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of Ontario



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**Official Report
of Debates
(Hansard)**

M-5

**Journal
des débats
(Hansard)**

M-5

**Standing Committee on
the Legislative Assembly**

Providing More Care,
Protecting Seniors,
and Building More Beds Act, 2021

2nd Session
42nd Parliament

Wednesday 24 November 2021

**Comité permanent de
l'Assemblée législative**

Loi de 2021 visant
à offrir davantage de soins,
à protéger les personnes âgées
et à ouvrir plus de lits

2^e session
42^e législature

Mercredi 24 novembre 2021

Chair: Laurie Scott
Clerk: Valerie Quioc Lim

Présidente : Laurie Scott
Greffière : Valerie Quioc Lim

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON
THE LEGISLATIVE ASSEMBLY**

**COMITÉ PERMANENT DE
L'ASSEMBLÉE LÉGISLATIVE**

Wednesday 24 November 2021

Mercredi 24 novembre 2021

The committee met at 0901 in committee room 1 and by video conference.

**PROVIDING MORE CARE,
PROTECTING SENIORS,
AND BUILDING MORE BEDS ACT, 2021
LOI DE 2021 VISANT
À OFFRIR DAVANTAGE DE SOINS,
À PROTÉGER LES PERSONNES ÂGÉES
ET À OUVRIR PLUS DE LITS**

Consideration of the following bill:

Bill 37, An Act to enact the Fixing Long-Term Care Act, 2021 and amend or repeal various Acts / Projet de loi 37, Loi visant à édicter la Loi de 2021 sur le redressement des soins de longue durée et à modifier ou à abroger diverses lois.

The Chair (Ms. Laurie Scott): Good morning, everyone. I'm going to call the meeting to order. We are meeting today for public hearings on Bill 37, An Act to enact the Fixing Long-Term Care Act, 2021 and amend or repeal various Acts. Are there any questions before we begin—and for the presenters who have just come on, raise your hands.

This morning's presenters have been grouped in threes for each one-hour time slot. Each presenter will have seven minutes for their presentation. After we have heard from all three presenters, we will have 39 minutes of questioning, divided into two rounds of seven and a half minutes and one round of four and a half minutes for the government members, as well as two rounds of seven and a half minutes and one round of four and a half minutes for the official opposition members. I'm going to say there's one minute left when we're at that time. You don't have to stop talking; I just want to give you the one-minute wrap-up time. When you first present, you need to state your name for Hansard, which is our recording, and then you may begin.

**ALZHEIMER SOCIETY OF ONTARIO
CANADIAN UNION OF
PUBLIC EMPLOYEES
ADVANTAGE ONTARIO**

The Chair (Ms. Laurie Scott): I will ask the Alzheimer Society of Ontario to begin.

Ms. Cathy Barrick: Good morning, Madam Chair and committee members. Thank you for the opportunity to speak with you this morning and begin public consultations on Bill 37. My name is Cathy Barrick. I'm chief executive officer with the Alzheimer Society of Ontario. I am joined today by Kyle Fitzgerald, the Alzheimer Society's manager of public policy and government relations.

The Alzheimer Society is a federation of 27 health service providers offering community support services to people living with dementia and their care partners in every corner of the province.

During our testimony this morning, I ask that you keep one simple fact in mind: In Ontario, dementia is long-term care. Just over two thirds of all long-term-care residents live with dementia, and as a person ages, their likelihood of both developing dementia and requiring admission to a long-term-care home increases. All decisions related to a home's design and care must respect the unique needs of the majority of residents who live with dementia.

The Alzheimer Society is generally supportive of Bill 37. The legislation does not make radical changes to the long-term-care or retirement home sectors, but the small amendments that are made to the current acts are positive.

We support the enhanced compliance powers contained in schedule 3 and new mandatory channels for resident and family feedback.

We also applaud the inclusion of a resident's right to caregiver support, something that was inhumanely denied throughout much of 2020.

We are pleased to see training requirements that have been extended to include home leadership in section 82. It is vital that both front-line and management staff have a shared understanding of the needs of residents under their care, so everyone involved in care provision is speaking the same language. This is especially true for residents living with dementia.

We strongly urge that a minimum baseline knowledge of dementia for both front-line and management staff be incorporated into the regulations. The Alzheimer Society's U-First! program offers a quality, scalable training that could be quickly rolled out to give all long-term-care-home staff this baseline understanding of dementia as a disease and how it changes behaviour.

A diagnosis of dementia changes how someone responds to the world around them and, consequently, how the person's care must be approached. For example, a resident living with dementia might refuse to eat if another of

their needs is unmet, such as if they are experiencing unaddressed pain or if their room is too hot or too cold. Knowledge of how dementia impacts behaviour would help a personal support worker understand that refusing food is a way of communicating and respond accordingly. This sort of person-centred care lies at the heart of what residents deserve and expect, and it begins with a baseline level of dementia-specific knowledge shared by all long-term-care-home staff. Training and knowledge cannot, however, change the reality that many homes today are understaffed. Knowing how to properly meet a resident's needs will not help if the staff member does not have the time they need to do so.

We acknowledge the efforts the government has made to date to address critical staffing shortfalls and appreciate that action is being taken. We applauded the government's decision to introduce a target of four hours of direct care per day as a move in the right direction, giving staff the time they need to deliver the level of care they want. It is disappointing to see that this move has been watered down in Bill 37. Instead of a target for all homes, section 8 establishes an aggregate goal for the province as a whole. This allows the minister to declare that the target has been met even if some individual homes or the provincial median are below the target level. While this would still indicate most homes and residents are benefiting from improved hours of care, the goal must be to create a uniformly high standard of care for every resident in every home everywhere.

To ensure the highest level of direct care for all residents, we suggest measuring this goal against the average for all homes individually, rather than collectively. If even a small number of homes are not meeting the annual target, then the minister would be obligated to report that that year's goal was not met. This approach would strongly incentivize the ministry to support any home struggling to meet the annual direct care target, as well as give families peace of mind that no matter where their loved one lives, they will receive a similar level of care.

This is particularly important for families of those living with dementia. Applications for individuals with dementia are regularly denied on the basis of a cognitive impairment. This is not allowed under the current act, but happens anyway. People living with dementia often apply to dozens of homes, some hours away from where they live, and jump at the first bed they are offered. By mandating a four-hour standard of care for each home, not the province as a whole, individuals and families affected by dementia can accept a bed knowing they will receive the same minimum level of care as if they had been admitted to their first home of choice.

The possible alternative is frightening: a two-tiered long-term-care system where quality of care varies wildly by home and residents with a diagnosis of dementia are largely shut out of homes with the highest average care hours. Mandating an average of four hours of direct care per resident for each and every home would not prevent homes from going beyond this minimum level, but would

ensure that such homes do not inflate the overall provincial average while other homes continue to suffer a substandard level of care.

Further, public reports compiled by the minister should include data on the average daily hours of direct care offered by each home. This would empower families to make informed decisions, encourage homes to go beyond the minimum targets, and help focus resources and attention on homes that need additional support to meet the annual care target. We suggest language to this effect should be added to section 10.

Bill 37 is a welcome indication of the government's intention to improve quality of care for long-term-care residents. We reiterate the importance of treating dementia as the rule, not the exception, as regulations under the new act are being written, and we look forward to contributing to that process.

Thank you for this time this morning. I look forward to your questions.

The Chair (Ms. Laurie Scott): Thank you very much.

I'm sorry; at the beginning, I should have introduced everyone who is presenting today. The next presenter is the Canadian Union of Public Employees, and then that will be followed by AdvantAge Ontario.

Please go ahead, the Canadian Union of Public Employees.

Ms. Debra Maxfield: Good morning. My name is Debra Maxfield. I'm chair of the health care workers coordinating committee for CUPE Ontario. I also work in long-term care as recreation and leisure staff and as a personal support worker.

CUPE is the largest union in the province, with more than 280,000 in every community in Ontario. Over 35,000 of our members work directly in long-term care—in municipal homes, private for-profit homes and private not-for-profit homes. We represent members across all classifications, including but not limited to PSWs, RPNs, RNs, dietary, laundry, housekeeping, maintenance, and recreation and leisure.

Working in this sector was a challenge prior to COVID-19, but the last two years have highlighted just how badly the system is broken.

This bill is an opportunity to lay out a clear and decisive plan to fix the system, but unfortunately it falls short. In far too many cases, important details are left undefined or left to regulation. We will take you through some of those areas now.

Dave?

0910

Mr. David Hauch: Thank you, Debra.

My name is David Hauch. I'm the staff coordinator for our long-term-care sector here in Ontario. I'm going to speak about the four-hour care standard that's included within the legislation and echo a number of the comments of the previous speaker.

We would be remiss not to point out that a legislated four-hour care standard is something that we and many others have been advocating for for over a decade, but we are gravely concerned that we will not be able to meet that

goal. We were in a staffing crisis before COVID-19 occurred, and we're still now losing staff to exhaustion and burnout, as well as normal attrition throughout the sector. We're not going to be able to maintain current levels, let alone a four-hour standard, without a bold strategy that addresses recruitment, but also addresses the working conditions in the sector, so that we can retain the staff we have and the staff we recruit to be able to meet these targets.

A few issues with the way that the four-hour standard is laid out in this legislation: The timeline for implementation is too long. Tragically, 2025 is too long for many of our residents to be able to wait to benefit from this standard. A bold recruitment and retention strategy will allow for the staff to be able to make this a reality and to escalate that time frame.

The targets that are set out need to actually be framed as requirements and not as targets. This legislation includes plans for what happens when targets are not met right off the hop, and this seems like admitting defeat before we even start down this path.

The legislation also needs to clearly require licensees to report staffing data, and that those reports have to be subject to random audits to ensure accuracy. In the same vein as the previous speaker mentioned, the data that's reported needs to include data at the home level. We need to be able to see not just the provincial average but where each home is relative to the care standard. That's a basic accountability mechanism. That data needs to be easily reviewed by staff, by residents and by families. And those homes that regularly fail to meet the standard need to be held accountable to avoid a situation where those homes that do exceed the standard float the provincial average up and provide cover for those homes that regularly don't.

