better staffed:
  - There is more internal capacity and capability to run significant portions of the strategy development process.
- TSHC has developed its own, distinct culture around work and how it serves its tenants:
  - Staff can be consulted with more extensively to inform various aspects of the strategy.
- Relationships between staff, tenants, board and other stakeholders such as TCHC and the City have deepened and evolved:
  - Tenants and partners can be engaged more extensively in developing the new strategy.
- There is more data to inform new strategy development such as the Tenant Experience Survey, Employee Engagement Survey and various events and activities happening across TSHC buildings
  - KPI's can be refined and better utilized as well.
  - Literature on seniors and housing can be utilized more extensively.
- New issues have emerged that may require attention in the new strategy such as:
  - Exploring innovative solutions to support aging in place.
  - More resources to support tenants with complex needs.

Expected Outcomes

The new strategy will be based on the framework of the current strategic directions. Based on this framework, the strategic planning process will achieve the following:

- Maintain a clear, measurable, and achievable strategy for TSHC to efficiently and effectively meet the needs of its tenants. To achieve this, the strategic planning process must be:
    - Based on relevant data, research and meaningful consultations that balances tenant needs, staff capacity and fiscal constraints.
- Clarify the vision of the strategy and ensure that it is focused on outcomes:
    - Ensure the vision is aligned with the City's of Toronto's shareholder directions.
- Tenants, staff and other key stakeholders have a sense of ownership of the strategy. This means:
    - Ensuring all stakeholders are meaningfully engaged in the strategy development process.
- Additional considerations:
    - Ensure the strategy is developed in a timely manner.
    - Ensure ongoing operations and tenant obligations are upheld while the new strategy is developed.

Governance – Roles and Responsibilities

Actor	Function
TSHC Board	- Signs off on approach to strategy development - Contributes to strategy development, refines priorities and clarifies vision
TSHC Staff	- Sets project direction, oversees project - Strategy and Business Management will manage the initiative. Other teams will shape strategic priorities by participating in consultations
Consultant	- See Proposed Strategy development approach
STAC	- Input into priority issues and refining tenant facing objectives and initiatives
Tenants	- Input into refining all tenant facing objectives and initiatives
City of Toronto	- Input into strategic direction to check for alignment with Shareholder direction and Seniors Strategy
TCHC	- Input to check for alignment with TSHC-TCHC agreement
Other Partners	- Provide subject matter expertise in areas such as health and wellbeing

Key Project Functions, Deliverables and Resources

Toronto Seniors Housing Corporation

Planning

Research & Review

Consultations

Synthesis & Analysis

Strategy Development & Implementation

Deliverables

- Strategic Directions
- Roadmap
- KPI's

Project Management & Monitoring

Communications

Aug-Nov 2025	Nov 2025 – Jan 2026	Nov 2025 – March 2026	April – May 2026	May - July 2026

Resource Requirements	
- Project Manager - Strategy Consultant - Researcher/ Analyst - Facilitator	- Event Coordination - Communications - Procurement

Assumption

Current Strategic Direction template will be used to inform strategy

Recommended Strategy Development Approach

HYBRID MODEL: TSHC will manage the initiative, lead research, analysis and the development of the strategy while the Consultant will lead the consultations and if needed support in developing the strategy	
Function	**Responsibility**
Planning and Project Monitoring	- TSHC sets out project scope and charter.
Research and Review	- TSHC reviews and synthesizes key data such as Tenant Survey results.
Consultations	- Consultant leads consultations with innovative engagement models. - TSHC provides logistical support and guidance where required.
Synthesis and Analysis	- Consultant synthesizes findings from consultations. - TSHC synthesizes all input from research and consultations.
Strategy Development	- TSHC incorporates findings and insights from research and consultations to develop strategy, roadmap and KPI and adapt it to current framework. - Consultant may be asked to support if there are capacity constraints at TSHC.
Communications	- TSHC will promote the upcoming engagements to relevant stakeholders. - TSHC will produce the final strategy.

Recommended Strategy Development Approach

Rationale	- Tenants and other partners need to be consulted more extensively to get more meaningful input. - A consultant would fill a capacity and capability gap to engage stakeholders more extensively, meaningfully and creatively. - TSHC will leverage internal expertise and staff knowledge of current strategic directions to lead research, analysis and strategy development. - The implementation model keeps some flexibility for a consultant to support the development of the final strategy if TSHC staff are facing capacity constraints.
Estimated Cost	- Estimated $100K to $150K

Next Steps

Item	Date
Draft Project Charter and Workplan	September 30
Present Project Approach to QTEC	September 30
Finalize RFP	First week of October
Advertise RFP	October
Review Applications and Select Consultant	October/November
Finalize Contract and Onboard Consultant	November
Initiate Research and Review	November
Plan for Consultations	November/December

Appendix

2023-2025 Strategic Directions Progress

Objective/Enabler	Progress Towards Completion (as of Q2 2025)		Q4 2025 Projection
Objective 1: An Excellent Landlord	18 of 23 time-limited activities completed	78%	96%
Objective 2: Tenant Engagement	16 of 20 time-limited activities completed	80%	95%
Objective 3: Partnerships	2 of 4 time-limited activities completed	50%	75%
Objective 4: Innovation	7 of 13 time-limited activities completed	54%	69%
Enabler 1: Organizational Excellence	39 of 63 time-limited activities completed	62%	92%
Enabler 2: Employer of Choice	16 of 25 time-limited activities completed	64%	88%
Total	**98 of 148 time-limited activities completed**	**66%**	**90%**

Strategy Development Options

Toronto Seniors Housing Corporation

	Consultant Led (Performs all functions)	Hybrid 1: Consultant Leads Strategy and Analysis	RECOMMENDED Hybrid 2: Consultant Leads Consultations	In House – Staff Run	Phased Mode: Consultant leads research, consultation with extension if required
Pros	- Frees up capacity - Impartial - Leverage new perspective/expertise	- Frees up some capacity - TSHC continues consultations (holds relationship with tenants)	- Allows for more extensive and meaningful consultations with tenants, staff etc. - TSHC retains control over SD	- Most cost effective - Minimizes ambiguity and need for coordination with third party	- Provides some flexibility for TSHC to adapt, depending on other priorities and bring on a consultant as needed
Cons	- Lack of contextual understanding/ may substantially alter strategic direction from current SD - Potentially adds more work for TSHC (cleaning up data etc. - Expensive - Will take more time to complete	- Can significantly alter direction of strategy if not managed well - Lack of contextual understanding - Doesn't leverage in-house expertise to conduct analysis	- Consultant may not be able to establish trust/relations with staff/tenants - TSHC staff will still need to support (frees up limited capacity) - Consultations won't begin likely till early 2026	- Strain on capacity - Other priorities may be compromised - Not leveraging external expertise	- Increases ambiguity and coordination problems, potentially causing delays to the project

Toronto Seniors Housing Corporation

Consultation Options

	Light	Medium	Intensive
Tenants	2 STAC Meetings	**Recommended** 2 STAC Meetings 4 Regional Meetings 2 Online Meetings	2 STAC Meetings 4 Regional Meetings 2 Online Meetings 4 – 6 Thematic Meetings (e.g. Maintenance, Security, Community etc. or by SD Objective)
Staff	4 Regional Meetings	4 Regional Meetings 1 LT Meeting 1 ELT/Corporate Meeting	**Recommended** Meetings by departments, broken down into regional level, focusing on particular themes
Board	1 Meeting	**Recommended** 2 Meeting	2 Meetings + thematic areas
Other Partners	1 or 2 meetings with key stakeholders like TSHC and City	1 or 2 meetings with key stakeholders and select partner agencies	**Recommended** More complex, thematic meetings (particular focus on partnerships)

Risks of Recommended Approach

Risk	Mitigation Strategy
Consultant doesn't have a relationship with tenants	- TSHC will onboard consultant - Consultant will be selected based on expertise in trust building
Consultant's engagement approach does not inform strategy	- TSHC will work closely with consultant to communicate expectations
Consultant can't support strategy development if needed	- TSHC will select a consultant that has the capability to run consultations and contribute to strategy development

Toronto Seniors Housing Corporation

Quality and Tenant Engagement (QTEC) Meeting

Meeting Date: September 30, 2025

Item Number: 13

Report Name: Q2 2025 CSU Report on TSHC Safety Activity - CSU

To: Quality and Tenant Engagement Committee

From: Grant Coffey, Director, Strategy and Business Management

Date of Report: August 6, 2025

Purpose: For Information

Recommendation:

It is recommended that the Quality and Tenant Engagement Committee (QTEC) receive this report for information.

Reason for Recommendation:

The Community Safety Unit (CSU) at Toronto Community Housing Corporation (TCHC) provides services tied to the buildings owned by TCHC, including buildings managed by Toronto Seniors Community Housing Corporation. As recommended in the Safety and Security Quality Improvement Projects activity, with regards to more granular data to be provided to TSHC to inform tenancy management and integrated team meetings, CSU will be providing quarterly reports going forward on Community Safety related activity and performance.

Enclosed is their report for Q2 2025.

Grant Coffey

Director, Strategy and Business Management

List of Attachments:

13.1 - Q2 2025 CSU Report on TSHC Safety Activity

Q2 2025 CSU Report on TSHC Safety Activity
September 30, 2025

Quarterly Safety Report:

To: Toronto Seniors Housing Corporation

From: Community Safety Unit, Toronto Community Housing

Date: August 6, 2025

PURPOSE:

To report on Community Safety related activity with Toronto Seniors Housing Corporation (TSHC) staff on a quarterly basis. This report includes quarterly data for all TSHC including the Violence Reduction Program ('VRP') in the Seniors communities.

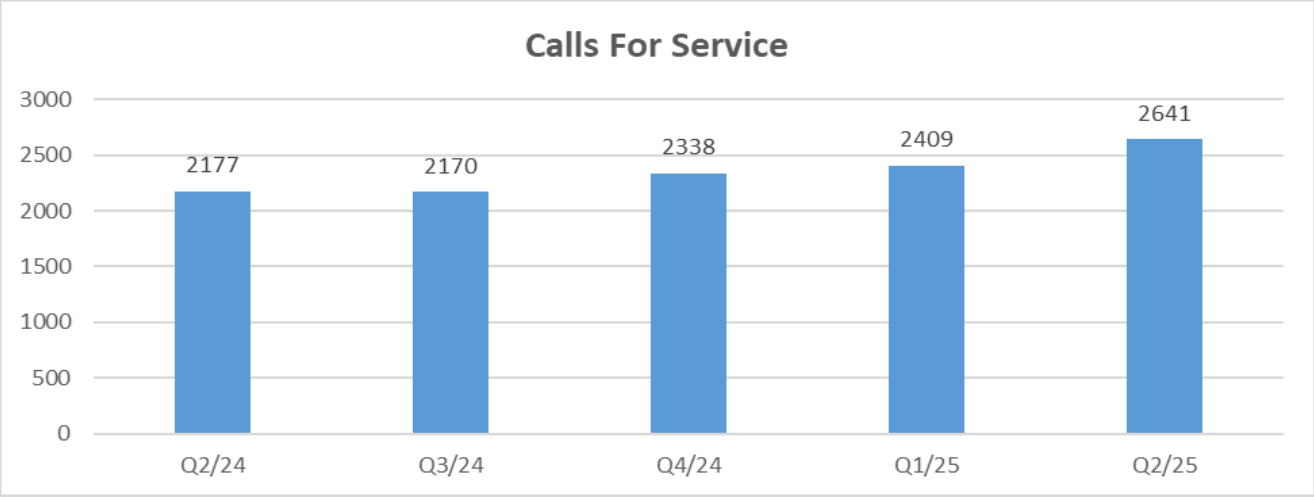
COMMUNITY SAFETY RELATED ACTIVITY WITHIN TSHC

CSU Officers respond to calls for service for both TCHC and TSHC communities throughout the city. Their work includes conducting various proactive patrols and crime prevention work to help deter antisocial behaviour ('ASB") and criminal activity. Below is the number of calls for service received and attended at TSHC buildings.

CALLS FOR SERVICE (CFS)

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Calls For Service *	2177	2170	2338	2409	2641

SOURCE: Dispatch Application (>Mar 2024) & CORA (pre-Mar 2024)
**Excludes CSU Patrols and Meetings Attended*



In Q2 2025, CSU received 2641 calls for service to Senior's buildings across the TSHC portfolio. This is an increase of 232 calls compared to the previous quarter, Q1 2025, primarily due to an increase in trespassing incidents and check welfare incidents. There was an increase of 464 calls for service compared to the previous year Q2 24. This is an 11% increase. The interaction between CSU staff and TSHC tenants has allowed for improved lines of communication that has led to an increase in reporting incidents to CSU.

PROACTIVE WORK IN TSHC BUILDINGS (CSU)

Proactive work is work that is being done by CSU staff in an effort to reduce anti-social behavior ('ASB') and criminal activity in TSHC communities.

This proactive work is conducted by both Special Constables which are typically through on-site patrols and Community Safety Advisors ('CSA') through various engagement activities which includes Community Events, Crime Stoppers Presentations, Critical Incident Responses, Presentations and Safety Meetings, Tenant Visits, Tenant Management Meetings, Referrals and Crime Prevention Through Environmental Design ('CPTED') Audits. Definitions can be found in the glossary in Appendix A.

<u>Community Safety Unit Patrols</u>

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
CSU Patrols	245	202	301	256	179
Buildings Patrolled	36	30	34	35	35

SOURCE: CORA and Niche RMS

Engagement Activity

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Engagement Activity*	4	10	44	18	24

SOURCE: CSA Activity Tracker, CORA, and Niche RMS (Special Constable Community Events).