Finally, we are encouraged to see that the hours that are contemplated in this care standard are dedicated only to PSWs, RPNs and RNs, and are based on hours worked, not on hours paid. But we are troubled that the details of how this is going to be calculated are still not clear and are left to regulation. It's a very essential component to the legislation. This particular measure, as well as those details, needs to be fleshed out and included in the legislation.

I'm going to turn things over to our first vice-president, Michael Hurley.

Mr. Michael Hurley: Thanks very much, Dave.

There's huge public support for long-term care to be delivered on a not-for-profit basis, and that's based on the fact that, particularly during the pandemic, the great majority of deaths occurred in for-profit long-term care—a much higher rate than in the not-for-profits and municipal homes. As the army and other journalists reported, these homes were understaffed. They had been chronically understaffed before the pandemic, but they were understaffed during the pandemic. Staff had no PPE; they wore garbage bags while they cared for these patients who died in disgusting conditions.

We are deeply disturbed by the fact that not only are we not talking about a march to convert these facilities to not-

for-profit, but in fact, we're moving away in the preamble from the whole issue of a bias towards not-for-profit. I don't think there could be any clearer example of the inappropriateness of the role of profit in these institutions than that huge amounts of money were withdrawn during the pandemic while the residents lived and died in squalor and the staff had inadequate protection. So we would dearly love to have that addressed.

The legislation refers to a palliative care philosophy. This is a concern to us. I had the privilege of working for a couple of years in palliative care. Palliative care is a service that requires multiple therapies, pharmacies—it involves a high level of staffing. At the moment, this is just beyond the level of real imagining for residents in long-term care, given the staffing levels. So we're hoping that when you flagged this for us, you're not thinking of some way of having seniors in long-term care—

The Chair (Ms. Laurie Scott): Forty seconds left.

Mr. Michael Hurley: Yes. I'll go back to you, Debra. Go ahead.

Ms. Debra Maxfield: I want to see that no changes have been made to the whistle-blower provisions of the act, despite the existing provisions being in place and a culture of fear persisting in the sector, where staff, residents and family do not speak out of fear of reprisal. Provisions should be added to allow for an anonymous means of information to be reported. The roles of PSWs—among many things that have been highlighted by COVID-19, the important and skilled work of PSWs is high on that list. Currently—

The Chair (Ms. Laurie Scott): Sorry. Thank you very much.

We'll now move to AdvantAge Ontario. Please state your name before you begin.

Ms. Connie Lacy: Thank you, Madam Chair. Good morning to the members of the committee and to the other presenters. My name is Connie Lacy. I am the board chair of AdvantAge Ontario. I'm also director of seniors' services for the region of Waterloo. I am accompanied today by Lisa Levin, the CEO of AdvantAge Ontario.

I am very pleased to speak to you today. AdvantAge Ontario is a provincial association representing community-based not-for-profit providers of long-term care, community services and housing for seniors. Our members include municipal, charitable, not-for-profit long-term-care homes, seniors' housing, supportive housing and community service agencies serving seniors across Ontario. Our member organizations serve over 36,000 long-term-care residents annually and operate over 8,000 seniors' housing units across the province.

We strongly believe that changes to the act and its regulations are not only warranted but also imperative to achieve transformational change in long-term care, to sustain its leadership, and to support direct care staff who are on the brink of collapse.

We acknowledge and applaud the government's proposed improvements, including targets for direct care hours and the recognition of the importance of residents' emotional well-being. We appreciate that the government

also retained the support for not-for-profit and municipal delivery of long-term care in the preamble and in the penalties and licensing provisions.

While we acknowledge that a significant amount of change can occur through the regulatory process, we recommend the following critical amendments be made to the legislation prior to it being passed.

I'm going to take you through the main areas of focus of our submission, and we would then be happy to answer any questions you may have. Please note that we have sent in our submission to this bill to the Clerk and included some proposed wordings of the amendments for your consideration.

The first area of focus is mission-driven organizations. The preamble to the proposed act states a commitment to all long-term-care homes operating as mission-driven organizations. The core value of mission-driven homes is to improve resident care, which we feel can only be true of homes that do not hold profit, including the returning of value to shareholders, as main operating principles. We believe that without a clear definition of "mission-driven," this can open interpretation of this key principle to mean any home operating in Ontario, regardless of its focus.

AdvantAge Ontario provided a proposed definition of the meaning of "mission-driven organizations" in a previous submission to the government, and we've included an amended version of this definition as an amendment to the act. It reads as follows: "A mission-driven long-term-care home is responsible to the community in which it operates or serves and is guided solely by the primary, non-commercial goal of delivering resident-directed, safe and quality care for seniors."

The next area of focus is emotion-focused care. The preamble to the proposed act refers to residents' emotional well-being, as does the residents' bill of rights. We believe that a resident's emotional needs are as important as their physical, social and other needs. We recommend adding emotional needs to the list of needs in the fundamental principle. At minimum, the act does not impede the delivery of innovative models of emotion-focused care. We recommend adding a statement to the act to promote these models of care, and also recommend adding support for emotion-focused models of care to the functions of the long-term-care quality centre.

The next area is compliance and enforcement. Modern regulators recognize that support for achieving compliance leads to improved regulatory outcomes. A focus on technical compliance and punitive enforcement without resources and guidance about how to effectively achieve compliance is not in the best interest of resident safety and well-being. We recommend that the new long-term-care quality centre play a role in providing compliance resources to the sector. Having the centre fulfill this role provides separation from the ministry's inspection and enforcement function.

0920

Focusing on compliance requirements that relate to resident safety and well-being would improve the effectiveness of regulations and lessen the burden on homes. We

are recommending that inspectors have the flexibility to forgo documenting non-compliance if there's no evident harm or risk of harm to a resident.

The proposed act adds administrative penalties as an enforcement measure. The logic of financially penalizing the publicly funded sector is unclear, particularly in the context of municipal, First Nation, hospital, and not-for-profit homes. We recommend that the act significantly cap the amount of penalties for not-for-profit and municipal homes, to recognize the shortcomings and potential unintended consequences of financial penalties in the government-funded long-term-care sector.

We also propose amendments to require that inspectors identify themselves upon entering a long-term-care home and wear identification, and to limit inspectors from being able to inspect homes where they are former employees, which we see as a conflict of interest.

The next area is on direct hours of care, particularly around allied health care professionals. We recognize and applaud the inclusion of the direct-hours-of-care targets in the act with respect to allied health care professionals. Recreation staff, as an example, connect residents to loved ones via technology and provide social activities that are crucial for psychological and emotional well-being. Our recommendation is to increase the target from 36 minutes, which is proposed, to 60 minutes.

The next area is management contracts and limitations on eligibility. The proposed act makes the approval of management contracts a subject of public interest—which can be issued a licence—but omits any reference to limitations on eligibility for a licence, which exists under the current act. The effect of this is that the assessment of past conduct and competency and other factors would not apply to the director's approval of a management contract, as they do currently. We do not believe there's a justification for management companies to face a lower bar with respect to past conduct, competency to operate the home, legislative compliance, and other eligibility criteria.

The Chair (Ms. Laurie Scott): One minute.

Ms. Connie Lacy: Our recommendation ensures that management companies are subject to the same eligibility criteria as licensed applicants. This is essential to the protection of health and safety of residents.

The last area of focus is risk-based admissions. Long-term-care homes must provide a safe and secure home for all residents, but they have very limited ability to refuse a high-risk admission, even if admitting the applicant will create a grave risk of harm to other residents and/or staff. We recommend that the act permit homes to withhold approval if, in the specific context of the home admitting this resident, the admission would pose a significant risk of serious harm to staff and/or other residents.

In conclusion, we believe the time for transformation of long-term care is right now. The amendments proposed in this submission are crucial to charting the path forward. We hope that the committee will consider our requests.

The Chair (Ms. Laurie Scott): Thank you very much. We're now going to move to questions. But just before

that, I will ask MPP Singh if she would state her name and if she's in the province of Ontario.

Ms. Sara Singh: I'm MPP Sara Singh, and I am indeed here in Ontario.

The Chair (Ms. Laurie Scott): The first round of questions will start with the government, and that is seven and a half minutes. MPP McDonell.

Mr. Jim McDonell: Thank you to the speakers who have come out today.

I have a question for Cathy Barrick.

Our government, after more than a decade of adding more beds, adding more staff, has taken action. We saw a report before 2010 that talked about the need to raise the hours of care each day to a minimum of four hours—and no action until this bill. So we've taken steps in our economic statement, which made it—almost \$58 million beginning in 2022, to hire 225 new nurse practitioners. This was in addition to \$270 million announced in October, to support 4,050 new long-term-care staff. So we see there's a need, and we see this as an urgent factor to address.

Can you tell us how the increased hours of care will help those living in long-term care and suffering from Alzheimer's and other forms of dementia?

Ms. Cathy Barrick: Thank you for the question.

For sure, increased hours of care means that the front-line care providers have more time to spend with residents to complete care—which is a really important factor in person-centred care, to be able to devote enough time, especially in dealing with folks with dementia who sometimes have challenging behaviours. It may take longer to do things, and it may take some different kinds of approaches to help them do things like toileting, eating, bathing etc., so the increased amount of hours is crucial, absolutely, to give the staff time to do it.

On top of that, though—and I think it's a really important point—the number of hours is not enough. Comprehensive, dementia-specific care training is required. You can have as many hours, I suppose, as you want, but if the staff providing the care do not have dementia-specific training on how to approach people and provide care in a patient-centred or client-centred way, the hours alone are not enough.

Again, thanks for the question.

Mr. Jim McDonell: I know that we've committed \$342 million to add and upskill over 5,000 nurses and 8,000 personal support workers, so your point on addressing the skills is important and something we've identified.

I go back to before this pandemic started. Our then long-term-care minister, Merrilee Fullerton, had started to address the staffing issue, because it was very obvious when we took over government that there was, even then, a huge shortage. Of course, when the pandemic hit, this was only magnified by the number of personal support workers and nurses who, because of their health or age, were forced to retire or withdraw from services just because of the concern for their own health. This just made the issue worse. At that time, she had already started to

look at increased enrolments in schools, in post-secondary, but of course we know that that takes some time.

I also have a question for AdvantAge. Maybe Lisa or Connie could answer this.

Improving residents' lives and the quality of care they receive in homes across Ontario is important for this government.

Can you please let us know, as the representatives of many operators, how the proposed legislation will improve the quality of care and the quality of life for those who are living in long-term-care homes across Ontario?

Ms. Lisa Levin: I think there are a number of elements of the new act that will help improve quality of life, such as the focus on diversity. It does talk about emotional well-being, which is a new piece of it, so that could have a significant difference, as well. But the biggest thing to me is the four hours of care, because there will finally be enough staff to provide the care for residents whose acuity has increased significantly. As you heard from others, we've been asking for years for this. So that, to me, will be a game-changer, when we get that.

We also need to take the emotion-focused care and embed it more directly and eliminate barriers to it, because that will also make a huge difference. That is one of our suggestions.

Mr. Jim McDonell: I'll pass the questions over to MPP Daisy Wai.

Mrs. Daisy Wai: Thank you very much to all the stakeholders coming in this morning. I want to reassure you that improving residents' lives and the quality of care received in long-term-care, in residents' homes, is the top priority of our government. I appreciate all the comments that you've made.

Before I get into my question, I just want to clarify one point from CUPE's comment that the whistle-blower provision was not changed. That is not correct. In fact, in section 30(c), there is a new provision added that widens the scope, stating that any information disclosed to the ministry or any individual specified in the regulation is protected.

0930

I also want to ask this question to all of you: In fact, yesterday the minister shared that we are having the data more widely accessible. I just want to see if there is anything that you see that we're doing now—

The Chair (Ms. Laurie Scott): One minute left.

Mrs. Daisy Wai: —is good.

Perhaps I'll give you the time to answer this: How can we have this time, have this data helping you more?

Ms. Debra Maxfield: I'll let David answer the question.

Mr. David Hauch: Being able to see the data and track the data has been a really important accountability mechanism. For residents, staff and family members to be able to see the numbers and to actually be able to reconcile that with their lived experience in the homes—we're not able to do that if the numbers and data that are being presented and being reported publicly are provincial in scope and not broken down to the individual home level. So the data is

very important. I think we all have a shared interest in having as much of this information available publicly for review—

The Chair (Ms. Laurie Scott): Thank you very much.

Now we'll go to the official opposition. They have seven and a half minutes. MPP Singh.

Ms. Sara Singh: Thank you, everyone, for your presentations this morning. I think they really help shed some light on what folks in the sector are feeling around Bill 37, and some of the important work that still needs to be done to create the transformative change we need to see in long-term care.

Perhaps I can start with Cathy. I think you highlighted some important concerns about the four hours of direct hands-on care and the provincial target versus the homes having this target. Cathy, can you explain to the committee why this is such a concern for the folks in this sector?

Ms. Cathy Barrick: Thank you for the question.

It's a very huge concern, actually, and particularly related to providing care for folks with dementia. It's really important for families and people with dementia themselves to feel a sense of security, knowing that whatever home they go to, they will be receiving a minimum standard of care. As I mentioned in my comments, by aggregating that data across the province, over-performers—which we applaud, and hope that all homes over-perform and provide care beyond the four hours—will water down or misrepresent the data so that homes that are not providing that level of care will not be noted and notable. So I believe a transparent approach to this, to increase pressure on all homes to provide the amount of care that is required, is necessary.

I should also mention that that level of care being provided needs to come with adequate funding for the homes to be able to provide that care.

As I mentioned—again, I'm going to keep beating this drum—dementia-specific training is necessary. Increasing the number of hours is not enough. The training that PSWs receive in their programs is not adequate in terms of dementia-specific training. They need specific training over and above their regular training.

Ms. Sara Singh: Thank you for highlighting the importance of training. It's something we've heard from a number of different stakeholders, with respect to specialized training, whether that's in dementia care or people with, for example, cognitive limitations or intellectual disabilities. That training simply isn't there right now—for a PSW to receive that specialized training to engage with residents in, I think, a meaningful way.

My next question I'll ask to Lisa and the folks at AdvantAge care, because I think your presentation, Connie—thank you so much. I know in my conversations with Lisa, as well, we've discussed the concerns around mission-driven organizations and the focus of the government on mission-driven organizations rather than looking at this as an opportunity—actually, as Michael pointed out, too; “march to convert” was, I think, the language he used—to convert those homes to not-for-profit ones. Can you elaborate in terms of why this is so important right

now, at this critical juncture, and why this transition to investing more in not-for-profit care is one that will benefit the province of Ontario?

Ms. Lisa Levin: Firstly, I just want to state that the legislation is not consistent with what the long-term-care commission recommended. The legislation, when you read it, implies that all homes can be mission-driven, but the long-term-care commission talked about that not all operators are mission-driven, and others that have shareholders and owners whose motive is profit are not.

Secondly, hundreds of studies over many years have shown that quality of care is better in not-for-profit and municipal long-term-care homes. There are more hours of care that are provided. There are less hospitalizations. Generally, residents do better. And then, of course, we saw through COVID-19 that the outbreaks were much worse and the number of deaths were much higher in the for-profit homes, which is why we're recommending that, on a go-forward basis, all new allocations go to not-for-profit and municipal homes. To do that, we are recommending that a series of changes be made for not-for-profit and municipal homes to enable them to be able to develop new beds and redevelop their beds.

Ms. Sara Singh: I think, as the members from CUPE also highlighted, the need to do this is fundamentally critical to ensure that we're addressing the levels of care in homes. As you point out, Lisa, I think we saw, and studies have demonstrated, that in municipally operated and not-for-profit homes, the outcomes of care are better for residents.

Perhaps I can ask my next question to the folks at CUPE—as you highlighted, and all presentations highlighted, the concerns around the four hours of direct, hands-on care, and perhaps the government's inability to meet those targets because the staffing is still in crisis. The health care sector, in general, is in crisis, but when we think of long-term care, we have a mass exodus happening. There isn't a real campaign to train, recruit and retain PSWs in the sector.

So to the folks from CUPE: I know these are your members who were on the front lines providing care, as well. Can you highlight why it is so important to ensure that we are recruiting, adequately training, but also addressing wage disparities for folks in this sector to help to retain these folks in our long-term-care homes?

Mr. Michael Hurley: We estimate that given the growth in long-term care and the increased staffing, given attrition and given the early exodus of people because of demoralization due to their conditions, we're going to have to recruit about 54,000 new PSWs, RPNs and RNs over the next five years. Part of the problem we have in Ontario—distinct from Quebec, where the government has behaved differently—is, we don't have a commitment yet to full-time employment in the sector, and we don't have a commitment to a minimum wage standard—

The Chair (Ms. Laurie Scott): One minute left.

Mr. Michael Hurley: —which exists in Quebec. There's a \$26 minimum wage, full-time employment for

PSWs, and we're not dealing with the ramifications of that for classifications like RNs and RPNs.

This issue of creating full-time work and providing a minimum rate and dealing with some of the other issues—for example, the violence in long-term care would be an example—to make the work easier, dealing with the understaffing, would really go a long way. But we're far, far away, with the government's targets, from even being able to meet the four hours of care, let alone any of the other areas of health care which are going to be affected by the shortage of work. This is a crisis that needs to be addressed in a very straightforward way.

Ms. Sara Singh: For the record: Do all the presenters agree that the government will fail to meet the four-hours-of-direct-hands-on-care target—you can just answer by saying yes—because they aren't addressing the staffing crisis?

The Chair (Ms. Laurie Scott): Thank you. The clock is up. You'll have another round.

I will go to the government side for another seven and a half minutes of questioning.

Ms. Goldie Ghamari: Thank you, everyone, for your presentation and for your comments so far. It has been really informative.

Michael, I have a question for you and CUPE.

One thing that we've been working on and one thing that we've committed to is enshrining four hours of care per long-term-care patient in legislation. This is something that I know CUPE and a lot of other people and organizations had been calling for, for several years, and these calls were ignored by previous governments. This is something that our government implemented and put into legislation.

0940

I was wondering if you could talk a little bit about how you see four hours of care being enshrined in legislation impacting the working conditions for those you represent in long-term care.

Mr. Michael Hurley: Four hours of care will make a very significant difference to the quality of working life, obviously, of people in long-term care. More importantly, it will make a huge difference to the quality of care for residents in long-term care. But the fact that it's a target in this legislation is a concern to us—and the fact that the government has not established concrete targets, as the Quebec government has done, to facilitate the recruitment and retention of occupations where we have critical shortages. Quebec took measures to recruit 10,000 PSWs. They knew that full-time work would be attractive. They offered full-time employment. They've retained 87% of all the people they recruited. That's not—

Ms. Goldie Ghamari: I'm sorry to cut you off, Michael, but my time is limited.

I am the parliamentary assistant for the Minister of Colleges and Universities. When you're speaking about recruitment and training, that's something that our government has done, as well, in the past. In the past year or so, we've committed to training PSWs, completely funding their education, and providing them with the money that they need for the work placements, for their supplies, for

their PPE. This is, again, something new that our government introduced in the last year or so.

So while I do appreciate you mentioning that this particular legislation doesn't talk about training and recruitment, that's because this particular legislation is about protecting our long-term-care residents and the targets for training and encouraging people to get into those desperately needed trades, not just PSWs.

The Minister of Colleges and Universities and I made an announcement a few weeks ago in Ottawa that we're working with local French universities and colleges to help recruit bilingual and French-speaking staff, whether it's PSWs or nurses. So we have acted on that as well. It just might not be in this particular piece of legislation, but it is there.