**Community Events, Crime Stoppers Presentations, Critical Incident Responses, Presentations and Safety Meetings.*

Tenant Visits and Tenant Management Meetings

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Tenant Management Meeting	3	7	7	6	12
Tenant Visit	16	37	13	45	27

SOURCE: CSA Activity Tracker

Referrals

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Referrals	2	12	13	4	3

SOURCE: CSA Activity Tracker

Crime Prevention through Environmental Design (CPTED) Audits

	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
CPTED Audits	2	3	5	6	5

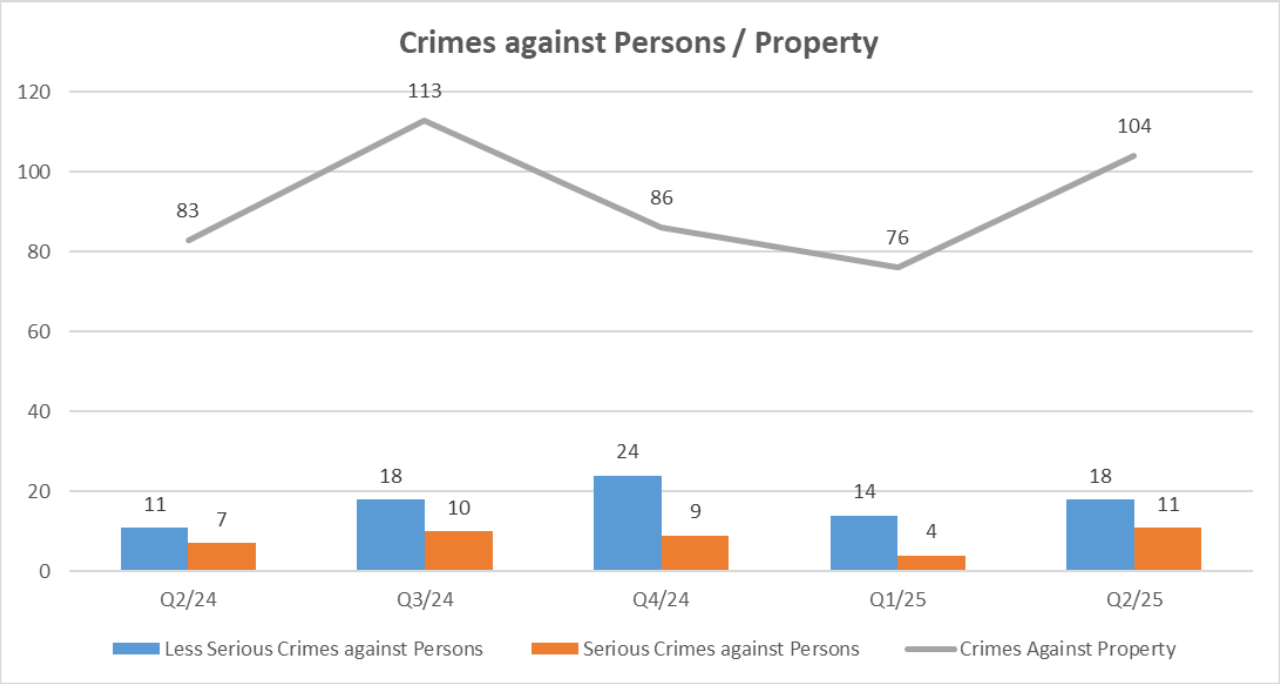
SOURCE: CPTED Audit DB – Senior

CRIMINAL AND ILLEGAL ACTIVITY ON TSHC PROPERTY

Crimes committed on TSHC are grouped into two categories, those against persons and those against property. Quarterly data shown below.

Stat Category	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Total Crimes against Persons	**18**	**28**	**33**	**18**	**29**
Less Serious Crimes against Persons	11	18	24	14	18
Serious Crimes against Persons	7	10	9	4	11
Crimes Against Property	**83**	**113**	**86**	**76**	**104**

SOURCE: CORA and Niche RMS



SOURCE: CORA and Niche RMS

Crimes against Persons

These crimes include assault, sexual assault, attempted homicide, discharge firearm, homicide, manslaughter, robbery, criminal harassment, indecent exposure, threatening etc.

In Q2 2025, reported Crimes against Persons increased by 61% (11 incidents) overall compared to Q1 2025:

- Serious crimes against persons increased by 175% (7 incidents). There was an increase in reported assault with a weapon (SSE and SSW).
- Less serious crimes against persons increased by 29% (4 incidents). There was an increase in reported threatening incidents (SSW region),

Compared to Q2 2024, reported crimes against persons increased by 61% (11 incidents) overall:

- Serious crimes against persons increased by 57% (4 incidents). There was an increase in reported assault with weapon incidents in SSW and SSE regions.

- Less serious crimes against persons increased by 64% (7 incidents). There was an increase in reported threatening incidents in SSE and SSW regions and utter threats in SSE regions.

Crimes against Property
These crimes include break-and-enters, theft, mischief, arson, vehicle thefts, etc.

In Q2 2025, reported crimes against property increased by 37% (28 incidents). There was an increase in reported thefts in SNE, SNW and SSE regions and mischiefs in SNE and SSE regions.

Year over year, in Q2 2025, reported crimes against property increased by 25% (21 incidents) compared to Q2 2024, primarily due to an increase in reported mischiefs in SNE, SNW and SSW regions and an increase in reported break and enters in SNE and SSE regions.

CSU actively works to mitigate crimes against property on TSHC property through the proactive work outlined above. In addition, we are looking to champion a community-based approach to safety, working with tenants, police, local safety organizations and partners. Here we will employ a community development approach to engage tenants to help plan, design, and implement safety initiatives. We will also continue to educate tenants with more opportunities to learn about safety and the actions they can take.

VIOLENCE REDUCTION PROGRAM ('VRP')

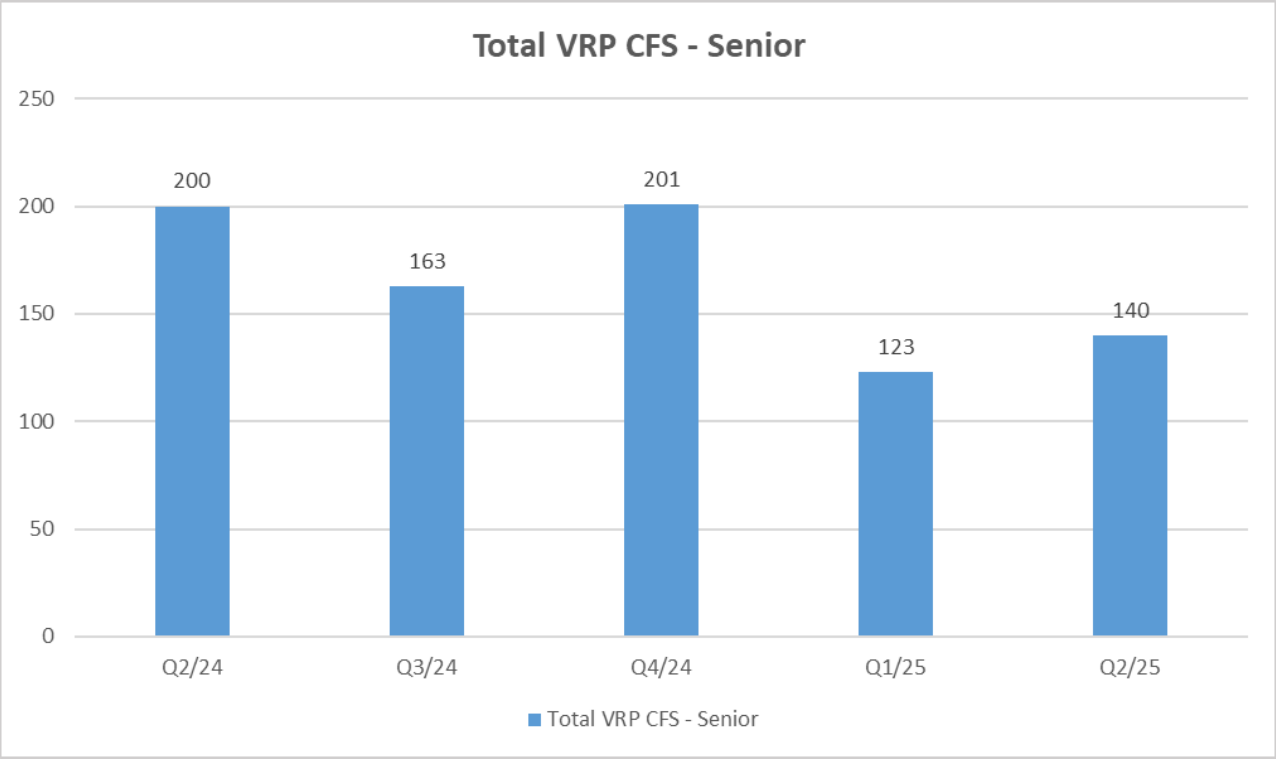
The Violence Reduction Program (VRP) began in Q3 2019 and was intended to reduce violent activities in the VRP communities. This program has been operational for more than five years and are slowly transitioning the work related to violence reduction, mitigating chronic gun violence and the impact of tenant vulnerability.

Calls for Service - TSHC - VRP Sites (note one call can have multiple incidents)

Dev Name	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
William Dennison Apartments (310 Dundas St E, 237 Sherbourne St)	46	41	81	57	46
Edgeley Apartments (35 Shoreham Dr)	79	52	60	30	29

Glenyan Manor (10 Deauville Lane)	51	42	26	14	28
Northacres Apartments (2 – 20 Flemington Rd)	13	21	14	8	19
Sackville St (252) (252 Sackville St)	11	7	20	14	18

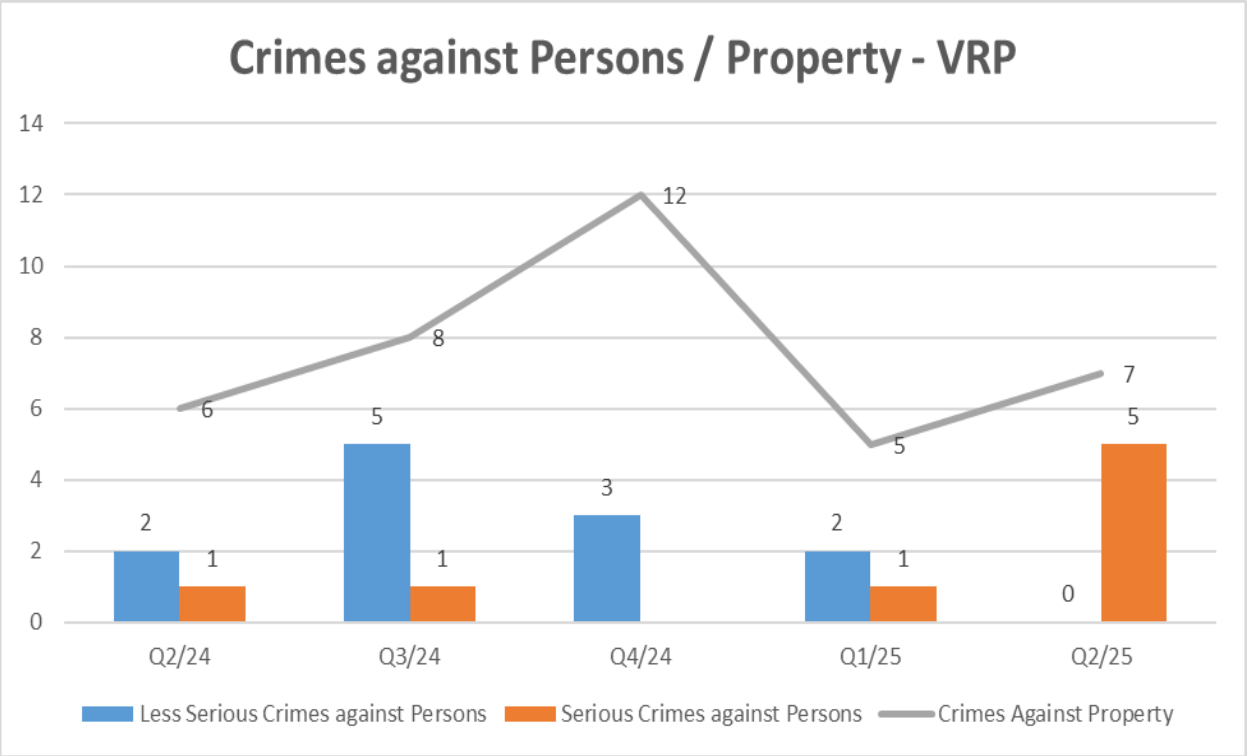
SOURCE: Dispatch Application (>Mar 2024) & CORA (pre-Mar 2024)



Crimes against persons / Crimes against property (VRP)

Stat Category	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Total Crimes against Persons	3	6	3	3	5
Less Serious Crimes against Persons	2	5	3	2	0
Serious Crimes against Persons	1	1		1	5
Crimes Against Property	6	8	12	5	7

SOURCE: CORA and Niche RMS



The increase in crimes against property incidents in Q2 was as a result of an increase in reported mischief incidents in William Dennison (1), Glenyan Manor (3) and Edgeley Apts (1). There was a decrease in reported thefts at William Dennison (1) and Edgeley Apts (2). There was an increase in Aggravated Assault at Sackville (1) and an increase of an assault with weapon and robbery at William Dennison.

OTHER STATISTICAL CATEGORIES (TSHC)

Stat Category	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Cause Disturbance Incidents	177	227	275	264	292
Check Welfare Incidents	171	215	223	216	249
Neighbour Disputes	236	220	253	294	244
Noise Complaints	167	158	155	157	136
Not Counted	9	4	5	9	7
Parking Incidents	231	191	184	213	242
Trespass Incidents*	109	84	185	160	135
Video Requests	61	63	72	70	87

SOURCE: CORA and Niche RMS

*****Trespass Incidents includes when notices are given to a person who has been cautioned for an offence under the Trespass to Property Act and the person is identified by the officer. The person is advised that they are not to return to the property for a period of one year. *Note, there are incidents where the person has left the property upon the arrival of the officer or leaves without providing their information. In these cases, no trespass notice would be issued and recorded.*

Q2/2025 UPDATE ON OTHER SECURITY MEASURES (TSHC)

Third Party Security update related to TSHC sites

Deployment of STAR security guards continues at the TSHC sites listed below. At the end of Q1 2025, the CSU launched a Graffiti and Vandalism reporting portal for TCHC, TSHC, and Third-Party Security staff to report minor incidents of graffiti and vandalism. Third-Party Security staff have been actively using this tool to report minor graffiti and vandalism, reducing response times and ensuring that incidents are cleaned up in a more efficient manner. The CSU is also in the initial exploration of on-line incident reporting tools which would be made available to tenants, staff, and other partners to report incidents assisting in enhancing access to reporting incidents to the CSU. These projects combined will help the CSU enhance its reporting capabilities and provide more accurate and wholesome data.

Southwest Region:
- 100 Cavell Ave. (Edwards Manor)**
- 2835 Lakeshore Ave. E. (Woods Manor)**
- 423 Yonge St. (Collegeview Apartments)

Northwest Region:
- 1775 Eglinton Ave. W. (Doug Saunders Apartments)

Southeast Region:
- 310 Dundas St. E. (William Dennison Apartments) **
- 80 Danforth Ave. (Broadview Manor)

** indicates coverage split between two buildings.

CSU Deployment Model

The CSU Deployment Committee continues to meet to analyze, discuss, and make recommendations on deployment strategies for the high-needs developments based on data collected. The committee will expand as we move forward and will include a representative from TSHC to discuss the allocation of resources.

Community Safety Advisors and Camera update

The CSA's assigned to the Senior's portfolio have completed five (5) CPTED audits this quarter Q2.

The CSAs, along with the assigned Field Intelligence Officer ('FIO') also participate in security systems upgrade planning with the Smart Buildings & Energy Management unit ('SBEM') in relation to new camera locations, scope of the work, requirements, etc. within the TSHC portfolio. SBEM works with CSU when new camera designs are introduced to a building so that we may provide input from a safety and security lens.

ATTACHMENT: Appendix A – Glossary of Terms

APPENDIX A

GLOSSARY OF TERMS

Community Safety Unit Patrols:

Patrols of the community by special constables. Patrols may be self-initiated, directed by a supervisor due to ongoing identified issues or patrols joint with Toronto Police officers.

Crimes against Property:

The number of incidents involving unlawful acts with respect to property but do not involve the use or threat of violence against a person (included are theft, break and enter, trespass, mischief, arson, etc.)

Serious Crimes against Persons:

Intentional use of force which results in serious injury or bodily harm, or use of an offensive weapon against a person. (included are: sexual assault, aggravated assaults, assault peace officer, assault with weapon, robbery, homicide, discharging a firearm, etc.)

Less Serious Crimes against Persons:

The number of incidents involving the application and/or threat of force to a person that are less serious in nature (included are: assault, criminal harassment, utter threats, etc.)

Referrals:

Community Safety Advisors (CSA) refer tenants to various agencies or business units and record this referral into HoMES and into the CSA Activity tracker. Numbers are calculated using the CSA Activity tracker.

Tenant Visits:

Community Safety Advisors (CSA) visit or contact tenants for various reasons and record this activity into the CSA Activity tracker. Numbers are calculated using the CSA Activity tracker.

Engagement Activities:

These numbers are collected from both the RMS systems (CORA and Niche) where a community event was captured by a special constable and from the CSA Activity tracker where Community Events, Crime Stoppers Presentations, Critical Incident Responses, Presentations and Safety Meetings were recorded by the community safety advisors.

CPTED:

An audit conducted by the community safety advisor in relation to crime prevention through environmental design (CPTED). Recommendations are recorded to enhance the safety of a community. For example, lighting may be poor in an area, a fence may be broken, hedges may be overgrown, graffiti may be present. Fixing these types of issues contributes to the safety of the community.

Toronto Seniors Housing Corporation

Quality and Tenant Engagement Committee (QTEC) Meeting

Meeting Date: September 30, 2025

Topic: Aging at Home Service Delivery Model Review Report

Item Number: 14

To: Quality and Tenant Engagement Committee

From: Deanna Veltri, Director, Engagement, Partnerships and Communications

Date of Report: September 16, 2025

Purpose: For Information

Recommendation:

The Aging at Home Service Delivery Model Review Report is being submitted to the Committee for information.

Reason for Recommendation:

In Q1-2025, the Partnership Table commissioned an examination of various service delivery models currently in use across Ontario, which was sponsored through the Office of the CEO and executed by the Strategic Partnership Advisor. The research and subsequent report sought to compare how seven different service delivery models integrate housing and healthcare services.

The attached report outlines the findings. After reviewing the findings in late July, the Partnership Table made recommendations, which are included in the report along with a summary of key next steps.

Deanna Veltri

Director, Engagement, Partnerships and Communications

List of Attachments:

1. Aging at Home Service Delivery Models Review.ppt
2. Aging at Home Service Delivery Models Review Report.pdf

Toronto Seniors Housing Corporation

Aging at Home

Service Delivery Models Review

Lessons to Strengthen the Integrated Services Model (ISM)

Review of Programs Across Ontario

Arlene Howells, Strategic Partnerships Advisor, Office of the CEO

arlene.howells@torontoseniorshousing.ca

September 30, 2025

Why We Undertook The Review

To understand what is being done across Ontario to improve access to health and social care programs through housing providers

To learn more about consistencies and differences in service delivery models

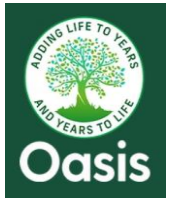
To help TSHC decide on how it could innovate, improve, and scale programs to better support aging at home for tenants

To understand how others manage governance and evaluation of their service delivery programs

Process


January 2025
Partnership Table Request Review
February 2025
Reviews Began
May 2025
Reviews Concluded
May-July 2025
Draft developed with further input from participants
July – September 2025
Circulating draft report for review, input and finalization to determine future planning

Models Explored



Common Across Programs

One Team – Anchor Agency in many cases focused on collective impact

Trust

On-site non-housing coordinators build trust and uptake

Housing focuses on space and supporting communications – stabilizing tenancies

Providers focus on program delivery and reporting

Community-driven, co-design, asset-based community development

Governance and managing people are change key levers

All are willing to collaborate to support aging at home

Using similar but not the same outcome measures – quality of life indicators are key

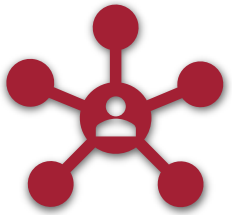
Program Options

Building Based

Preferred by housing tenants due to vulnerabilities of the populations as well as safety and security concerns

Community and Building-Based

Preferred by health and social care systems which are generally tasked with finding population-based funding solutions



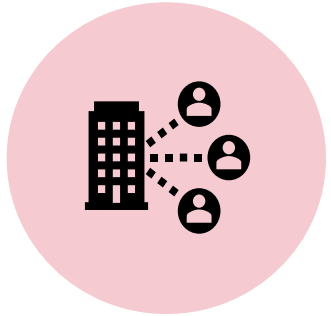
Outreach

Allows for solutions in communities where space, population health and access issues can be better addressed

Key Themes – Quick Summary

People

- One Team – One Voice – A coalition of the willing
- Guided by Community Voices
- Onsite Accessible non-housing Coordinators Are Vital



Delivery

- One Site At A Time
- Dedicated Space
- Managing Service Provision Costs
- Develop Minimum Standards – One Size Does Not Fit All
- Governance Models Differ
- Anchor Agency

Policy

- Privacy
- Evaluation and Value for Dollar Metrics Differs
- Fragmented Funding

Programs, Tools and Partnership Summary*

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Services/Programs							
Coordinator/Navigator	●	●	●	●	●	●	●
Access to Primary Care	●	●	●	●	●	●	
Home Care Services	●	●	●	●	●	●	
Social and Recreational Programs	●	●	●	●	●	●	●
Mental Health Programs	●	●	●	●	●	●	
Healthy Aging Programs	●	●	●	●	●	●	●
Allied Health Support	●	●	●	●		●	

Programs, Tools and Partnership Summary*

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Tools and Partnerships							
Robust Engagement Model	●	●	●	●	●	●	●
Measurement and Evaluation Framework	●	●	●	●	●		●
Governance Structure	●	●	●	●	●	●	●
Implementation Plan and Tools	●	●	●	●	●	●	●
Codesign with Members/Tenants	●	●	●	●	●	●	●
Privacy Framework	●	●	●	●	●	●	●
Ontario Health at Home	●	●	●	●	●	●	
Ontario Health	●	●	●	In Progress	●	●	

TSHC’s Unique Context and Considerations

Seniors Mandate

Unlike most housing providers that serve a broad age range, TSHC’s seniors focus may present unique legislative challenges in tailoring services and programs specifically for older adults. TSHC is built on the **Integrated Services Model** (ISM) to support aging at home, whereas other organizations are using similar principles to guide their work.

Programmatic Advantages

TSHC benefits from dedicated initiatives like **Community Connect+** and the **Community Activities Fund**, which enhance tenant engagement and ensure that seniors’ voices are heard in shaping services.

TSHC's Unique Context and Considerations

Existing Models

TSHC already has service delivery models in place through its partnerships, which provide a foundation for informed decision-making and potential scaling. It also has ties with TCHC, which may offer collaboration opportunities.

Complex Health and Care System Navigation

TSHC regions span eight different Ontario Health Teams (OHTs), each at varying stages of development and priorities. This complexity requires extensive coordination to ensure consistent and effective program delivery across all regions. Anchor Agency partners would be key in navigating the complexities.

TSHC's Unique Context and Considerations

Health and social care sectors already have many assets to support aging at home including funding, mandates and trained staff. TSHC may want to leverage a series of anchor agencies to help coordinate service delivery.

Anchor agencies can:

1. Lead partnership development and management.
2. Coordinate reporting, accountability, and associated risks and liabilities.
3. Establish unified service agreements with partner organizations.
4. Address operational partnership issues and concerns.

In this model, TSHC would:

- Provide physical space for service delivery
- Support relationship-building among staff, tenants, and providers
- Gather and communicate tenant needs to inform service planning

TSHC Current and Future State Considerations

Current State

- Many programs through many providers to meet immediate needs – lack of service coordination
- Already working with anchor agency model within limited scope – continue existing approach while building out future state

Current Considerations

- Board seeking innovative program delivery solutions
- Actively engaged in an environmental scan (i.e., this report)

Future State

- Many programs coordinated through an anchor/lead agency to meet immediate and emerging tenant needs

Future Considerations

- Multiple models across TSHC buildings based on the approach to partnership and the capacity/maturity of models
- Partnerships beyond health and social care (i.e., digital literacy)

Partnership Table Recommendations

The Partnership Table recommends that TSCH continue its multi-pronged approach to provide services today.

1. TSHC must continue its multi-prong approach of direct engagement with smaller providers and the use of existing anchor agencies, as they both are working to meet tenant needs today.
2. To better position TSHC to meet the growing needs of its tenants in a more coordinated way across more buildings, the Partnership Table recommends that TSHC expand its approach to coordinated program delivery into a building that is currently underserved in an area with high needs.

Partnership Table Recommendations

3. The site should have available space for coordinated service delivery through an anchor agency partner. Depending on the capacity and capabilities of the anchor agency partner, the pilot would focus on results related to:
    I. Facilitating more coordinated access to services for tenants, to meet their needs, using an approach that is repeatable and can be scaled across other buildings;
    II. Testing of a new housing and health dashboard to track and report on results related to stabilizing tenancies and improving care in communities;
    III. Investigating specific research findings that speak to the needs of older adults in social housing; and
    IV. Contributing to a larger body of evidence-based work that demonstrates positive outcomes for community and systems collaboration.

Partnership Table Recommendations

4. To support this work, and based on the findings of this report, the Partnership Table encourages TSHC to assist with the following:
    I. Creating a set of standards for what TSHC wants to build from (and systems partners can support), to build similarities across programs, such as:
        i. Neutral third party to support tenants and staff
        ii. An anchor agency approach
        iii. An evaluation framework
        iv. Complementary training for TSHC staff to support aging in place, as TSHC staff have stronger daily interactions with tenants
        v. Leverage the existing work of a local Ontario Health Team

Partnership Table Recommendations

5. Finally, the Partnership Table also supports pursuing funding to support this work between the housing and health sectors. Funding will help to deliver on the objectives articulated for this expansion, the development of a health and housing dashboard, and a standardized evaluation framework.

Next Steps

- Share report with participating organizations
- Consider site location(s)
- Tenant engagement/staff engagement at potential site(s)
- Continued work on dashboard development
- Implementation considerations and planning

Toronto Seniors
Housing Corporation

Thank you

Toronto Seniors Housing Corporation

Aging at Home

Service Delivery Models Review

Lessons to Strengthen TSHC's Integrated Service Model (ISM)

Final Report – September 2025

Table of Contents

Background

Toronto Seniors Housing Corporation (TSHC) was created to do more than just provide clean, safe, affordable housing. The Integrated Service Model, which underpins its work, means TSHC must also offer access to services and support so seniors can age at home with dignity. It is well accepted that access to housing, social services, and healthcare services are key social determinants of health. For TSHC to deliver on its full mandate, strong and mutually beneficial partnerships are required with various parties across diverse sectors.

In December 2023, TSHC initiated a Partnership Table to advise the organization on how best to align existing health and social care resources to better support the 15,000+ tenants, aged 59-100+, who call TSHC home. This table, made up of leaders from hospitals, Ontario Health Teams (OHTs), community services organizations, the City of Toronto, Ontario Health, Ontario Health at Home, and tenant volunteers, comes together about six times a year to offer guidance and advice to TSHC leaders. In early 2024, the table agreed on six key priorities to begin to build stronger bridges across the various sectors:

- Transition in care from hospital to home
- Intergenerational program support
- Education
- Improving language support
- Data analytics
- Building healthier communities

In subsequent meetings later in 2024, the table acknowledged the importance of all areas but agreed to refine its priorities due to capacity constraints, focusing instead on the following:

- Transition in care from hospital to home
- Data analytics
- Education

In the short term, the table agreed that immediate steps could be taken to support its education priority. In consultation and co-design with tenant volunteers at this table, three learning modules were developed with table partners on how to navigate topics deemed important to seniors by the Partnership Table volunteers. In the summer of 2024, those modules were delivered at TSHC's Regional Volunteers Meetings. It was very well received by the over 100 tenants in attendance, and they asked for more. The table once again stepped up in 2025 to provide more education sessions to give tenants more agency on how to access the services and support they may need. This work will continue as tenants value growing their knowledge and retaining their independence.