Mr. Michael Hurley: In fairness, the recruitment targets are less than 20% of what we estimate the actual need is going to be in terms of allowing four hours of care to actually materialize. That's why, in that context, this can't be magical thinking on the graves of all these seniors who perished during COVID-19. We need long-term care—four hours—to be a real thing, and to do that, we need to establish concrete targets and have a path to get there. We have to make the work attractive, and that means making the work attractive by making it full-time and paying properly and other things which are all involved, I think, in—

Ms. Goldie Ghamari: Sorry, Michael—just because my time is limited. I appreciate how passionate you are about this. It is an important topic. My mother works in a non-profit dealing with seniors, especially newcomers. This is something that I've also been involved with as a volunteer, prior to getting elected. So I appreciate how important this situation is.

What other data, then, do you believe should be made public or available in order to increase transparency in long-term care, or to perhaps assist us with reaching those concrete targets that you're mentioning?

Mr. Michael Hurley: I'll give that to Dave, if that's okay, from CUPE.

Mr. David Hauch: Thank you, Michael. I think there are a few different pieces. There's definitely payroll data that is going to be necessary to actually ensure that what is being reported in terms of the hours of care—there needs to be an ability to check that data to make sure that it's accurate. We need to be able to know the number of hours that are being worked, broken out by classification, and not just simply across the board in the home. There are a lot of different pieces when you get into the minutia of the data. I think a fuller set of information allows for a fuller understanding of the reality of what's on the ground. There is a real risk in this, because we're talking about a lot of numbers, that numbers can be gamed, and that you can frame numbers to support your own conclusions. So it is really important that we have an open set of data that can be reviewed by advocates and experts to be able to ensure that we're not playing funny games with the numbers at either a provincial or at a home level, so we can actually make sure that the targets are real and tangible.

Ms. Goldie Ghamari: Sorry; I didn't quite understand. Are you implying, then, that the province would fudge the numbers? I'm just trying to understand where this is coming from. Is there any evidence of provincial—

Mr. David Hauch: Not at all—

The Chair (Ms. Laurie Scott): One minute left.

Mr. David Hauch: I'm suggesting that in the reporting from homes, if the only data that is released publicly is provincial data, that looks at the provincial average—

Ms. Goldie Ghamari: So then what steps should be taken to improve that accountability or transparency of the data coming from long-term-care homes?

Mr. David Hauch: I think there needs to be a clear requirement in the legislation requiring that licensees have to provide all of this data, that that data has to be subject to random audits to ensure that it's accurate, and that when we look at what we're looking at in terms of a provincial scope, we're able to see where homes are exceeding those targets so we can celebrate success, but also where homes are missing those targets so we can actually hold those homes accountable—and we're not looking at an across-the-board average in the province, that we're actually looking at the care at the bedside for each individual resident to ensure they have what we've been advocating for so long: that each and every resident has at least an average of four hours a day.

The Chair (Ms. Laurie Scott): We'll now move to the official opposition for seven and a half minutes. MPP Singh.

Ms. Sara Singh: Thank you, again, to all the presenters.

I'm just picking up where we left off around the four hours of direct hands-on care, as I think that this is really a huge concern for a lot of folks in the sector—that the capacity simply isn't being built to meet those targets, as you all have outlined.

My question earlier was whether you think the government was going to meet those targets. It's really a yes-or-no question. Maybe we'll start there, and then I'll ask some more specifics around this.

Dave, I'll start with you. Do you feel that the government is going to meet the target that it set out in this bill?

Mr. David Hauch: Without a very bold plan, no.

Ms. Sara Singh: Cathy, would you mind sharing some thoughts on that as well?

Ms. Cathy Barrick: Agreed. I would say not without, as Dave just mentioned, a plan, obviously, particularly related to the staffing shortages.

Ms. Sara Singh: Lisa?

Ms. Lisa Levin: I think that there are some major impediments to that. One of them is the fact that wages have been increased for PSWs, which is great, but not other staff, so we have RPNs fleeing the sector and other staff very demoralized and leaving.

Also, Bill 124 limits wage increases in long-term care to non-profit and hospital homes, but not to municipal and for-profit homes.

So although there are a number of really good initiatives the government has put forward and is working on and rolling out, without increasing the wages in the sector

overall and for everyone, and without getting rid of Bill 124, there are going to be very large challenges meeting this.

We also need to look at the north, MPP Singh, because the north is having an even worse crisis, and we need specific programs and incentives directed to northern Ontario for people to work.

Ms. Sara Singh: Thank you so much for highlighting that, Lisa.

I think it's important to understand the scope of where homes are across the province and the differences in the needs that they have. It doesn't seem as though there's a targeted approach being taken here to build that capacity in sectors to identify where those gaps may be and help meaningfully recruit and train the individuals who are needed.

I'll pick up on what Michael was saying earlier when the government was asking questions around the training.

Michael, do you mind elaborating a bit in terms of why—training is obviously important, but why the other factors like pay, quality of work and full-time work are also so important? And maybe share what other provinces have done to help ensure that they are more effectively building that capacity in the sector.

0950

Mr. Michael Hurley: Quite some time ago, the Quebec government made a very dramatic assessment of what it would take to retain personal support workers in its CHSLDs. It said that they were going to hire 10,000 people, that they were going to make the work attractive by raising the compensation floor, providing pension and benefits, and they were going to make the jobs full-time. They've been able to retain 87%. They're 40% smaller than we are, but the numbers that they've recruited are actually more than the government is contemplating so far in the announcements that they've made, although we're so much bigger. So this is a huge problem.

In long-term care, where 60% of the workforce is part-time and casual and working at multiple institutions, where the wages vary so widely and where full-time work is so hard to get, these are all fundamental conditions.

As you can see, and as Lisa said so eloquently just a minute ago, people flee for better work. Why wouldn't they? Their wages are held down; they were low to begin with. The work is terribly hard. Psychologically, emotionally, physically, it's so difficult. If you can go to a hospital or somewhere else and earn \$5, \$6, \$7 an hour more, why wouldn't you?

So how would you keep people here? You would keep people here by trying to meet some of their basic needs. Unless we see that from the government in terms of the same bold announcements that came out of Quebec, we aren't actually going to address the staffing shortage. The numbers that are going to be needed to deal with attrition, the increase to four hours of care, the backlog of surgeries in the hospitals, the attrition in long-term care—because people are fleeing there as well, to higher pay and full-time jobs. These things are going to require the government to act much, much more boldly than it has so far, by a factor

of about 400%, in terms of the announcements it has made so far.

Ms. Sara Singh: I'll ask Lisa to share a little bit about your concerns around the lack of capacity that's being built, but in particular for the not-for-profit sector. As we know, Bill 124 disproportionately impacts those homes. Can you help shed light on the staffing needs in those homes and how this bill impacts them, but also help the committee understand what happens in those homes when there aren't enough staff to provide care and the sort of burden that's placed on the existing staff who are showing up as well? I think it would be helpful for committee members to get a sense of what this looks like in reality.

Ms. Lisa Levin: What's happening is that we're seeing unprecedented levels of overtime and agency staff in the homes. It's just a matter of time before the people who have been working overtime constantly burn out and leave—and many have already. Many staff are on sick leave. We're collecting data on this that we're going to be presenting to government, to give some hard facts. We really feel the system is on the brink of collapse, from an HR perspective. It also impacts the leaders of the homes; I've never seen so many people retire.

The other thing I want to mention is that with the enhanced—

The Chair (Ms. Laurie Scott): One minute left.

Ms. Lisa Levin:—enforcement, non-profit leaders are concerned that they could be put in jail or fined hundreds of thousands of dollars.

Really, are these the homes that should be targeted by the enhanced enforcement without any compliance, education or information to help them get through?

The Chair (Ms. Laurie Scott): Thirty seconds left.

Ms. Sara Singh: Lisa, would you say that these enforcement mechanisms are creating a culture of fear in the sector?

Ms. Lisa Levin: Absolutely. I think the bad actors need to be dealt with. We need enforcement. But we need to look at the broader sector, and we need to provide assistance to homes. We're in a staffing crisis, and we're having enhanced enforcement. People are leaving. They're scared.

The Chair (Ms. Laurie Scott): We will now move to the final round of four and a half minutes, and we will start with the government side. MPP Thanigasalam.

Mr. Vijay Thanigasalam: Thank you to all the presenters for your presentations today.

Before I go to my question, I want to highlight that in terms of—there were some dialogues regarding that there was no recruitment campaign for workers in long-term-care facilities. I just want to highlight that a digital recruitment campaign, with a significant investment to have this digital recruitment campaign, is about to begin tomorrow. So that's coming up. I just want to let all the panels of speakers and presenters know.

My question is generally to all three presenters, starting with AdvantAge, and then we'll go to CUPE and the Alzheimer Society of Ontario.

As you all might know, Minister Phillips and the government have committed a record amount of money for

training staff, for retaining them, to ensure the highest quality of care in homes across the province. When I talk about this investment, I'm talking about \$100 million for career laddering, which will lead to almost 200 more nurses. We have invested in more than 16,000 PSWs, which is, I believe, 10,000 more than have graduated in any previous years. We're talking about 16,000 PSWs.

With these plans and these investments from our government, nurses and clinicians have been supportive. They have openly and publicly expressed their support for these plans, especially when it comes to investment for training, investment to hire more nurses, to have more PSWs. So that's already public.

Can the panel of speakers please help me understand if you are in support of these investments, whether it's investment to have more nurses or the investment to have 16,000 PSWs? As I said, this is 10,000 more than in any previous year of graduation. What's your take? Maybe you can elaborate on it or you can express whether you support these investments.

The Chair (Ms. Laurie Scott): Go ahead, Lisa. Your hand was up first.

Ms. Lisa Levin: Absolutely, these are unprecedented investments that we have not ever seen. The number of initiatives that the ministry and government have put forward respond to what we've asked for and are excellent.

However, without having fairness in salaries and only increasing the salary of one group—PSWs, who absolutely deserve it—these investments are not going to be successful in getting what we need and in retaining the existing staff. Also, with Bill 124, the not-for-profits and hospital long-term-care homes are at a huge disadvantage. So we need to look at the whole picture.