Transitioning care from hospital to home is the Partnership Table's key longer-term priority as it impacts the use of scarce system resources and outcomes for all involved. Many TSHC seniors are high users of health and social care services. Transitions across various providers and services can be difficult for older adults. There was also recognition that areas for improvement could be made in transitions in care across providers with social housing tenants. The table further agreed that transitions are tied quite closely to the Data Analytics priority, which assists system planners in understanding the current state and setting future goals for better outcomes.

To support these two longer-term priorities, in January 2025, the table agreed that the next step was to investigate existing service delivery models, including those currently being used at TSHC, and develop and pilot a project for TSHC to support more coordinated service delivery. While the current models work, they are limited to certain geographies, modalities, and populations, causing inequities across the 83 buildings that TSHC manages. The model review would look at a range of factors and seek to strengthen ties between providers, TSHC, and tenants. It would also seek to improve person-centred outcomes, system reporting, and improve system benefits for all parties. The Partnership Table has representatives from several OHTs which include North Toronto and North York OHTs through Baycrest, the East Toronto OHT through East Toronto Health Partners and the West Toronto OHT, through Unity Health. These, along with other models across the province, were put forward for consideration.

In February 2025, work began to learn more about the following models:

- Community Wellness Hub, Burlington
- East Toronto Health Partners
- North Toronto OHT/Baycrest's Neighborhood Care Team
- NORC Innovation Centre, University Health Network
- iHelp, Toronto Community Housing
- Ottawa Community Housing
- Oasis

Concurrently, discussions were held between Ontario Health, Toronto Community Housing, and Toronto Seniors Housing to develop a Performance Dashboard that links health indicators to housing indicators, showcasing the broader system impact of collaborating between housing and healthcare. When developed, this would be the first of its kind for both sectors in the province. A Performance Dashboard feeds directly into the Partnership's Table priority of Data Analytics.

Housing, health and social care currently have different outcome measures related to efficacy and impact, focusing on tenant/patient outcomes that improve quality of life and enable seniors to age at home with dignity and comfort. The following pages outline the findings from the model review.

Areas of Review and Approach

The review gathered information in the following areas, from the organizations and programs noted previously. An at-a-glance view of how each program manages service and system planning, can be seen later in the report.

Service Planning

- Volume of people served
- Types of people accessing services and what services are not used (needs-based) vs. what they requested
- What did they have before
- Serving the community or building only
- Space needed, and what other services are available in the area
- Intended and unintended outcomes
- Impact from the tenant, provider and staff perspectives

System Planning

- How they work with their partnership agreements
- Adoption and change management approach
- Measurement and evaluation criteria
- Human and financial resources to support project implementation and ongoing operations
- How is Ontario Health or Ontario Health at Home involved
- Legislative challenges
- Privacy

Members of the Partnership Table, including tenants, were invited to participate in the learning opportunities. Those who were able to attend included:

Tenants	• R. Butler • K. Fines
Delivery Partners	• Melissa Chang, University Health Network • Einat Danieli, Baycrest • Jagger Smith, Baycrest • Margery Konan, East Toronto Health Partners • Tory Merrit, Unity Health
TSHC Staff	• Darryl Spencer • Arlene Howells

Onsite in-person discussions were held with team members (and in some cases participants) for each program with TSHC staff, tenants, and partners attending, as they were available. Being able to see the sites, and in some cases, meet program participants, and meet with providers, offered insights that cannot come from reading a report.

The staff and participants in each of the programs that made themselves available were welcoming, open, and generous with their time and sharing lessons learned. We are deeply appreciative of each and every person who took the time to meet with us to share their knowledge and experiences. Special thanks to the primary contacts within each program, who helped to gather partners and participants to enrich the discussions and learning.

For each of the programs, the overview gleans information gathered from websites or program collateral to ensure the best possible representation of their purpose and intended outcomes. Discussion notes inform the themes and key takeaways.

Consistent Themes

While each program may have a slightly different approach to service delivery, there were some consistent themes across all those interviewed. Those themes have been distilled into three buckets: People, Delivery and Policy.

People Related

One Team – One Voice – A Coalition of the Willing

- Each program said that alignment and managing the people side of change, particularly amongst providers, including housing, is pivotal to success
- Change management work to develop trust and collaboration takes time, but each team puts in the time, understanding that this work is relationship-based

Guided by Community Voices

- Designing solutions with tenants/members is important and necessary
- Voices that shape solutions can be voices that share good news stories and give you insights into how programs are being received
- Approach to engagement varies from program to program, but co-design is key

Onsite Accessible Coordinators Are Vital

- Each program has some type of coordinator role, be it a Care Coordinator, a Community Connector, or some other name
- Individuals stay in these roles for some time; have set onsite hours for tenants/members to access individuals with whom they develop trusting relationships
- Those relationships can lead to better conversations about health and care needs, which can guide the Coordinator/Navigator/ Connector in better supporting the person
- Posted hours for coordinators and programs are needed
- Having access to a service and support coordinator from outside of housing is highly recommended

Delivery Related

One Site at a Time

- Most recommended to undertake no more than one pilot at a time
- Grow from initial pilot, capture lessons, tools, evaluation methodology, and then work to spread and scale
- Develop a strong governance structure and ensure people understand the implications of working as one team

Dedicated Space

- Having an accessible, dedicated space for both private and group programs is important
- Housing providers seek solutions whenever possible to create or adapt space to offer what the service providers need

- Space needs include office space for providers to complete desk work

Managing Service Provision Costs

- Through reallocation and reassignment of existing dollars, health and social care organizations are finding ways to deliver community-based care and support with existing dollars
- Housing providers play a vital role by providing in-kind offices and spaces for program delivery
- Housing is a key program promoter for tenants/members

Develop Minimum Standards – One Size Does Not Fit All

- While each community may have variations in needs and desires, some minimum standards should be in place
- Basic services should include access to primary care, access to community paramedics, access to community-based social activities, and capacity-building programs for tenants

Governance Models May Differ

- Having a clear governance model from the outset is necessary
- Determining acceptable governance takes time and a shared vision
- Governance depends on each team's collective appetite to support strategic and operational pathways to moving their work forward

Anchor Agency

- Designating an anchor agency can increase time and cost savings to the health and care systems
- Tenants/members would have better and more coordinated access to services to age at home
- Housing providers also gain efficiency by working with a single agency instead of navigating a complex network of service providers
- In anchor agency models, aggregate reporting between providers and the housing partner is managed by the anchor agency

Policy Related

Privacy

- Tenants/members prefer a third party rather than the landlord being involved in their care needs or concerns
- Privacy restrictions across multiple government agencies make information sharing challenging from a person-centred approach
- Providers have developed and use guidelines to manage consent protocols

Evaluation and Value for Dollar Metrics Differs

- There is no standardized evaluation assessment tool to measure and demonstrate impact and results across all programs
- Healthcare has some lagging indicators related to hospital visits and use of community paramedics

- Housing has indicators primarily related to bricks and mortar to show the impact of programs on stabilizing tenancies and helping people to age in their homes
- Social care indicators appeared intertwined with health indicators
- There are metrics on quality of life used by some providers that can inform the impact of housing, health, and social care providers working together

Fragmented Funding

- Services are funded in a fragmented way, making coordination across sectors challenging
- Partners from across many systems are finding workarounds to support aging at home

Summary of Observations

One Team – Anchor Agency in many cases focused on collective impact

Trust

On-site non-housing coordinators build trust and uptake

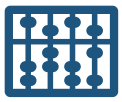
Housing focuses on space and supporting communications – stabilizing tenancies

Providers focus on program delivery and reporting

Community-driven, co-design, asset-based community development

Governance and managing people are change key levers

All are willing to collaborate to support aging at home



Using similar but not the same measures – quality of life indicators are key

Programs Overview

Community Wellness Hub, Burlington

Primary Contact: Adeeta Aulakh, Program Manager
Burlington OHT

About

The Community Wellness Hub (CWH or sometimes just called the Hub), developed in Burlington, is an innovation in integrated care. It brings health, housing, and social service providers to work together as one team. It also enables preventative and maintenance care for vulnerable seniors in the community.

The CWH is part of the Burlington OHT team's work in managing population health for seniors. It is inspired by the American PACE model, which has been adapted to support Canada's publicly funded health and social care systems. Currently, programs are underway in Burlington and Oakville, with inquiries from other municipalities within Ontario and other parts of eastern Canada to bring this program to their community. The CWH provides tenants and community members with health and social care by professional community partners. It is open to both tenants and non-tenants. "Services provided in a CWH are at the intersection of four systems: health, wellness, social services, and housing. Each CWH is co-designed with its local community members to provide services specific to the needs of the local target population." (Burlington Ontario Health Team, 2025)

The Hub improves access to community support services for seniors, improves preventative care, reduces reliance on institutional care, and honours seniors' wishes to age in their homes. It is strategically

embedded within senior housing complexes owned and operated by Halton Housing. The CWH reduces barriers to access, recognizes the value of housing partners in addressing social determinants of health, and enables a relationship between housing and community support services that benefit seniors. (News, OHA, 2025)

Vision (OHT, Burlington, 2024-25)

To keep seniors who are at risk of hospitalization or institutional care living healthily and happily at home for as long as possible.

Mission

To offer care and support through trusting relationships and an integrated approach that proactively identifies and responds to physical, mental, and social “flags” before individuals get into crisis, where they require acute care resources.

Motto

“One Team, One Vision, One Plan”

Services Include

- One-to-one support to connect to local health and wellness services.
- A community connector who helps coordinate care.
- Social events, exercise classes, and recreational activities to stay active and make new friends.
- Workshops about healthy living, mental health, managing medications, etc.
- Tablet device loans and Internet, so you can keep in touch with friends and loved ones.

Their metrics tell a story of meeting the needs of the population they serve: (OHT, Burlington, 2024-25)

- 307 people served between two hub locations
- 94% felt safe at the hub
- 81% made friends at the hub
- 93% have unlocked services they need through the hub
- 92% agreed that the hub will help them age at home
- 99.8% gained knowledge
- 99.3% will apply that knowledge

Site Observations

The Burlington Community Wellness Hub has three sites in the service area for the Burlington OHT. There are plans to expand to other sites in their service area. The model is also being used at two sites served by the Greater Hamilton Health Network (OHT) and two other sites are served by Connected Care Halton OHT. The model review team visited the John Street location in Burlington. We met with Hub partners and toured the site. We were impressed with the purpose-built spaces, such as the reception area, an adult special needs bathroom, a large community room, offices, and access to outdoor spaces for activities. That location also has a dedicated dining hall where meals are served, or groceries can be ordered for a nominal fee. For those unable to come down to the dining room/servery, food can be ordered and will be delivered to their home. This service is only available to tenants.

Partnerships and Collaboration

In conversation with the Hub partners, they spoke warmly of their relationships with each other and stressed that they are better and stronger together. Partners work as one team, with one voice. Partners noted that there were obvious challenges at first about boundaries, roles, and responsibilities for individuals and organizations; however, there was also a deep commitment to being better together. A team-based approach is taken in working with tenants, with clear lines drawn around protecting tenant/member privacy.

Halton Community Housing Corporation (HCHC) provides space in the buildings and coordinates communications between providers and tenants. They are also responsible for any capital investments and maintenance needed to support access to services. HCHC benefits in this partnership by being able to offer access to a range of supports

that meet the needs of vulnerable tenants. This can aid in stabilizing tenancies so that tenants can age at home. HCHC provides meeting rooms for private appointments and community rooms for group activities. As HCHC adds buildings to its portfolio, it includes purpose-built space to support more programming and activities for tenants.

The Community Connector Role

There is a lead organization for the Hub (an anchor agency) that employs the Community Connector, who is key to building trusting relationships with tenants regarding their health and wellness needs. The Community Connector can come from a health or social service organization. The Community Connector has fixed hours in the building and is on-site for those hours. This consistency aids in building trusting relationships with tenants. The Community Connecter acts as a system guide or navigator to external supports while also working with the building providers to further support members. “An on-site Community Connector is foundational to the CWH model. They work closely with the Hub’s members (i.e., residents and community members who access the Hub) and service providers.

The Community Connector is responsible for onboarding members, identifying member needs through goal-based care planning, connecting members with the CWH’s service partners, leading interdisciplinary rounds or individual care conferences, and fostering an environment for person-centred holistic approaches to care. The result is one intake point for services, one coordinated care plan for members, and one interdisciplinary team made up of staff from a range of services that work together to provide wrap-around health, wellness, social, and housing services.” (Burlington Ontario Health Team, 2025)

Frameworks and Tools

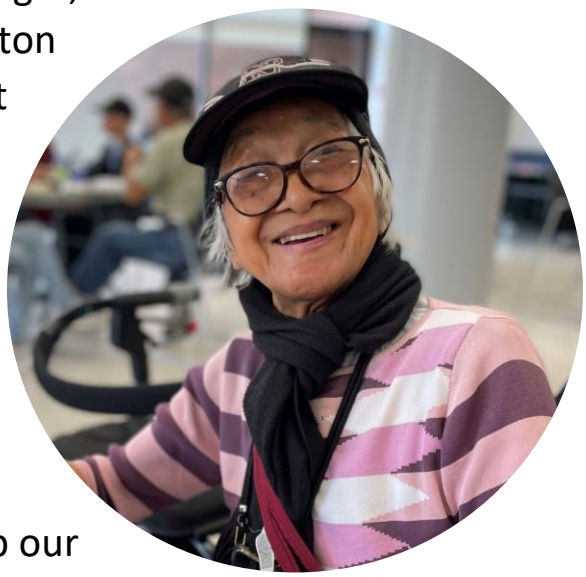
The Hub has a well-developed implementation playbook as well as an evaluation framework built around best practices in care and community development. The Hub has a Memoranda of Understanding (MOU) and Letters of Intent to support their partnerships. Those delineate roles, responsibilities, resource allocation, reporting parameters, and governance structure for the Hub. They also have operational tables for local and regional decision-making, communities of practice, and an evaluation framework. Some of their developed tools include:

- Operational metrics data collection sheet
- Hub partner and external data collection sheet
- Acute care data collection sheet
- CWH member experience survey
- CWH provider experience survey
- CWH data tracking dashboard

Demonstrated Outcomes and Benefits

Over time, Hub members have reported an improved sense of health or wellness. Hub members use the emergency department less than non-Hub members, have shorter lengths of stay in the hospital, and get hospitalized less often. These are benefits not only to the members but also to the health, housing, and social care sectors.

According to Dr. Reham Abdelhalim, Manager, Population Health and Evaluation, Burlington OHT, speaking in a video about the impact of the program on tenants, she notes, “They have longer average tenancies in the building, compared to non-members…members report feeling safe and respected in the Hub”. Tamara Warwick, Support Services Coordinator, Services for Seniors, Halton Region, says, “We provide wrap-around services to help our clients live more independently, which has led to improvements in their mood, mobility, and overall well-being.”



Implementation Challenges and Learnings

For their initial implementation, it took about five years to create an integrated vision that all partners could support. A lot of personal and organizational change was required. They alluded to this being one of the biggest challenges. Going from thinking about your work and your organization to thinking about other organizations and your role in a broader, multi-sector, multi-disciplinary team is considerable change. Once they figured out the roles, responsibilities, and navigated the inevitable change management issues, they created a playbook that allows future implementations to happen in a matter of months.

Key Takeaways

- **Improved outcomes:** Demonstrated benefits for members and service providers
- **Evaluation framework:** Structured assessment validates the outcomes
- **Onsite coordinator:** A dedicated, trusted coordinator builds rapport and continuity with members
- **Member-driven programming:** Services are tailored to identified needs
- **Dedicated spaces:** Housing provider allocates appropriate physical space for service provision and activities
- **Hub and spoke model:** Combines on-site services with broader community outreach
- **One team:** Emphasizes a collaborative, “better together” mindset across partners
- **Housing as liaison:** Housing staff play a key role in allocating space and communicating with tenants
- **Playbook for scale:** A proprietary implementation playbook with tools and templates supports efficient rollout
- **Phased development:** Sites are developed one at a time
- **Change management:** Significant effort is needed to navigate concerns from staff, partners, and tenants/members

East Toronto Health Partners Ontario Health Team (OHT), Thorncliffe Park Community Hub

Primary Contact: Margery Konan, Manager, Integrated Care, East Toronto Health Partners, Member of TSHC Partnership Table

About

East Toronto Health Partners Ontario Health Team (ETHP OHT) is a group of more than 100 community, primary care, home care, hospital, and social services organizations in East Toronto working together to create an integrated system of care across our communities. (East Toronto Health Partners, 2025). They are represented at TSHC's Partnership Table and have shared their experiences, insights, and guidance.

The ETHP OHT serves over 20 neighbourhoods, with the following being the top priority areas identified by the City of Toronto: Thorncliffe Park, Flemingdon Park, Taylor-Massey, Victoria Village, and Oakridge. As an OHT, their focus is on population health and care in the community, serving over 300,000 people.

ETHP OHT's shared purpose is to build a healthier and more equitable East Toronto, enabling every person and neighbourhood to thrive. They focus on four key areas.

- **Collaboration**: Every organization and provider has a responsibility to help create an integrated system of care and work collaboratively in the best interests of the community
- **Equity by design**: By mobilizing our community and amplifying the voices of those not typically heard, we can co-design a more

inclusive system that delivers high-quality care and equitable health outcomes for everyone

- **Community-led change:** Our community inspires us to be bolder, push harder, overcome systemic barriers, and create the conditions to achieve and sustain positive change
- **Collective impact:** The strength of our relationships is our greatest asset. Together, we are #OneEastToronto

ETHP OHT strategic priorities are to:

Enable an equity-based approach to population growth.

Build structures and systems that connect us.

Advance a connected and sustainable system centred around primary care.

Partner with our communities to co-lead change.

Neighbourhood Access Model

Many programs within ETHP OHT are designed for those who experience language and cultural barriers, low income, or who are newcomers, to name a few areas of focus. ETHP OHT is advancing a neighbourhood health access model grounded in primary care. The neighbourhood health access model focuses on team-based primary and community care that is integrated with multiple providers and services within a neighborhood so that it is easy for local residents to access. The model aims to improve health outcomes, reduce barriers to care, and address health inequities. They integrate health services with

community services, like social supports and mental health resources, enabled by low-barrier access points for the community, often featuring a physical hub location.

Services offered by ETHP OHT partners at Health Access sites include: (Flemingdon Health Centre, 2020)

- Primary Health Care
- Nutrition and Food Security
- Social Work
- Health Education and Promotion
- Foot Care
- Community Resources and Referrals
- Family Support
- Home Care and Chronic Disease supports

The Health Access teams include several key roles including:

- Community Health Ambassadors
- Holistic Intake and Navigation Counsellors
- Care Coordinator(s) - employed by Ontario Health at Home and embedded within the neighbourhood team
- Primary Care Providers
- Broader community and social care teams

Thorncliffe Park Community Hub Site Visit

Unlike some Neighbourhood Care Teams (NCTs), which might only deliver services to a specific building or buildings, the neighbourhood health access models serve the larger communities where they are situated. We visited with ETHP OHT representatives at the impressive

Thorncliffe Park Community Hub, which serves as the main site for one of two Health Access Teams within ETHP OHT (the other being Health Access Taylor-Massey). Thorncliffe Park Community Hub is surrounded by over 90% vertical housing. Clients can access services directly where they live or in one of the hubs where ETHP partner organizations deliver services.

The Neighbourhood Organization's (TNO) Integrated Services for Seniors Program has its home base at Thorncliffe Park Community Hub and is a core program within the Health Access Thorncliffe Park offerings. There are two TSHC buildings nearby, 12 Thorncliffe Park and 10 Deauville, that have access to this program. In each building, over 100 tenants benefit from the services offered through TNO's Integrated Services for Seniors Program.

Programs include weekly onsite sessions for fitness, balance, body strength, and wellness along with special workshop topics and offsite outings. There are social/recreational components included in onsite programming, with activities selected by tenants on each day of programming, for example Mahjong, armchair travel, or arts and crafts. Typically, 50-75 tenants attend each session.

Personal support services provided by TNO are provided to help tenants with household needs and personal care. Personal Support Workers also bring clients into the lower-level recreational spaces and support residents in participating in group programming. Partners noted that their programs would benefit from having more space in TSHC buildings for program delivery. This would also enable more collaboration between housing staff and their team, and greater community engagement to support tenants.

Below is data from April 1st, 2024, to March 31st, 2025, specific to TSHC tenant interactions with the Integrated Services for Seniors Program.

	Program Facilitation Interactions	Personal Support Services - Interactions	Case Management – Hours of Support	Personal Support Services – Hours of Care
10 Deauville Lane	1,281	582	1,543	1,269
12 Thorncliffe Park Dr.	1,041	1,662	1,056	3,500
Total	**2,322**	**2,244**	**2,599**	**4,769**

Key Roles in Service Delivery

As part of their service delivery model, the Health Access teams have Community Health Ambassadors (CHAs) who are community members with lived experience. Many CHAs come through TNO. They help other community members who may experience inequities, such as those in the TSHC buildings. Community Health Ambassadors are also hosted at Flemingdon Health Centre, WoodGreen, The Neighbourhood Group, and Access Alliance Community Health Centre.

The Ambassadors have supported:

- Vaccine Engagement (volunteers at the vaccination clinic; outreach in the community, information sessions, mobile clinics, door-to-door appointments, food delivery, provided free testing kits)
- Community events e.g., virtual art sessions to help reduce isolation and address mental health
- Cancer Screening – generating blueprints around culturally specific supports for cancer screening conversations

Connecting the dots:

- CHAs know their communities
- CHAs are champions for health promotion

The Community Health Ambassador initiative has been recognized as a "Leading Practice" by the Health Standards Organization, highlighting its innovative and people-centred approach.

The Holistic Intake Navigation Counsellor (HINC) role is another essential role within ETHP that provides direct client care involving connections to primary care, social care services, and the broader determinants of health. They ensure clients with complex, overlapping needs receive coordinated, holistic care that includes intake, tailored care plans, referral and follow up and ongoing advocacy and monitoring. The HINC role is accessible at several access points within the ETHP's Neighbourhood Care Model, including within the Health Access models, within primary care practices, and within the local hospital Emergency Department, where clients who do not have access to primary care and social services can become connected to services close to home.

Partnership and Philosophy

In speaking with partners, they said they focus their energies on solutions built by the team, not any one organization. Acknowledging that they do not have a lot of extra resources to work with, they support their communities by aligning their efforts and pooling their resources. In doing so, they are seeing the value of their collective impact. They do not have one legal entity for their collective work, but they do have formal agreements between partners to guide the work.

Through the Health Access approach, all partners speak to their clients with one voice as one team. In digging deeper into this idea of creating one team, it was noted that teams had to give up some of their own way of doing things to be part of this team. While the transition may have had personality, jurisdictional, privacy, and organizational challenges, they continued to strive for one voice, one vision to support one team.

Thorncliffe Park Community Hub Details

The Thorncliffe Park Community Hub, as one of the two Health Access Hubs within ETHP OHT, provides a clean, safe, and easily accessible location for the members of that East Toronto community to get the services and support they need, closer to home.

The Thorncliffe Park Community Hub is a bright, welcoming, and beautifully designed, state-of-the-art, accessible space with different provider amenities available in a “one-stop shop” model for many services. It launched in February 2025 after many years of consultation, planning, coordination, and collaboration.

The Thorncliffe Park Community Hub serves over 30,000 people in its catchment area. They serve a very large immigrant population with

diverse values, beliefs, languages, and histories. The hub is a cradle-to-grave service provider that supports all ages from newborns to older adults. The anchor agencies for this hub are The Neighborhood Organization, Flemingdon Health Centre, and Michael Garron.

Hub programs include (not an exhaustive list):

- Integrated Services for Seniors
- Personal Support Services for Low Acuity Home Care Seniors
- Youth and Youth Employment Programs
- Maternal and Newborn Programs
- EarlyOn Family Resource Centre
- Resettlement Services
- Primary Care, Mental Health Services
- Housing Supports
- Food Collaborative
- Legal and Notary Services

Subsequently, they have space in the hub to offer programs. They also use the hub to reach out to the surrounding vertical housing communities to offer programs that community members want in their buildings. Community members have the benefit of many health, wellness, education, social, and other government services available within walking distance of their homes.

ETHPs was pivotal in launching the Thorncliffe Park Community Hub. A newer hub location in the Taylor-Massey neighbourhood is being developed, following the Health Access Thorncliffe Park model.

Key Takeaways

- **Broader scope:** ETHP's model appears more expansive than some of the Neighbourhood Care Teams currently used at TSHC
- **Outreach and hub models:** TSHC tenants can access support both in-building and through the Thorncliffe Park Hub
- **Direct tenant engagement:** They use co-design to understand tenant/client goals and needs, to improve population health outcomes
- **One Team philosophy:** Ideally, this would include TSHC staff in solutions planning while respecting privacy boundaries as they seek broader collective impact
- **On-site TSHC programming:** More space is desired in TSHC buildings to expand on-site service delivery
- **Care coordination:** A consistent and trusted care coordinator is key to building strong, lasting relationships along with Community Health Ambassadors and Holistic Intake and Navigation Counsellors
- **Evidence of improved outcomes:** Their evaluation framework shows that they are seeing improvements in health and wellbeing for those they serve

North Toronto OHT/Baycrest's Neighbourhood Care Teams (NCT)

Primary Contact: Einat Danieli, Clinical Manager, Ambulatory Care Services, Baycrest Hospital and Neighbourhood Care Team Lead in North Toronto Ontario Health Team and North York Toronto Health Partners, Member of TSHC Partnership Table

About

The Baycrest Neighbourhood Care Team (NCT) works with two OHTs to support TSHC tenants in eight buildings in North Toronto. The North York Toronto Health Partners and North Toronto Ontario Health Teams collaborate as one team with Baycrest Hospital serving as a coordinating and integrating entity for the delivery of health and wellness programs to tenants in the North Toronto and North York regions. They bring health and social service providers together to strengthen aging in the community. Baycrest is a member of TSHC's Partnership Table, serving a dual role, representing both its organization and two Ontario Health Teams.

As noted on their website, "Baycrest is an academic health sciences centre providing a continuum of care for older adults, including independent living, assisted living, long-term care, and a post-acute hospital specializing in the care of older adults, all within one campus.

Baycrest is a global leader in geriatric residential living, healthcare, research, innovation, and education, with a special focus on brain health and aging. They offer a full spectrum of specialized inpatient care services for the older adult population, from inpatient to ambulatory rehabilitation patient needs."

For Toronto Seniors Housing, Baycrest is an anchor agency that works with over 20 other organizations to bring services and support to TSHC tenants in north Toronto. Partners include Sunnybrook Health Sciences and Family Health Team, SPRINT Senior Care, LOFT, Circle of Care, and VHA, among others. For the past three years, NCT partners provided vaccines, wellness clinics, falls prevention training, attachment to primary care providers, diabetes education, foot care, social recreation, and other essential services to tenants at eight TSHC buildings.