But absolutely, we really support these investments and we applaud them.

The Chair (Ms. Laurie Scott): Cathy Barrick, you have 30 seconds to respond, also.

Ms. Cathy Barrick: I'll do it quickly, to give Dave a chance as well.

We applaud the government's investment and fully support the investments so far. My only comment would be that the number of bodies is not the complete answer. There are, as Lisa just mentioned, multiple factors, including the quality of the training with regard to dementia. So it's a lot of the way there, but there's still some room to go.

The Chair (Ms. Laurie Scott): Unfortunately, we're out of time. I'm sorry.

I will now turn it over to the official opposition for their four and a half minutes. MPP Singh.

Ms. Sara Singh: I think there are still a lot of concerns that remain around building the capacity in the sector. I know that the government has made some investments, but perhaps we can focus a little bit on what is actually needed in the sector. I know, Michael, you were alluding to this earlier in your response, in terms of the actual capacity that's needed.

Can you share with us—and I think for others as well, Cathy and Lisa—what are some of the numbers of new

hires that you would estimate we need in the sector to truly build that capacity?

Maybe we'll start with you, Michael.

1000

Mr. Michael Hurley: Dave will take this one, if that's okay, Sara.

Ms. Sara Singh: Absolutely. Thanks, Dave.

Mr. David Hauch: As Michael mentioned, our estimates are over 50,000, in terms of the bodies that are needed to be recruited. But I think the really important piece of the equation that's being lost in the mix is that recruitment is only one issue. Retention is the key. I know Lisa mentioned the issues around wages, the impact of Bill 124 on the sector. Michael mentioned the prevalence of part-time work and the need to flip that so that we are creating good and stable full-time jobs. If we don't address the working conditions in the sector in an holistic and systematic way, we can recruit all the people we want; we're not going to be able to keep them.

Ms. Sara Singh: I think you have all highlighted the importance of not only recruiting but actually retaining those staff through proper staffing ratios and increasing pay as well as improving working conditions.

Earlier, Cathy also spoke of the importance of adequate training. I think that lack of training also often creates a lot of barriers and impediments to folks staying in the sector.

I'll start with you, Cathy. Can you elaborate on what is important about providing specialized training, especially in the dementia care sector?

Ms. Cathy Barrick: Thank you for the question.

It's critical. PSWs are well trained in the provision of care, and we applaud the hard work that they do, but providing care is affected in every single way by someone's cognitive abilities. So the way that you have learned, perhaps, to bathe someone needs to change and be responsive to people's individual needs. This is not just related to dementia, obviously. That's why I am advocating for it, but for all clients, care needs to be very specific to their emotional, physical etc. needs.

But dementia-specific care is absolutely critical, and by not having it—related to some of the other comments—it actually creates a retention issue. It makes the work very difficult, if you're trying to provide care to someone who is combative, difficult, aggressive etc. All of those things can be addressed by providing patient-centred care. PSWs—it's a really hard job, and when they're getting hit, pinched etc., it's not a very good working environment. We believe that dementia-specific training could alleviate most of that.

The Chair (Ms. Laurie Scott): One minute remaining.

Ms. Sara Singh: Thanks, Chair.

I'll ask the same question to Lisa, in terms of some of the specialized care that's needed to help build that capacity but to also help train staff adequately. Can you elaborate on that, Lisa?

Ms. Lisa Levin: I would talk about emotion-focused care. There are amazing models out there, like the butterfly model and the Eden Alternative and Green House models, as well as others. Currently, the act has so much red tape

that it's an impediment. There's also financial investment needed to create these models, which, by the way, have been shown to not only dramatically improve resident outcomes, but also enhance staff retention and recruitment.

The other thing I would say about training is that every other type of inspection system in Ontario and in many other parts of the world has compliance assistance. That's another kind of training homes need. The Retirement Homes Regulatory Authority has compliance assistance. The Ministry of Labour—

The Chair (Ms. Laurie Scott): Thank you. I'm sorry.

Thank you very much, everyone, for being before committee.

This committee now stands recessed until 1 p.m.

The committee recessed from 1005 to 1300.

The Chair (Ms. Laurie Scott): Good afternoon, everyone. We're meeting today for public hearings on Bill 37, An Act to enact the Fixing Long-Term Care Act, 2021 and amend or repeal various Acts.

Our presenters are grouped in for one hour, and there are three presenters. Each presenter will have seven minutes for their presentation, and after we have heard from all three presenters, we will have 39 minutes of questioning, divided into two rounds of seven and a half minutes and one round of four and a half minutes for the government members, as well as two rounds of seven and a half minutes and one round of four and a half minutes for the official opposition members. I will remind you that there's one minute left so that you can summarize, whoever is speaking.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

ONTARIO HEALTH COALITION

UNITED STEELWORKERS

The Chair (Ms. Laurie Scott): The three presenters for this round are the Association of Municipalities of Ontario, the Ontario Health Coalition, and the United Steelworkers.

We'll begin with the Association of Municipalities of Ontario. For Hansard, just introduce your name, please, before you begin.

Mr. Colin Best: Thank you for the opportunity to appear before this committee on the topic of Bill 37. I'm here on behalf of the Association of Municipalities of Ontario, or AMO. My name is Colin Best. I'm a board member and chair of the association's health task force, which considers matters such as long-term care and seniors' services. I'm also a councillor in the region of Halton.

Presenting to you today and joining me are two staff who will participate in the hearing by answering your questions. Monika Turner is director of policy. Michael Jacek is the senior adviser for health and human services policy. My presentation will be brief so we can answer your questions.

To begin, let me highlight the major points as outlined in our written submission to the committee.

First, I'll say that AMO appreciates the opportunity to provide comments on Bill 37. It is appropriate, as municipal governments are deliverers, co-funders and employers for long-term-care homes in Ontario.

The municipal sector operates 16% of the homes in the province. This accounts for approximately one in five long-term-care beds. They do this primarily as municipalities in southern Ontario are mandated by the act to operate a home. However, many exceed this basic requirement and operate more than one home, often larger ones. There are also municipal homes in the north; although they are not required to operate them, they do so to meet the local needs. In fact, municipal governments are major contributors to long-term care in paying for operations and capital needs where provincial funding has fallen short. In 2016, this contribution was estimated at \$350 million annually. This is only operating costs; it does not include capital expenditures.

Communities have high expectations for municipal homes. We pride ourselves on providing a high standard of quality care and keeping our residents well and safe.

AMO is in support of the transformation and modernization, not only to respond to the learnings of the COVID-19 pandemic, but also to address long-standing issues. We have examined the bill closely and are generally supportive of it. The proposed legislation meets many key priorities that resonate or are in line with the changes sought by AMO's board of directors. We do, however, have suggestions for a few substantive amendments to the bill.

Our association's comments relate specifically to long-term-care homes as they will be impacted by the changes outlined in schedule 1 concerning the Fixing Long-Term Care Act, 2021. We are mindful to focus our attention on significant aspects of the act relating primarily to impacts on systems policy, governance and funding commitments. We appropriately defer to long-term-care associations and health providers on a wider range of operational technical matters. We encourage the committee members to carefully consider their advice to you through these hearings.

Today we wish to highlight three suggested changes to the act. The first is about residential emotion-focused care; the second, enforcement and compliance; and thirdly, allied professional services and level of care. As detailed in our submission, we are seeking amendments in these three areas. We feel this will significantly—

Interruption.

The Chair (Ms. Laurie Scott): I'm sorry to interrupt. We can hear paper shuffling. If you could just adjust somehow, so we don't get distracted with the paper shuffling—we can't hear you. Thank you.

Mr. Colin Best: My apologies.

On the first topic, emotion-focused models of care: We are asking the committee to amend the act to include explicit wording to enable emotion-focused models of care. The fundamental principles of the act should include the words "emotional needs." This should be in addition to the commitments to adequately meeting the physical, psychological, social, spiritual and cultural needs of the

residents. This is proposed given the rising acuity levels and complex needs of residents, including dementia and cognitive impairments. Long-term care should be home-like settings and not an institution. Emotion-focused models pay attention to the mental health and well-being of residents. This is just as important as physical care and should be reflected in the act as such.

Increasing to four hours of care will increase quality of care. However, this alone does not ensure that the emotional needs are met. A commitment to these models in legislation is needed, along with accompanying guidance and additional funding for long-term-care homes to implement them. In short, we need a comprehensive enabling legislative and regulatory framework, as well as resources to implement emotion-focused models of care that will provide residents with the highest standard of care possible. It will also contribute to making long-term care an appealing environment to work in for existing and new staff.

Next, on the topic of enforcement and compliance: We are proposing that the act be amended to commit the government to providing compliance support for long-term-care-home operators. AMO is supportive of strengthening enforcement. It certainly plays a role in providing oversight to help ensure that residents are safe and ensuring good-quality care. However, it cannot be just punitive, with a "gotcha" culture, or else we will not achieve success and desired outcomes. It is equally important to provide compliance support for home operators to continuously improve and make all operators aware of their obligations. As well, a focus on just punitive enforcement is creating challenges to attract and retain staff to work in that sector.

The bill should balance the need for more inspections and effective enforcement with compliance support from the government. This could be achieved by incorporating the coaching-for-quality proposal made by AdvantAge Ontario, the staff association representing municipal non-profit homes. Compliance support should be built into the role of inspectors, including guidance through coaching.

The ministry should also provide tools to the home operators. Expertise from homes can be leveraged through the collection and dissemination of best practices throughout the sector. This will improve compliance, increase quality of care and facilitate innovation.

Lastly, I'll speak to the allied professional services.

The Chair (Ms. Laurie Scott): One minute left.

Mr. Colin Best: The proposed act provides a minimum of 36 minutes of care; we suggest it be increased to 60 minutes. Our recommendation is based on what we are hearing from our members, and it was a recommendation of the long-term-care commission. Enshrining four hours of care to residents in the act is the right thing to do, and we commend the government for doing this.