As of February 2025, they reported the following about their programs at TSHC:

- Accessible to 1,219+ tenants across eight buildings, with an average of 350-400 visits per quarter
- Tenants co-design the care and services
- 20 delivery partners; structures for collaboration
- 80 tenants connected to primary care

Neighbourhood Care Team Structure and Responsibilities

Baycrest organizes collaborating clinicians and organizations into "one team" called the Neighbourhood Care Team. Baycrest is the primary point of contact for the NCT and TSHC, where they:

- Oversee model of care development and implementation, including partner engagement and structures for collaboration

- Coordinate tenant engagement to ensure health services are tenant-driven
- Broker services for each building are based on the identified and expressed needs of tenants.
- Serve as the primary contact for TSHC leadership and as the representative at the Partnership Table
- Hold the Use of Space agreement with TSHC to establish and manage space for OHT providers to use for program delivery and use sub-leases to integrate services seamlessly
- Centralize evaluation and metrics collections and provide quarterly reports to TSHC and partners to demonstrate service utility, impact on health, and use of health system resources, complemented by impact stories
- Identify funding envelopes and serve as lead author for funding proposals

Their materials noted that: “The North Toronto Ontario Health Team co-created a Neighbourhood Care Team. It is an integrated geriatric model of care that unites dedicated health care organizations, providers, and their clients (patients, families, and caregivers) to improve integration and coordination of care as one team. This outlook was also adopted by the North York Ontario Health Team.”

Baycrest's NCT team's mission is to establish neighbourhood wellness centres in Toronto Seniors Housing buildings. Their goals include:

- Improving health outcomes and quality of life.
- Supporting attachment to primary care.
- Increasing access to health and social services.
- Promoting early identification of needs.
- Facilitating an appropriate level of care based on tenant needs.

Program Model and Community Integration

Baycrest's NCT model treats each TSHC building as a unique community/population. Programs are designed to meet the needs of TSHC tenants, not those who live outside of the building. This can create cognitive dissonance for some providers who are funded to deliver services to the entire neighbourhood and wish to use TSHC's community space to support the larger community.

For some tenants, where programming support has been offered to others in the community, this has given rise to fears and anxieties. For clarity, this practice is not widespread. It should be noted that the majority of TSHC tenants do not wish to have others coming into the buildings. There are fears related to safety, security, and unwanted visitors because many feel more vulnerable as they age. As part of the NCT, they work to balance these expectations while emphasizing

tenants' safety and input. NCT intends to continue to serve each building as a unique community/population, and at the same time, will work with OHT and City Developer partners to establish hubs and service solutions outside of TSHC buildings to support the rest of the community.

Collaboration and Communication

Further work is needed to structure pathways for communication and information sharing between NCT providers and TSHC to allow a more seamless collaboration and coordination on the ground.

Innovative Approaches

Baycrest's NCT has had the opportunity to test new approaches for capacity building with tenants, such as the implementation of their Health-Bay kiosks. They developed and implemented a self-serve health kiosk in common areas. It is a digital enabler that allows tenants to access information about their health and wellness. This helps tenants to better manage their health, self-assess their own health and risk factors. It also helps the team to identify when a tenant needs support in a specific area once a tenant brings the information forward. Tenants were engaged in the design and trained on how to use the kiosk.

Comprehensive Services Provided

Collectively NCT partners provide many services, such as (not an exhaustive list):

- Attachment to Primary Care
- Fall Prevention
- Exercise

- Farmers Market
- Transportation
- Social Workers
- Nursing Wellness Check
- Ontario Health at Home Coordinator
- Dental Hygiene
- Hearing checks
- Chronic Disease Management
- Brain Health
- Foot Care

Integrated Care Approach

Baycrest works closely with social service providers as well as other healthcare providers, such as primary care physicians. Together, they support tenants in getting as many of their needs met in their buildings rather than having to go outside or use an emergency room or Emergency Medical Services.

Evaluation Framework and Outcomes

The NCT evaluation framework includes four main pillars:

1. Population health outcomes – using a quality of life questionnaire and attachment to primary care
2. Quality of care – self-reported access, service utility, and early identification
3. People's experience – self-reported tenant and provider experience surveys

4. Value for money – reduction in avoidable admissions and institutional care

Their money for value evaluation highlights these key findings:

- 11.65% reduction in avoidable emergency room visits
- 4% reduction in re-admission rates within 30 days
- 25% time savings for providers
- Just over a 2% increase in hospital re-admission rates within seven days

They rely on their well-developed governance model to manage the relationships with provider organizations. Here are some reported results:

- 100% of tenants rated their experience with the team as good to very good.
- 85% of tenants reported that they can access the care they need. They have shared results internationally on their work with TSHC tenants.
- 100% of NCT providers reported they felt this model was effective in helping tenants to better manage their care and stated that they liked working on the team.

During our interview process, they noted that having a primary care provider should be core to each team, along with a care coordinator. Having a presence in the buildings allows them to grow trusting relationships. It also contributes to the team's ability to reach those who are at risk but are not yet seeking care. This allows for earlier support.

Key Takeaways

- **One Team:** Redistributing existing system resources across systems can improve health outcomes and reduce care costs sustainably
- **Minimum standards:** Establish baseline service standards for all support teams, including guaranteed access to a primary care provider and a care coordinator
- **Holistic care:** Address both social and health needs of tenants to eliminate barriers to care
- **Local presence:** Teams embedded in the community foster trust, early issue identification, and smoother access to services
- **Cross-sector collaboration:** Strengthen partnerships between housing, health and social care with a renewed commitment to shared goals
- **Proven impact:** Evidence shows improved outcomes for both tenants and service providers
- **Infrastructure challenges:** Lack of dedicated space limits the ability to expand services to more buildings
- **Partnership expansion:** Engage more closely with the NORC Innovation Centre and include social service providers in planning and decision-making
- **Privacy barriers:** Privacy regulations (e.g., MFIPPA, PHIPPA) complicate cross-sector interventions
- **Tenant engagement:**
    - Use pre-engagement and co-design events to shape services
    - Establish clear guidelines for tenant interaction
    - Begin with social events to build trust and familiarity

- Maintain ongoing tenant involvement in all stages

NORC Innovation Centre (NIC), University Health Network

Primary Contact: Melissa Chang, Senior Director, Connected Care and NORC Innovation Centre at University Health Network, Member of TSHC Partnership Table

About

Naturally Occurring Retirement Communities (NORCs) are popping up in many jurisdictions globally. A NORC is a neighbourhood or area where a significant number of older adults live. It is not a purpose-built space for aging adults. It makes the most of what already exists, whether it is a cluster of single-family homes, condos, or apartment buildings. The NORC Innovation Centre (NIC) taps into these developed communities and offers support to residents through health and social service providers so that people can age in their homes rather than in other institutions of aging.

In Toronto, the NIC, part of the University Health Network, Canada's largest academic and research hospital, is playing a pivotal role in creating NORCs as a new option to age at home.

The NIC acts as:

1) a resource to older adults and health and social system partners, providing access to important data, research, and training, and

2) is implementing a "first-of-its-kind" community-led integrated model of care, which is redefining community leadership capacity for the formal health and social care system. (NORC Innovation Centre, 2022)

The NIC is a member of TSHC's Partnership Table and currently works alongside tenants in five TSHC buildings. They have provided resources to advance TSHC's work in tenant capacity building, addressing gaps and access to health and social supports, education, and overall leadership on strategic partnership opportunities.

Unlike most programs, the NIC is supported through a combination of philanthropic contributions and grant funding. It collaborates with care providers in the publicly funded system, complementing their efforts. While the NIC's approach is inclusive and not based on income or social status, it prioritizes regions with the greatest need, particularly those lacking adequate services and resources.

Knowledge and Expertise

There are a number of ways TSHC might be able to tap into their knowledge and expertise.

- NORC Accelerator spreading the UHN NORC Program model – this is a model that leverages knowledge from the centre and combines it with the local expertise of communities and care provider groups across the city (e.g., leveraging the work of various Ontario Health Teams). This model starts by building strong local older adult leadership (NORC Ambassadors) and partnering with local organizations to address key aging in place challenges, including social isolation, loneliness, limited access to primary care, and difficulties with care navigation. They partner with over 30 sites that deliver health and wellness support and services, serving over 4,500 older adults.
    - The UHN NORC program is adaptable with different intensity levels of support to meet the needs and preferences of the

building; there is a NORC Connector identified as a key contact for the building (some buildings have dedicated on-site support) as well as connection to a clinical team that can help with navigation and coordination. This is especially important in cases where someone may not be able to access primary care or is having difficulty navigating the health system. In all cases, primary care and local care delivery partners are involved.

- Aging in Community and NORC Ambassador Training and Engagement works with local leaders and service providers to build skills and capacity to reduce isolation, foster informal care, and build stronger peer support networks. The NORC Ambassador Program offers participants the chance to stay engaged, active and most importantly drive what and how support and services are delivered in their building. Four TSHC buildings have already taken part in the NORC Ambassadors program and a group of TSHC staff have taken the Aging in Community Training. Feedback is now being incorporated to improve the program to be able to expand more broadly.
- Presently, the NORC Ambassador program provides capacity-building skills in four TSHC buildings. The aim is to have between three to five tenant volunteers who can commit to meeting once a month for nine months for training. About halfway through their nine months of training, a wellness survey is conducted to identify gaps.
- Research and Evaluation – the Centre has developed an evaluation framework to help assess how best to implement NORC programs as well as provide a consistent way to measure

the impact of the program model. TSHC buildings that are currently participating are already involved in this research and evaluation effort.

- Data Tools and Policy Recommendations – with links to health and social system data the Centre leverages the information to help communities determine what supports and services might be most helpful to them. Where there are gaps or opportunities for innovation, they are developing policy recommendations for government leaders at all levels e.g., what supports are needed to expand NORC opportunities, improve home care services, and advocate to fund aging in place initiatives.

  For example: In a recent policy paper published by the NIC in 2024, they made a series of recommendations to the Government of Ontario to help people age at home while redistributing resources to improve service delivery: (NORC Innovation Centre, A Home Care Model for Naturally Occuring, 2024)

  - One lead home care agency per NORC
  - Dedicated PSWs with the ability to support multiple clients within the same NORC, who are able to work a full-time or part-time shift with minimal travel, and provide client visits of varying duration and frequency based on need
  - Local decision-making on day-to-day care scheduling and coordination by the lead home care agency that's responsive to client needs
  - Funded on a NORC population basis rather than an individual service episode basis

These recommendations represent a significant advancement in the delivery of community care programs.

Guiding Principles

Their guiding principles are clear and build from other models of asset-based community development:

Community Leadership: An asset-based approach leverages local strengths and existing networks to build sustainable systems led by community expertise.

System Integration: Collaboration with health, housing, and community care resources ensure seamless service delivery while avoiding duplication. Needs assessments and community mapping guide program design to align with local priorities.

Relational Care: Trusting relationships are the cornerstone of the program. By dedicating time to relationship-building and understanding community needs, the program ensures person-centred and effective solutions.

Adaptability: Flexible and modular in design, the program evolves to meet the changing needs of communities. Engagement levels range from light to high touch, depending on readiness and capacity.

Network Focus

They focus on using networks so that there are diverse perspectives, mutual support and built-in sustainability. It can be an Ambassador/Neighborhood network, a Provider Network, a NORC Connector network, or an Integrated Health and Social Care Network. Each has a distinct role in creating better overall outcomes for systems and people.

Sample TSHC experience from one building

- People value the social connections made in the building. Friendly neighbours and the social atmosphere were what people liked most about living in the building. People mentioned the friendly and helpful building staff.
- Approximately 65% of people who responded to the survey felt they had neighbours they could call on for help if needed.
- Over 60% of older adults in the building have two or more active chronic conditions.
- The average number of emergency department visits per person each year is 0.75, which is higher than the average.
- 73% of the 81 people who responded to the survey plan to live in the building for many years and would recommend living in the building to family and friends. However, many (close to 30%) have safety concerns.
- One of the largest health concerns is the potential for falls. TSHC's group is part of an NIC pilot for falls prevention programming.

NORC Program Model in Practice

The NORC Program Model focuses on working alongside tenants, not doing it for tenants. With a focus on building trust and open communications with Ambassadors, the NORC Connector uses this information to inform discussions with Ambassadors to identify priorities, set goals and plan supports. In discussions with both NORC Program staff and tenant Ambassadors, it was noted that there is a high degree of trust and respect that runs both ways. NORC staff noted an important concept that others did not: you need to go slow to go fast. They underscored that their approach to community development is built on trust, and trust takes time to develop.

NORC Connectors are full-time resources who work on a time-limited engagement with each site they support. NORC Connectors use a strength-based approach to support tenants in self-managing their health and social care needs. This includes providing guidance and resources to connect with health and other community support agencies. For some sites, NORC Connectors are available on specific days and times, interacting primarily with tenants. Tenants have access to a clinical team should they need to which includes an Integrated Care Lead and Nurse Practitioner working in coordination with Toronto Community Paramedicine.

Across all sites, Connectors work collaboratively with Ambassadors to listen deeply to the community to plan and promote programs that support aging in place needs, greater social connectivity and inclusion. This could include a need for certain things in the building. This information will be correlated with health data and networks to

confirm what services or programs could be brought in to address the need.

Advancing Partnerships and System Changes

The other vital role that the NORC Program plays is in advancing partnerships to inform system changes. They have worked with the Toronto Transit Commission to study how the distance from an apartment building to a bus, train, or streetcar stop can impact the quality of life for older people. They have used this data as part of their input into the City of Toronto's Seniors Strategy 3.0. Their advocacy work on behalf of older adults ensures that issues that matter to the aging population do not get overlooked as new programs and policies are introduced.

Key Takeaways

- **"Go slow to go fast":** Sustainable progress requires patience and trust-building while being very adaptable
- **Trust as a foundation:** Relationships grow at the speed of trust, emphasizing the need for consistent, respectful engagement that dedicates time to relationship building
- **Strategic planning:** NORC research offers valuable guidance for broad system planning to support aging at home
- **Ambassador program:** Asset-based community development model that enhances engagement and amplifies tenant voices
- **Community connectors:** They provide hands-on support and act as vital links between systems and community members, helping with practical tasks like posting information and resources

iHelp: Toronto Community Housing Corporation (TCHC)

Primary Contact: Joseph Greer, Manager, Community Safety and Support, Toronto Community Housing Corporation

About

Toronto Community Housing Corporation, in collaboration with the West Toronto OHT, created two pilot projects in 2024 to bring critical services to two TCHC buildings in West Toronto.

Their program was built on the premise that giving people access to services and support in their communities can improve quality of life, improve safety and well-being in these communities, and support better tenancies. From a health system perspective, it helps to get people connected to care closer to home to address non-urgent care in the community.

Partners and Services

The West Toronto OHT brings 38 partners together as part of their team. Partners who serve the iHelp centre include: (Toronto Community Housing, 2025)

- Progress Place/Community Place Hub (case workers; navigation)
- VHA Home Healthcare (social worker)
- LAMP Community Health Centre (onsite preventive health workers; nurse practitioner)
- Dorothy Ley Hospice (grief and bereavement services; holistic body therapy), and

- Communiticare Health (case workers; navigation – one location only)
- Unity Health

Program Development and Focus

In visiting the two sites, we had a chance to learn more about their offerings, successes, and challenges from providers, housing staff, and tenants. To develop their approach, they spent time speaking with members of each community to gather input on their needs. Three key areas were identified by both communities where support was needed:

- Mental health and addictions
- Access to primary care
- Aging in the community

They focus on hard-to-reach populations and adapt to their needs. The centres are intentionally designed to help direct people to the right place to get the right care. TCHC provides the space for service provision, and their Engagement and Community Services Coordinators work closely with tenants to identify programs and partners. Their Access and Support Community Service Coordinators help to identify tenants who would benefit most from the services provided through the OHT partnerships. TCHC has a long and strong history of working with community partners to help tenants access the services and support they want or need. How they provide services differs by location. Between the two sites, staff speak five languages, which can help to increase understanding and sharing.

TCHC has taken a targeted approach to iHelp by focusing on their top five buildings in their western region that have the highest needs as evidenced by data from housing and healthcare. With each building,

they have also sharpened their focus on safety and security, as tenants will not access services in the buildings, if they do not feel safe leaving their homes. They have collected evidence that shows that including the safety and security elements in their model encourages tenants to access services and support.

Site-Specific Implementations

In one location, they occupy modest retail space at the bottom of a TCHC building. At this location, access to iHelp is open to tenants and the community. It is a community hub. This location has an open door to anyone. Consultation services are delivered in this space filled with resources. An on-site coordinator, from the West Toronto OHT, assists people who come in. TCHC's Engagement, Community Services Coordinator works closely with the West Toronto OHT coordinator to understand and support tenant needs. Here, there is a need for more mental health support for older adults, who are re-integrating into housing through the Rapid ReHousing program from the City of Toronto. They understand that for most people, it can be impossible to know where to look to get what they need. Keeping the doors open, having someone on-site five days a week, full-time, encourages people to come and ask for help. Seeing a familiar face in the centre helps to encourage people to take that important first step to building trust and getting help. Initially, it served as an information and navigation hub and has evolved to emphasize the needs of Toronto Housing tenants and care services at the sites. This community's needs differ from their other iHelp location.

In their second location, services are for senior tenants only. Access to the building is controlled by FOBs, which are issued to tenants and service providers. The site was only six months old when we visited.

They had five active program participants. We were able to speak with one and generally, that participant agreed that having this new approach to access care was very helpful to him. The space they use for programming was previously occupied by LOFT, and it was also a library. TCHC worked with LOFT to repurpose the space. They also redesigned the space to create a room for group activities and another as a quieter space. Twice a week, an onsite nurse conducts outreach, encouraging building tenants to come down for services. She can make referrals to primary care. She also visits people in their homes as needed. There is an Ontario Health At Home assigned Care Coordinator onsite every day. The service office is located close to the common room to encourage tenants to come and visit. The Access and Support Community Services Coordinator for TCHC works closely with the community partners on identifying tenants with needs and moving them to the Care Coordinator for appropriate support.

Consistent Services Across Sites

Consistent to both sites, iHelp offers access to:

- Residential Support Workers
- Grief/Bereavement Counsellors
- Social/Recreational Workers
- Care Coordinators
- Nurse Practitioners
- Case Managers
- Personal Support Workers
- Counsellors
- Addiction Support Teams
- Harm Reduction Program

Tenant Engagement and Impact

At both sites, there is ongoing engagement with tenants and community members to understand their needs and concerns. They noted that their model is rooted in asset-based community development practices, and they seek co-design solutions. TCHC offers in-kind staff support, identifies tenants who could most benefit from health and social care support, they also offer outreach support and education to tenants. Health and social care agencies offer a case management approach to working with tenants. Tenants who access the services have been offering very positive feedback to TCHC. Tenants are getting out more and socializing, getting help during bereavement, or help as they navigate health challenges such as breast cancer.

TCHC's Role as Landlord and Partner

TCHC, as the landlord, can decide which spaces it can repurpose to provide services. They redesigned spaces to meet the needs of the community and the providers. They offer the space at no cost to the providers. They noted that TCHC acts only as the landlord, providing space. TCHC receives aggregated reports from the lead agency that coordinates all the partners at the site. The OHT manages the funding and delivery of services to tenants of TCHC.

Future Directions and Learnings

They are also working with the Social Development Office at the City of Toronto to test an anchor agency model and develop reporting metrics related to being a landlord+ that offers access to health and social care to TCHC tenants. Through this relationship, they are seeking to offer more consistent, recognizable yet targeted programs to meet the unique needs of each building.

In further discussions, it was noted that TCHC's call centre does not manage calls related to their iHelp program. They can, however, direct tenants to an iHelp number to get more information. TCHC does not have an iHelp specific call centre that triages and redirects caller at this time, given their current reach. That may be a future consideration.

TCHC plans to expand its program in the coming years. They are targeting four new sites, with two coming in 2025 and two coming in 2026. Staff noted that it took about four months to open a site after they completed years of gathering input and developing partnership agreements. They also noted that only one pilot site, due to capacity, should be attempted at a time and that simple, catchy branding makes their work more recognizable in the community.

Key Takeaways

- **Start small, brand well:** Launch with a memorable program identity to build recognition and trust
- **On-site presence:** Ensure a dedicated resource is available with set hours for consistent support
- **Build one team culture:** Foster trust and collaboration across housing, health, and social care sectors
- **Ongoing community engagement:** Use frequent feedback loops to align services with tenant needs and preferences
- **Purpose-built spaces:** Housing provides dedicated areas for service delivery
- **Vulnerability index:** Tools developed to assess high-needs populations from a social housing lens
- **Specialized coordinators:** TCHC has two types of Community Services Coordinators. One to support tenancy management and another to support community development
- **Safety and security:** Built-in a commitment to increasing safety and security measures to encourage participation
- **Model variations:**
    - Community-Based vs. Building-Based
    - Data shows building-based models improve community safety and reduce call centre volume
- **Joint strategy for scale:** TCHC is interested in collaborating on models to support 100,000 tenants, optimizing health and social care resources to benefit larger population outcomes

Ottawa Community Housing (OCH)

Primary Contact: Steve Clay, Senior Manager, Community Development, Ottawa Community Housing

About

OCH is the second-largest social housing provider in Ontario. It owns and manages about 15,000 homes and provides housing to over 33,000 low and moderate-income individuals in Ottawa. (OCH-LCO, 2025) For over 17 years, Ottawa West Community Support (OWCS) has been providing services and support to seniors residing in 19 Ottawa Community Housing (OCH) buildings throughout the city.

In 2007, the Aging In Place Program (AIP) was established to provide an integrated mix of services to seniors living in 5 designated Ottawa Community Housing (OCH) apartment buildings, which has subsequently been expanded to cover 19 buildings in total. The program is a partnership that began between the Champlain Community Care Access Center (CCAC), the Ottawa Community Support Coalition (OCSC), Ottawa Public Health (OPH), and Ottawa Community Housing. Ottawa West Community Support (OWCS) acts as the agency lead for the OCSC.

Aging in Place Program Goals and Services

AIP aims to reduce hospital, emergency department, and long-term care admissions in the target population through streamlined community interventions. The primary focus is on at-risk seniors and seniors facing access barriers to health care. AIP works with OCH and other partners to identify isolated and at-risk seniors and to encourage

healthy community development through integrated services, including:

- On-site, no-cost crisis intervention and support.
- Coordinated, one-stop linkages to other community resources.
- Seamless/integrated community care and community and social service provision.
- Health promotion and community development (Ottawa Community Housing, 2017).

OWCS Service Coordination

In return for no-cost program delivery space, OWCS coordinates the following services to support OCH seniors: (OWCS, 2023)

- Homemaking and Meals
- Transportation
- Nursing and Allied Health Visits
- Personal Care
- Case Management
- Rapid Community Support Referral
- Crisis Intervention

OWCS also provides emergency meal provision and coordination of health promotion, education, and social activities in partnership with other community organizations. They host special events, exercise classes, and language classes to help reduce isolation and improve socialization. They also arrange taxi chits for tenants to attend appointments.

Community Support Outreach Coordinators

OWCS also has nine Community Support Outreach Coordinators (CSOC) working across 19 buildings. They are on-site part-time, Monday to Friday, during regular business hours. Each coordinator has fixed office hours to see tenants but remains available by phone (Mon-Fri) when not on site. The CSOC role is an on-site Social Worker (or Social Service Worker) who provides support for seniors so that they can continue to manage independently. It is a half-time role with each coordinator responsible for two locations. Coordinators provide and coordinate support, rent reviews, emergency transportation to urgent medical appointments, short-term homemaking (cleaning), and foot care. Additionally, the CSOC helps to organize social and health information events for tenants. These roles focus on providing community support to tenants.

Collaboration with Ontario Health at Home

In 11 of the 19 locations, the program is a partnership with Ontario Health at Home. Tenants have access to two nurse practitioners and three Care Coordinators. In those locations, there is a Care Coordinator (Registered Nurse) who is responsible for allied health services such as Personal Support Workers, Occupational Therapy, and Physiotherapy for tenants. The Care Coordinator and nursing roles provide health care support to tenants.

Program Reach and Governance

Overall, their AIP program serves between 2,500-3,000 tenants who actively use their services. They offer services to all tenants in the buildings where AIP is offered. Their community hub is solely for tenants, not community members at large. Before 2007, there were no

coordinated services in the building for tenants, but since then, OWCS has been busy connecting tenants with services in the community or their homes.

There is a robust governance model that guides their work, along with contracts and MOUs to ensure service levels are agreed upon and delivered.

Staffing and Skill Sets

OWCS noted that the work to support aging seniors requires, in their estimation, two different skill sets. One should be able to work with seniors in a compassionate, heartfelt way because some seniors are aging alone. Another person should be a crisis worker who has stronger skills in setting boundaries while case managing challenging personalities. “Having one person trying to do both would be like finding a unicorn,” said Jennifer Lalonde, Executive Director, OWCS.

OCH-OWCS Partnership and Benefits

OCH’s Steve Clay, Senior Manager, Community Development, noted in our discussions that the relationship with OWCS helps housing staff as much as it helps tenants. He shared that OCH makes accommodations for OWCS and their partner team members to make it easier for them to deliver services and programs to tenants. For example, if a partner requires office space at a building and space is not available, OCH reconfigures places, such as storage rooms, to provide that space. The spaces available for use range from 160 square feet for office space to 1500 square feet for dedicated programming space. Steve is the single point of contact (SPOC) for OWCS and OCH. If OWCS has concerns or wants to discuss space changes or needs an accommodation for staff access, for example, Steve is their contact for anything they need. “The

relationship has to be more than just landlord and tenants with our partners," says Steve.

Impact and Outcomes

This model has contributed directly to:

- Preventing unnecessary emergency room usage and extended hospital stays
- Delaying or deterring tenants from going into long-term care homes
- Helping people to age, and pass, in their homes, as they wish
- Stronger relationships have developed between neighbours
- Increased coordination to bring in programs between providers and OCH
- Tenants know there is someone there to help them
- The Tenant Support Centre for OCH saw a decrease in call volumes when support was in place
- OCH reported fewer arrears, an easier Annual Rent Review, fewer Landlord Tenant Board issues, and a reduction in expectations of housing staff to provide social services, particularly in mental health and addictions concerns

Key Takeaways

- **One Team philosophy:** Emphasizes a unified approach with partners
- **Relationship-driven:** Strong focus on building trust and respect between housing and service providers
- **Anchor Agency model:** A single agency brokers partnerships with health and care providers
- **Single point of contact:** One housing liaison simplifies communication for partners
- **Defined staff roles:** Recommends having separate roles for community development and crisis intervention to improve service clarity and effectiveness
- **Proven impact**: Limited data shows improved outcomes for tenants, providers, and housing
- **Long-Term indicators**: Use of 15+ years of data to track how increased health and social care support improve housing outcomes
- **Simple intake forms:** Streamlined partnership onboarding process.
- **Partner communications program:** Structured approach to keep partners informed and engaged
- **Creative space solutions:** Encourage innovative thinking to overcome space limitations for service delivery

Oasis

Primary Contact: Riley Malvern, Research Project Manager, Queen's University

About

Oasis is an innovative model that offers programming for older adults living within a NORC (naturally occurring retirement community). Oasis is unique as it seeks to empower older adults to identify their needs and determine the services and activities which best meet those needs (Donnelly et al, 2019). Oasis includes programming developed by and with members, designed to foster movement, healthy nutrition, and social connections to support older adults to age well within their communities. (Oasis, 2024) In addition to these core programming pillars, Oasis includes activities and events that increase members' awareness of and connection to health and social services and resources.

Oasis takes a community development approach that includes working with community agencies or health care organizations to bring representatives from those organizations directly to the building/neighbourhood Oasis serves to offer information or services related to the needs and interests of members. While they can seek out partnerships to support individual members to access information about health and care services as requested, the focus is largely on the community rather than individual navigation. For example, an expressed question or concern from a member about dental health, may trigger an information session on the new Canadian Dental Care Program from Public Health or a local dentist for all interested members in that community. This indirectly facilitates access for the individual member while increasing knowledge and access across the

entire community. “We help people upstream to avoid having to use emergency services or hospitals”, says Dr. Catherine Donnelly, Director, Health Policy and Research Institute, and co-Principal Investigator, Oasis.