At the same time, it has also been recognized in the act what the value of allied professionals is. They play a critical role for residents' health and well-being, both physically and mentally. Appropriate staff expertise by

professionals such as occupational therapists, physiotherapists and recreational providers is all needed. Increasing the minimum time will improve resident outcomes.

Interruption.

Mr. Colin Best: That concludes my presentation today. Thank you for listening. We look forward to answering your questions.

The Chair (Ms. Laurie Scott): If there are questions your way—whatever the noise is, it's hard for Hansard to do the recording. Just be mindful if you come back on.

Next up is the Ontario Health Coalition, and you will have seven minutes to present. Please go ahead.

Ms. Natalie Mehra: When analyzing this act—which is not a new act; rather, it's amendments to the existing act—I've been haunted by the images of the people who have suffered so egregiously in long-term care.

Diane, whose mom, for example, was in for-profit chain Southbridge, their Orchard Villa Home—when she was admitted to the home, Diane describes her as being 110 pounds. When she died, she was down to 68 pounds.

Andrew's mom was discharged from hospital to Southbridge's Orchard Villa while it was in outbreak and contracted COVID-19. She died alone in the home, and he describes her at her funeral as being so emaciated that she looked like she was a concentration camp victim.

Margaret—a pseudonym—whose mom was in a long-term-care home where she didn't see a physician from January till June. She didn't receive the foot care that she needed and for which her family was paying. She was in pain. Her daughter describes her screaming on the phone in pain to her. There was not enough staff. She ultimately died in hospital last year, in August, of an untreated urinary tract infection, that had gotten so bad she was in kidney failure.

Pierrette died in for-profit chain Extencicare's West End Villa in Ottawa in September, last year. Her daughter described the conditions in her room on the day of her death: Her hands had excrement on them. The walls had excrement on them. There was no staff to clean. She was severely dehydrated. Her tongue was dry. There were drink cartons in front of her which she couldn't open. She had dementia and COVID-19. Despite having symptoms of COVID-19, there were residents wandering into and out of her room, being exposed to the virus. There was no staff around.

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Does this legislation stop these things from ever happening again? It does not. That really is the test of this legislation.

The worst part of the act is in the preamble, the changes to the preamble. One of the things we won in the 2007 act was a requirement in the preamble that the government be committed to promoting non-profit long-term care only. That includes public and non-profit long-term care—not for-profit long-term care. This government is proposing to change that preamble to attempt to throw the doors wide open and take away impediments to handing tens of thousands of beds under new 30-year licences to for-profits, including those same for-profit chains that are responsible

for the deaths of literally thousands of the residents, in the last 20 months, they were entrusted to care for. It is a poison pill. If that clause remains in the preamble of the act and if the changes to the licensing section of the act remain as they are, this bill must be voted down.

The rest of the bill contains lots of nice-sounding language. Much of it is fairly meaningless on the ground without enough staff to actually provide the care.

I'm going to jump to the minimum-care-standards section, section 8. This does not actually establish a required minimum standard of care. It is far less than what we asked for. What it actually does is set a target. That target is to get to a safe level of care—four hours of care per resident per day, yes—but not until four years from now. In addition, it's completely unenforceable. It's not a minimum. It's an average across all of the homes in Ontario. If this target was ever reached—and we know there is no staffing plan that would actually get us there, but were it ever to be reached, your mom might get six hours of care in a great municipal long-term-care home, but my Auntie Usha might get two hours of care, in accordance with this minimum standard as it's written in the legislation, in a terrible for-profit home. This standard, if it's going to be in legislation, needs to be changed. It needs to be a minimum average per home, enforceable in the home.

There are no reporting requirements that are clear in the legislation. In the last set of government reports—and I have to say that we have to do freedom-of-information requests every time to even access this data, which in American jurisdictions is posted in the homes themselves. It should be publicly accessible. And certainly, once you've won a freedom-of-information request once, you shouldn't have to do it every year. Nonetheless, it needs to be posted in the homes. It needs to be posted on a government website, accessible to everyone. There needs to be required reporting. The inspectors need to be able to inspect to it. In the last government reports I saw, only six for-profit homes out of all of them in Ontario actually even reported their staffing levels. That's not acceptable, and this part of the act is far too weak.

Moreover, section 41(2)(f) is an escape-hatch clause, which allows the government, by regulation, to extend the target dates in section 8—so it's not five years; it might be seven or eight or nine or 10 years. I also don't understand: Why would you have legislation that the government can then change by regulation after the fact? That's not acceptable.

Quickly, because we only have seven minutes, I'll go on to some of the other sections.

Obviously, the deaths that I described to you in long-term care were largely due to understaffing. The minimum care standard is critical, but so are the actual requirements for staff. There is no change to the RN requirement in the act. Again, it's something that we advocated for in 2007—

The Chair (Ms. Laurie Scott): One minute remaining.

Ms. Natalie Mehra: Thank you—and won. That's one RN, 24/7, for a 500-bed home or a 50-bed home. That is

woefully inadequate for the acuity or the complexity of the care needs of the residents.

A PSW must be a PSW. As we know, they are being replaced by completely untrained staff. That needs to be in the legislation; it is not now.

The staffing mix needs to be appropriate to acuity.

There have been no changes to the medical leadership of the home—nothing to deal with these absentee medical directors and people like Margaret, who got no access to medical care for months as she was dying.

The whistle-blowing section could be strengthened significantly. I can answer questions about that if you have them.

And there should be a new anti-corruption section. We know that three former Premiers—Conservative Premiers—have left office to join the boards of for-profit, long-term-care-home chains after sitting in office. That's not acceptable. We know that key staff of ministers have gone—

The Chair (Ms. Laurie Scott): Thank you very much. Sorry; you're out of time.

We have one more: the United Steelworkers, please.

Mr. Kevon Stewart: Thank you, Madam Chair, and thank you to the Clerk, committee staff, interpreters and all committee members for the opportunity to make a submission and join you today. My name is Kevon Stewart. I'm district 6 co-ordinator for the United Steelworkers. We represent 75,000 workers in virtually every economic sector, including in long-term care in Ontario and across the Atlantic provinces. District 6 is the largest of 13 districts of the United Steelworkers, which is the largest private sector union in North America.

I am pleased to be joined today by my colleagues Matthew O'Reilly, who is a researcher in our national office, and our health care representative, Briana Broderick. Both of these individuals will be available at the end to help answer questions. I'm also pleased to be joined by the chair of our United Steelworkers health care council, Audra Nixon, who will continue our presentation.

Ms. Audra Nixon: Thank you, Kevon.

In the press release announcing Bill 37, Minister Phillips was quoted as saying, "Ontario has listened to the advice of the long-term care COVID-19 commission and the Auditor General—as well as residents, their families, the public and those working in the sector." Madam Chair and committee members, the government may have listened to our advice, but they did not put much of it into the bill.

As we outlined in detail in our written submission, we believe the following changes must be made to the bill so that it can achieve its stated goal:

- all references to so-called "mission-driven organizations" must be removed;
- the timeline for the implementation of a requirement for four hours of direct care must be moved way up;
- daily care hours must be calculated on a facility-by-facility basis and reported publicly;
- clear consequences for facilities that fail to meet care targets must be included;

- annual surprise home inspections must be reinstated; and

- crucially, the staffing crisis must be addressed.

To begin, the bill doesn't even define what a "mission-driven organization" is. At best, it's a glaring oversight; at worst, it's a wink and a nod to for-profit CEOs and board members that the money train will keep on rolling. Whatever else it is, the introduction of an undefined term like this is a move away from the clear commitment in the current act which promotes "long-term-care-home services by not-for-profit organizations." Given why we are here, we cannot allow legislation to further put quantity of profit ahead of quality of care.

When it comes to legislating a four-hour standard of direct care, however, in principle, it is good and a long-overdue idea. Unfortunately, under Bill 37, it wouldn't fully be implemented until 2025. As the long-term-care commission specifically and grimly said, "The staged approach likely means that the vast majority of current residents will have passed before the four hours of daily care is fully implemented."

The commission's report also warned that reporting hours of care as an average lets underperforming homes off the hook and leaves people in care in those homes unprotected. And they were clear in their report that failure to comply with standards and reporting should result in proportional and escalating consequences, including fines, suspensions of licensees, takeover of management and stopping new admissions. As it stands, the bill asks for not much more than a plan to make a plan to fix things.

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Another issue the commission report is very clear about is the need for inspections to be unannounced. It's the only way to make sure inspectors are seeing the truth. The legislation needs to be equally clear in mandating that.

Finally, and most importantly, to have any hope of improving the situation, the legislation needs to be amended to address the most pressing challenge facing long-term care in Ontario: staffing. Again, I quote the long-term-care-commission report: "There is broad consensus across the long-term-care community that staffing is a critical—if not the most critical—challenge facing the sector."

The current practice of favouring precarious jobs lowers payroll costs and helps the bottom lines, but it is harming the workers and hurting residents in long-term care. When SARS hit, the fact that health care workers are forced to hold multiple part-time or casual jobs across different facilities was identified as a vector of community spread, and we know that was true again in 2020. More full-time positions need to be made available, and wages of direct-care staff need to be in line with the wages and benefits provided in public hospitals.

Right now, despite initiatives during the pandemic, wages in the industry remain depressed by this government. Arbitrators continue to hold wage increases at 1.5% per year in private long-term-care homes, while employees in non-profit homes are subject to Bill 124's 1% compensation cap. This bill needs to be amended to improve compensation—

The Chair (Ms. Laurie Scott): One minute left.

Ms. Audra Nixon:—sorry—for workers in long-term-care centres.

Please allow me to add, as the first step towards making sure wages in the broader health care sector are sufficient to support the required staff, the government must repeal Bill 124.

On that note, I want to thank you for the opportunity for us to join you today. While it's true the pandemic made deficiencies in our long-term-care homes front-page news, the core problems and challenges have been recognized by workers' advocates, residents and their families for a long time, and the long-term-care-commission report added to the road map to make it better. After all that we have seen, after so many sacrifices and lives lost, we cannot let this moment pass without making meaningful change.

From someone who has worked in this sector for 34 years: Our seniors deserve better.

We look forward to your questions.

The Chair (Ms. Laurie Scott): Thank you very much for your presentations.

We will start with questions from the opposition, for seven and a half minutes. MPP Singh.

Ms. Sara Singh: Thank you so much, Chair. I do believe there may be some issues with your microphone. I'm not sure if others are hearing it as well. I just want to flag that for you and the broadcasting folks.

Thank you so much, everyone, for your presentations. I think that there is a common thread from all three presenters around concerns with the bill.

I think, Natalie, as you indicated, seven minutes is barely enough to get through all of the concerns that folks want to highlight. I appreciate you providing the context and sharing those voices of the families and the folks who have really experienced what is the horror of long-term care.

I know that there are a number of concerns with actually meeting the four hours of direct, hands-on care and the targets around that. Can you share a little bit more, from your perspective, in terms of why the government will not meet the targets it's intending to and how it is failing to address the current staffing crisis in long-term care?

Ms. Natalie Mehra: Thank you very much for the question.

Currently, we have lost hours of care. At the beginning of the pandemic, we were at 2.7, on average, across the sector, and that is self-reported by the homes. Of course, we know that the bad homes lie, and so that number is questionable in the first place. Nonetheless, we've never seen staffing levels so low.

I can't emphasize this enough: There is no care without staff. That's the bottom line here.

What we were hearing from resident after resident, family after family, is of units that would be anywhere from 28, 29, 30 or 34 residents in a unit, with only two PSWs; sometimes one PSW with a resident care aide who's not a trained PSW; one RPN who's split across multiple units; one RN, maybe, for the entire home. It's almost half of what we saw before the pandemic—and it

was in crisis then. We're way below, so if we're starting from that level and getting a 15-minute increase by April 2022, which is the target, that is inadequate.

In addition, the actual staffing announcements made by the government, while they sound like big numbers, are not even in the realm of what's needed for training. We need to recruit back the existing staff, and there hasn't been an improvement in the working conditions that would be sufficient to do that. We need a big bump-up. Quebec did that. It actually would help, because then the workloads would not be impossible and new staff starting wouldn't leave within a week.

But within the legislation itself, this target is not a minimum; it's an average across the whole sector. It's completely unenforceable. It's four years from now, with an escape hatch that allows them to stretch that out over even more years, so completely—it's not a minimum care requirement by any stretch of the imagination, and it's nowhere near good enough.

Ms. Sara Singh: I know we heard from earlier presenters this morning as well who echoed those concerns. The actual staffing ratios that are needed to even meet a minimum standard of care right now in those homes is something this government is not going to be able to deliver. They haven't really focused on what many have highlighted is not necessarily just a recruitment issue but a retention issue here in this sector, by ensuring that workers are paid a fair and decent wage and that there are ratios of full-time and part-time work.

Audra, if I may ask—and Natalie, feel free if there's something you'd like to add—with respect to the staffing ratios and the actual staffing resources that are needed in our long-term-care homes, can you elaborate a little on your perspective on this bill and whether it's going to address the retention and recruitment issue adequately to help make sure that we have the resources to provide at least a standard of care here in our homes?

Ms. Audra Nixon: We definitely need to have more staff per resident. In some homes, it's 1-to-15, one staff member to 15 people. Just remember, our seniors are people who have dementia. Some of them are violent, and some of them need help to just get their activities of daily living done. So one PSW to 15 people—that is scary, and it's horrifying for the families, that that is where their loved one is. When they put them in long-term care, they think, "Oh, my goodness, this is wonderful. You have these workers," and whatnot. But it's one to 15 people, and that one worker has to play God over trying to get somebody—"Do you want a drink of water?" or "Do you have to use the bathroom?" To that individual, that is very important. So it's stress from the time you get up—because you are on a time limit all the time. You have to have them up. You have to have them to a dining room. That's not taking into account that some people don't eat as quickly as other people. The time limits are very little per person. We think we have all the time in the world; we do not. The reality is, it's a scary, scary thing for the people who are living in long-term care—whether it's "How long do I have to wait to get a drink of water?" or "How long

do I have to sit in a wet diaper?" That's disgraceful for our seniors to even have to contemplate that. No wonder so many people are terrified of long-term care. And for working in there, the stress—we can't retain the staff because it's just too hard emotionally and physically to keep staff on at long-term care.

Ms. Sara Singh: Earlier presentations also highlighted the stress and the burnout that staff are facing because there aren't adequate staffing levels in the homes.

I think it's also important to distinguish between—

The Chair (Ms. Laurie Scott): One minute remaining.

Ms. Sara Singh: —thank you so much, Chair—the non-profit and for-profit sectors, in terms of the outcomes of care and the differences in the staffing ratios.

Colin, I know you spoke to the importance of investing in not-for-profit models in municipal homes, as well. Can you elaborate a little bit on the value for dollar in investing in not-for-profit care versus for-profit care?

Mr. Colin Best: Thank you for your question. Actually, I'll turn it over to Michael, who could answer the question in more detail.

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Mr. Michael Jacek: Thank you. In terms of the question, AMO is pretty laser-focused on what improvements to municipal homes are possible. Our board has not really taken a position about for-profit care as we're not the service system managers for long-term care, as we are for other human and social services, like housing, child care and social assistance. So our focus is on—

The Chair (Ms. Laurie Scott): I'm sorry; we're out of time for this round of questioning, but there will be opportunities later.

The next round goes to the government side, for seven and a half minutes. MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: I would like to thank all of the presenters for joining us today. Your feedback is very valuable to us as we move forward with this draft legislation.

The mission of long-term-care homes across Ontario is to give seniors high-quality care so they can experience the best quality of life, and we believe this legislation supports that mission. I understand that some of the presenters may not agree with everything in our plan, but we share a common cause to fix long-term care so that residents receive better quality of care and enjoy a better quality of life. So I therefore appreciate your feedback on ways in which it can be improved.

It's important to note that after decades of neglect, our government is the one that has taken decisive action to fix Ontario's long-term-care sector. As Minister Phillips has stated, for years, "not enough beds were being built, not enough staff were being trained and not enough attention was being paid to the concerns of the people who live and work in long-term-care homes."

A major part of this legislation is to address some of those wrongs. This legislation, if passed, would in fact restore, in my view, public trust through the measures that will improve resident care, transparency and accountability. Our plan is to fix long-term care, and it's built on

the three pillars: staffing and care; accountability, enforcement and transparency; and building modern, safe, comfortable homes for our seniors.

The first pillar is the one I'd like to focus on, which is improving staffing and care. This legislation would make our government's commitment to increase the hours of direct care provided to residents by registered nurses, registered practical nurses and personal support workers to an average of four hours, per resident, per day by March 31, 2025, to be the law. The legislation sets out the targets we need to hit on the way to that four-hour goal. The Minister of Long-Term Care would be required to assess and publicly report on the progress towards achieving these targets on an annual basis. The target, if not achieved—the minister would then be required to publicly identify reasons why it had not been achieved and present a plan to reach the target moving forward.

So my question to the presenters—and I'll start with AMO—is, do you fundamentally support the embedding of these targets in the legislation? Do you agree with the government that the four-hour commitment is core to ensuring the quality of care and quality of life of residents in long-term care that we all want to see and desire?

Mr. Colin Best: I'll turn this question over to Monika, who has more expertise in this matter.

Ms. Monika Turner: We do see that it is appropriate to see the four-hours-of-care commitment embedded in the legislation. It has been a long time coming. We have advocated for it, as has everybody else, and the residents deserve it, given the rising acuity levels and complex needs. It has been mentioned by others—the majority, if not 60% to 70%, of our residents in long-term care have dementia and have really complex care. They're not just homes; they are homes that need extra health support. We were pleased to see the funding committed by the government, but we need further conversations to make sure there are sufficient resources and supports for staff and the leadership. There's also a need for training for quality and technological investments, and we did put a fairly substantial submission out to the government; it's on our website.

I will have to say—and I think folks know this—that municipal long-term-care homes are above the mandated minimum cost, and we are well on our way to four hours of care. I need to say that that's because we've put in over 300 million of property tax dollars above what we get from the government, to make sure that there is that quality and that we have as stable a workforce as there is in this area.

I'll end it there. I'm sure there will be more questions.

Ms. Effie J. Triantafilopoulos: I have a follow-up question.

I hope we all agree that the legislation is really fundamental to supporting many years of studies that have been put out. In fact, at one count I think we had 21 different studies that were probably sitting on the desks of the previous government—where these studies and staffing plans were recommending four hours of care. Many of you, as stakeholders, were part of that advice that had been provided to the past government. This plan is really the largest

long-term-care staff recruitment and training drive in our province's history.

Let me share with you that in our fall economic statement, our government committed almost \$58 million, beginning in 2022, to hire 225 new nurse practitioners. This is in addition to the \$270-million investment we announced in October—

The Chair (Ms. Laurie Scott): One minute remaining.

Ms. Effie J. Triantafilopoulos: —to support 4,050 new long-term-care staff. We also committed \$342 million to add and upskill over 5,000 new nurses and 8,000 personal support workers. We're also investing \$12 million over two years to expand mental health and addictions supports for front-line health and long-term-care workers.

So I would ask the panel: What additional advice would you give to this committee in terms of continuing to improve on our four-hour commitment of long-term care for staff? Natalie, go ahead.

Ms. Natalie Mehra: Well, for a starter, make it an actual commitment. Make it a requirement, not a target four years from now that can be changed by regulation to be a target nine years from now.

The second thing is to make it enforceable across the homes. An average across all homes in Ontario is not enforceable on any single home. Also—

The Chair (Ms. Laurie Scott): Thank you very much.

Ms. Effie J. Triantafilopoulos: So, Natalie, you don't think that the annual targets—

The Chair (Ms. Laurie Scott): Thank you very much. I'm sorry, but the time is up.