The program began in 2011 at one site in Kingston and has expanded to 20 sites across Canada, with four emerging sites (as of July 2025). In 2019, researchers from Queen’s University, McMaster University, and Western University came together with the community Original Oasis to form the Oasis Collaborative. The collaborative set out to expand and evaluate Oasis in other communities. Funding was provided by the Centre for Aging and Brain Health Innovation at Baycrest, the Ministry of Health and Long-Term Care, and the Ministry for Seniors and Accessibility. Each grant was specifically designated to support the expansion of Oasis to a particular NORC(s).

As Oasis expanded, a network of communities formed to support the sustainability of all sites in partnership with the universities, building residents and onsite program coordinators. In 2021, a philanthropic, private donor provided funds to expand Oasis to six additional NORCs and Oasis also received a Canada Institutes of Health Research (CIHR) grant to support long-term evaluation of their work.

More recently, the team received funding from the Age Well at Home program (Employment and Social Development Canada) to support expansion to an additional six unique communities, and received an additional grant from the private, philanthropic donor to support ongoing site operations and the development of a new national not-for-profit to support and sustain the growing network of Oasis communities across the Canada. Core to this ongoing expansion and the creation of the Oasis Communities for Aging Well National Not-for-Profit includes the ongoing development and dissemination of

resources, and Communities of Practice to support communities to open, grow and sustain an Oasis Program in their neighbourhood or building.

In addition, new and existing sites will continue to be supported through a network-wide evidence-based standardized evaluation framework that includes process (e.g. participation, programming activities), experience (e.g. satisfaction, member ideas), and outcome (e.g. loneliness, physical activity, falls) related assessments. This ongoing work will provide critical insight into effective aspects of aging-in-place models to inform their design, and much-needed evidence on health and economic impacts to support their implementation and to secure funding supports. (Oasis, 2024)

Program Philosophy

Their programs aim to reduce isolation, increase physical activity participation, improve nutritional wellbeing, and build a sense of purpose, as many seniors are aging alone. Built on their three pillars of Nutrition, Socialization, and Physical Activity, they have the following underpinnings to their work (Group, 2024).

Vision

Embracing Aging

Mission

Oasis provides a member-driven approach to healthy aging and improved quality of life in neighborhoods across Canada. This is achieved through a collaborative approach to fostering safe and caring communities where everyone feels welcome.

Values

- Member-driven
- Community
- Social Connection
- Respect
- Equity
- Welcoming

Implementation and Impact

In 2024, they developed an Oasis playbook, which is part of their Ready-Set-Go program implementation guide. The playbook outlines the foundations of the program, its evaluation framework, and funding approach. It also includes some high-level data about Oasis benefits to members:

- 45% less likely to receive home care
- 26% less likely to visit an emergency department
- Can delay moving to a long-term care home by one year

Their pillars of Nutrition, Socialization and Physical Activities are supported by research. In research with the original Oasis community, older adults in the building with Oasis were compared with older adults living in buildings without an Oasis program, on a number of indicators of healthy aging (manuscript in preparation).

The research found that, adjusting for age, participants living in a building with the Oasis program were significantly less likely to report more than one fall in the past six months compared to those in buildings without Oasis, suggesting a potential protective effect of the Oasis program on fall risk. Similarly, older adults in the building with

Oasis scored significantly higher on tests of balance and mobility, and walking endurance. Finally, older adult participants living in the Oasis building were significantly less likely to report being lonely on the UCLA Loneliness Scale than those participants in buildings without the Oasis program.

Program Model and Adaptability

The model relies heavily on community engagement to determine programming. The Oasis Program has been successfully implemented in horizontal NORCs (e.g. neighbourhood, mobile home community, coop housing community) and vertical NORCs (e.g. apartment complexes, condominiums); and in a variety of ownership contexts (e.g. resident owned, market-rental, deeply subsidized rental) in large urban, small urban and rural environments in British Columbia, Ontario, and Nova Scotia.

In all settings, Oasis members determine the specific nature of the programming in their community, within the key pillars of the Oasis. Membership in any of the Oasis Communities is open to anyone who lives in that community. This may be people from the neighbourhood surrounding the common gathering space, or, to residents of the building, or complex of buildings where the programming is offered. With time, the Oasis Team has seen some communities hosting Oasis programs in an apartment building, open their doors to older adult residents from sister or neighbouring buildings. In all examples, the members and coordinators adapt their programs to best meet the needs

and interests of the communities they serve. Currently there are about 1,237 members. This does not include members who have transitioned to alternate living arrangements, or non-members served through programming not represented in this value.

Partnership and Space Management

The Oasis Team can work with multiple sites at a time to implement the Oasis model. They provide guidance and standards for new sites. The development of partnerships and relationships to create the infrastructure for a program is the responsibility of the new site.

They rely on relationships with landlords to provide in-kind space for program delivery. They are specific about what their needs are, which include exercise space, meeting space, and basic food prep space. In return, they note that landlords report seeing reduced turnover, improved building culture, fewer complaints, and more requests for Oasis Programming from other buildings in their portfolio.

On-site Coordinator Role

An on-site Oasis Coordinator is available at each site to bring programs to members. While the position is typically part-time, it could be a full-time position if adequate funding were available. Hiring a coordinator is usually done through a community partner organization, with local members involved in the process. The Coordinator works with the local members to determine programs and acts as a liaison with the housing partner and other partners on program delivery. They also become trusted voices for members. They form friendships over activities such as crafts, education sessions, exercise classes, gardening, or sharing a meal.

Member and Staff Experiences

During the site visits, members spoke of the tremendous value that the program brings to them. Members expressed warmth and appreciation for the staff and appreciation for the spaces they were able to occupy for programs. They spoke of having friendships that they never had before. Staff noted that while engaged tenants may move, the programs do not miss a beat. There is always someone in the wings who will continue to work with staff to get others involved. Staff also noted that while conflicts exist between tenants, which may involve the landlord, tenants are encouraged to take those issues to the landlord directly.

Quality Assurance

To ensure quality assurance, programming integrity and links to existing community services, Community Developers are also in place in some locations. These individuals support multiple sites on behalf of the Oasis team.

Key Takeaways

- **Proven outcomes:** Demonstrated improvements for both members and providers
- **Implementation tools:** A comprehensive guide with tools to support consistent rollout
- **Defined focus areas:** Clear impact zones and priorities are identified
- **Developed frameworks:** Research based evaluation and funding frameworks to support sustainability and scalability
- **Quantitative and qualitative data:** Information related to experience, efficacy and impact are available. This includes cross-sectional and longitudinal comparisons with further analysis planned
- **National identity:** A consistent corporate brand across the country enhances recognition and trust

Quick Summary View of Programs

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Services/Programs							
Coordinator/Navigator	●	●	●	●	●	●	●
Access to Primary Care	●	●	●	●	●	●	
Home Care Services	●	●	●	●	●	●	
Social and Recreational Programs	●	●	●	●	●	●	●
Mental Health Programs	●	●	●	●	●	●	
Healthy Aging Programs	●	●	●	●	●	●	●
Allied Health Support	●	●	●	●		●	

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Tools and Partnerships							
Robust Engagement Model	●	●	●	●	●	●	●
Measurement and Evaluation Framework	●	●	●	●	●		●
Governance Structure	●	●	●	●	●	●	●
Implementation Plan and Tools	●	●	●	●	●	●	●
Codesign with Members/Tenants	●	●	●	●	●	●	●
Privacy Framework	●	●	●	●	●	●	●
Ontario Health at Home	●	●	●	●	●	●	
Ontario Health	●	●	●	In Progress	●	●	

TSHC Unique Context and Considerations

For Toronto Seniors Housing, its focus on seniors may hold some unique challenges. Most providers offer services to an array of ages. TSHC's unique offering to the 59+ population is targeted to support aging at home. TSHC also serves the second largest population of aging adults at 15,000 with TCHC serving about 17,000. Most programs serve a few hundred or a couple of thousand older adults.

TSHC has the benefit of Community Connect+ and Community Activities Fund for engagement, access to tenant voices, and access to funding for tenant-led activities. The work done by its Community Services Coordinators offers tenants tools, funding, and access to program partners to create their sense of community. Tenants work with staff to secure funds to host social, recreational, and community-building events within their buildings. Staff work with tenants to understand the needs of each building and seek partners to deliver services that match the needs. This can lead to a myriad of providers being in a building, but not necessarily a coordinated approach to service delivery. The role of the Seniors Services Coordinator is important in identifying individual tenant housing or support needs, as they are on-site more often than the Community Services Coordinator. Both roles are related to providing some degree of landlord+ services,

but neither can meet the system navigation needs of tenants within the health and care systems.

Currently, TSHC benefits from having East Toronto Health Partners, Baycrest Neighbourhood Care Team, and the NORC Innovation Centre working with tenants across several buildings. Currently, these organizations do not yet collaborate on service delivery together, but there may be a desire to do so. Between the deep community engagement work that the NORC Innovation Centre does and the service delivery work that the other two partners provide, there may be an opportunity to develop stronger ties and improved coordination.

There are also more opportunities for TSHC and TCHC to work collaboratively, as TCHC already has an iHelp model that seeks to essentially do the same things TSHC is trying to achieve. Both organizations face the challenge of working with multiple Ontario Health Teams and Neighbourhood Care teams to deliver services across the City of Toronto.

Conclusion and Recommendations

The review offered TSHC an opportunity to learn more about what others are doing to help older adults age at home. The review found that all programs are working to deliver services within current funding envelopes wherever possible. All programs also rely on in-kind support from housing providers for space. Most programs have an evaluation and governance framework, but the criteria vary from program to program. All dedicate time to community engagement and co-design, and all rely on complete buy-in from a coalition of the willing or a One Team approach. Working with partners, members/tenants, and staff is the most challenging part of this shift to more coordinated, integrated service delivery: building trust is critical.

TSHC's Current Position and Opportunities

TSHC is fortunate that three of the organizations reviewed are already partners with experience, expertise, and a desire to do more. They are also members of the Partnership Table, where they can help to further guide TSHC on its mandate to provide access to services and support to help tenants age at home.

When this review began, it was envisioned that it would inform TSHC's decision about launching a pilot project(s) to deliver more coordinated services and support to tenants, per its commitment in its Integrated Service Model. The programs that were reviewed can offer insights and guidance into governance frameworks, evaluation frameworks, and engagement methodologies. TSHC, however, remains in the unique position of being the social housing provider in Ontario solely dedicated to supporting independent living for people 59+. TSHC is built on the

Integrated Services Model (ISM) to support aging at home, whereas other organizations are using similar principles to guide their work.

Unlike many housing providers in the province, TSHC must coordinate with eight Ontario Health Teams (OHTs) to deliver services across its four regions. Currently, TSHC partners with 54 separate organizations to provide health and social care to tenants. To streamline and strengthen service delivery, TSHC could consider designating one anchor agency per OHT—a total of eight anchor agencies. These agencies would serve as service coordinators, benefiting all stakeholders involved.

The health and social care sectors already have many assets to support aging at home, such as funding, mandates, and trained staff. TSHC may want to leverage a series of anchor agencies to help coordinate service delivery. Anchor agencies can:

- Lead partnership development and management.
- Establish unified service agreements with partner organizations.
- Coordinate reporting, accountability, and associated risks and liabilities.
- Address operational partnership issues and concerns.

In this model, TSHC would:

- Provide physical space for service delivery
- Support relationship-building among staff, tenants, and providers
- Gather and communicate tenant needs to inform service planning

Today, TSHC manages partnerships primarily through individual relationships with over 50 service providers across 83 buildings. Some buildings have many providers, and others may have a couple. Regardless, TSHC and providers work diligently to deliver services requested by tenants. Services, however, are not yet optimally coordinated or as timely as tenants would like. For the future, TSHC will need to determine a more coordinated path forward that minimizes fragmentation, improves timely delivery, and provides for broader reach.

While it is tempting to consider the future state as the ideal solution, it must be tempered with the reality of how quickly system change can happen. Older adults need solutions in the immediate or shorter term. TSHC will need to continue its current trajectory while working to incrementally and strategically introduce a more comprehensive and coordinated approach. As the program review has shown, a more coordinated approach has many benefits. Most importantly, older adults can retain agency over their health and well-being, given they have the right support, in the right place at the right time.

Through the Partnership Table, there is an appetite to support collective impact, or a more coordinated and comprehensive approach to working with housing, health, and social care. This represents a great opportunity for TSHC to work with existing partners to find solutions to

improve its service delivery model so that senior tenants can age at home in dignity and comfort.

Recommendations

The Partnership Table acknowledges the report and applauds the ongoing work of all partners supporting TSHC with multiple approaches to aging in place as directed by the Integrated Service Model.

1. TSHC must continue its multi-prong approach of direct engagement with smaller providers and the use of existing anchor agencies, as they both are working to meet tenant needs today.

2. To better position TSHC to meet the growing needs of its tenants in a more coordinated way across more buildings, the Partnership Table recommends that TSHC expand its approach to coordinated program delivery into a building that is currently underserved in an area with high needs.

3. The site should have available space for coordinated service delivery through an anchor agency partner. Depending on the capacity and capabilities of the anchor agency partner, the pilot would focus on results related to:

    I. Facilitating more coordinated access to services for tenants, to meet their needs, using an approach that is repeatable and can be scaled across other buildings;

II. Testing of a new housing and health dashboard to track and report on results related to stabilizing tenancies and improving care in communities;

III. Investigating specific research findings that speak to the needs of older adults in social housing; and

IV. Contributing to a larger body of evidence-based work that demonstrates positive outcomes for community and systems collaboration.

4. To support this work, and based on the findings of this report, the Partnership Table encourages TSHC to assist with the following:

    I. Creating a set of standards for what TSHC wants to build from (and systems partners can support), to build similarities across programs, such as:

        i. Neutral third party to support tenants and staff

        ii. An anchor agency approach

        iii. An evaluation framework

        iv. Complementary training for TSHC staff to support aging in place, as TSHC staff have stronger daily interactions with tenants

        v. Leverage the existing work of a local Ontario Health Team

5. Finally, the Partnership Table also supports pursuing funding to support this work between the housing and health sectors. Funding will help to deliver on the objectives articulated for this expansion, the development of a health and housing dashboard, and a standardized evaluation framework.

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