We'll now move to the opposition for the next seven and a half minutes. MPP Singh, please start.

Ms. Sara Singh: Perhaps I can let Natalie finish the thought around what is actually needed around four hours of direct care and how the government should be moving forward with meeting those targets.

Ms. Natalie Mehra: Well, a target in law is meaningless unless it's actually a requirement. There's no requirement here, and there's an actual escape-hatch clause that allows the government to pass by regulation. That means, in plain language, for Ontarians watching, that the ministers of the Ford government—cabinet meets in secret; it does not meet in public—could change that requirement themselves without ever going back to the Legislature.

My question is, why would you have a piece of legislation that can then be changed by a small group of ministers in a secret meeting, without ever going back to the Legislature and being reported somewhere in Hansard where people would have to go and find it, and actually have no ability to change it?

First, it's not a requirement; it's a target. Second, it's four years from now, with a possibility of extending that and making it longer. Third, there are no actual reporting requirements in this act. There's no requirement to inspect and to make orders for that. And it's not a requirement of each home—it's an average across the entire sector, which is completely unenforceable on any particular home. It needs to be a minimum average per home. Inspectors need to inspect to it. The actual reported staffing levels that they

self-support need to be posted so family councils can challenge them, staff can challenge them. Inspectors' orders, if they're inadequate—if there's corruption or if they're just inadequate—need to be challengeable by staff and family councils. All of those protections need to be put in.

1340

This is really just window dressing; it looks good, but it's meaningless. It's not enforceable.

Ms. Sara Singh: We have heard that from a number of different stakeholders, as well, who are very concerned with, as I highlighted earlier, the lack of commitment towards hiring and retaining the staff necessary to provide a minimum standard of care, but also the fact that this is an average across all the homes. And as Monika pointed out, some homes are already meeting those targets and providing value for dollar.

I think Matthew has his hand up. Would you like to elaborate on anything Natalie has shared?

Mr. Matthew O'Reilly: Yes. Just specifically on this four hours of care, I think one point that's important to grasp is, this legislation, by making it an average across the province, actually hides more than it reveals. As Natalie said earlier, it's an average for all homes across the province. So if you have a home that's delivering six hours of care and then a home that's delivering two hours of care, the average is four. But really, what we want to do with reporting is to identify the poor-performing homes and then address those issues. By having the average across all homes in the whole province, you hide the poor-performing homes under the great homes. We know that we have great homes and that we have terrible homes.

I just wanted to make that point, and I want to say that this is not a new idea. I have a quote from the long-term care COVID-19 commission that says, "[W]hen you start talking about what's happening in the average home, you miss the real challenge, which is identifying ... the poor performing homes and then helping those poor performing homes."

The legislation as it's currently written hides the poor-performing homes, and that's a problem.

Ms. Sara Singh: I think you really hit the nail on the head in terms of what the average hides. It kind of enables, I think, bad actors to continue on that course, without any actual recourse or enforcement in terms of what they're doing in those homes.

I know that my time is limited with questions, so I just want to pick up on some thoughts around the allied health professionals—we have heard from many that there needs to be an increase from 36 minutes to 60 minutes. I note that there also needs to be specialized care for patients with dementia, for example, or for those with intellectual or cognitive disabilities.

Perhaps I can have Colin start with why it's important that there is an increase in the allied health professionals and the amount of time that they have—and then, Natalie or Audra, if you can expand on the importance of specialized training for folks who are working in those non-profit homes.

Mr. Colin Best: Thanks for the question, Sara. I'll turn this over to Michael, who could answer with more details.

Mr. Michael Jacek: Thank you, Colin.

As indicated by Colin and in our written submission, we do support the increase of allied care from 36 minutes to 60 minutes. This is something that we've heard from our member homes. It was a recommendation of the long-term care COVID-19 commission, and it's supported by the long-term-care associations, such as AdvantAge Ontario. We think it's a way to provide a well-rounded balance of care. The four hours of care is important, but the allied professionals provide a range of care that's needed to meet all the needs that are laid out in the principles of the act.

In addition to the allied models of care, again, as Colin mentioned, we're also a big proponent of emotion-focused models of care. So we feel there need to be some specialized supports to help homes to implement that, with guidance, resources and funding.

Ms. Sara Singh: Chair, how much time do we have left?

The Chair (Ms. Laurie Scott): You have one minute and 25 seconds.

Ms. Sara Singh: Thank you. Natalie or Audra, please expand on the need for specialized training for PSWs and members in homes—an example being dementia care or other specialized care that may be needed.

Ms. Natalie Mehra: It's absolutely needed. We've long supported that there actually be behavioural supports available in all of the homes that need them; at the moment, it's maybe 50% of the homes where it's really inadequate.

In terms of rehabilitation, physiotherapy, occupational therapy, speech-language pathology and so on—we hear many, many complaints from families of residents and residents who are denied access to physio simply because they're elderly. It's discriminatory. People who are surviving strokes need that care to be able to live to their potential. Their lives matter. They're valuable. They're elderly, but it does not mean that they shouldn't have the same rights to health care that other Canadians have, simply because they're in long-term care. So that's critical.

In terms of specialized training: Absolutely, there needs to be proper training for dementia, but there are also ranges of residents who have mental health issues and very complex care needs indeed, so we need a better staffing mix that meets those needs, and definitely better training for dementia and for all of the other complexities.

The Chair (Ms. Laurie Scott): Thank you very much.

We will now move to the government's questions for the next seven and a half minutes. MPP Thanigasalam, go ahead, please.

Mr. Vijay Thanigasalam: Thank you to all the presenters for your presentation.

After decades of inaction, our government is fixing long-term care in Ontario, and we are acting on advice received from the long-term-care COVID-19 commission, the Auditor General and Ontarians who have seen first-

hand the long-standing challenges that we faced throughout the long-term-care sector, especially during the peak of the pandemic. This plan has three pillars: improving staffing and care; protecting residents through better accountability, enforcement and transparency; and building modern, safe and comfortable homes for seniors.

My question is for AMO. Colin, Monika or Michael can answer. I want to focus on the enforcement arm for a moment. Bill 37 entrenches enforcement measures in long-term care. It increases administrative monetary penalties, doubling fines for anyone convicted of an offence. As well, to enforce these new rules, the government is doubling the number of inspectors. For example, this means that the 156 inspectors we had last year will increase to 344, giving Ontario the best inspector-to-home ratio in Canada, about one inspector for every two homes.

Do you believe that these measures will increase the safety and security of long-term-care-home residents? And what advice would you offer about how these measures should be implemented?

Ms. Monika Turner: Thank you very much for the question.

We are supportive of strengthened enforcement and accountability, but we're looking at it from a risk-based approach. We want to focus our efforts and attentions on the homes that need it most.

The bill, as written, provides for an enforcement regime with steep fines for infractions, and we have some concerns about that, because it will take away funding for improving resident care. We'd much rather see homes compelled to make the necessary actions and invest the resources needed into resident care. So in our mind, yes, we're looking for enforcement and accountability, but we need an accompanying compliance regime.

And there has to be a balance between enforcement and compliance, because, as Councillor Best did say, just "gotcha" punitive enforcement doesn't work, actually doesn't improve patients' outcomes, and it's demoralizing to the staff. Our focus is improving outcomes.

We would like to see the government provide support to homes to help them achieve compliance and be fully aware of their obligations. In our mind, it's good that there are new inspectors, but we want the inspectors' role to be looking more at compliance as well as enforcement, and we're looking for supports such as training, tool kits and to share knowledge of best practices. We believe this will achieve success and improved outcomes for the residents and help to retain the precious staff we have.

1350

Thank you very much for the question.

I see the Steelworkers would like to respond as well.

Ms. Briana Broderick: Thank you. I'm Briana Broderick from the United Steelworkers.

As I understand it, the current legislation in place does in fact have enforcement provisions, which never have been used. So by my calculation, zero times two is still zero. If the government is not going to enforce regulations, then there's no point in doubling fines.

Additionally, given what we have just heard from Natalie from the Ontario Health Coalition, I would like to ask: What was the result of the inspections into those homes that had deaths and reports of terrible incidents during COVID-19? Have any of those private, for-profit care homes lost their licences? I would suggest that is something that can be done with the current legislation and something that should be done by the current government but has not been. So making changes to the current legislation will be of no use unless it is actually enforced.

Further, inspections are great, and they should happen, but there are no surprise inspections suggested by this legislation.

What currently happens is, inspectors call the homes—they get a heads-up; the homes force-book staff, which means that they force staff to come in and work additional shifts above their schedule, to ensure that they have the staffing ratios that are required; managers come out on the floor, and they provide hands-on care, which they don't normally; and the inspector comes by and sees all the workers on the floor providing all the care. All those workers and management know that as soon as that inspector leaves, they go back to skeleton crews, particularly at night and on the weekends, and the homes just hope that nothing happens.

So there is enforcement that needs to happen. There are no teeth in this current legislation, and without surprise inspections, the government and the public have no idea what actually goes on in these homes.

Mr. Vijay Thanigasalam: My question, back to AMO: I know that many of your members, municipalities, operate long-term-care facilities. Can you speak in some detail to the impediments that municipalities currently face?

More particularly, I'm keen on the level of data that you would want to see from us. For example, yesterday, Minister Phillips committed to publishing home-by-home-level data on hours of care. What other data do you believe should be made public or available to increase transparency in long-term care?

The Chair (Ms. Laurie Scott): There's one minute remaining.

Mr. Colin Best: Actually, Michael can answer this question.

Mr. Michael Jacek: I think there are measures that can increase accountability and transparency. AMO is supportive of that. There are measures in this act and provisions that would help achieve that. The public probably deserves to know what the performance is of their local long-term-care homes in terms of the care that their residents are receiving. Publishing data on the hours of care is one way to go. It should be, however, qualified that sometimes data on performance doesn't always necessarily tell the whole story. One of the challenges with achieving the four hours of care, for example—

The Chair (Ms. Laurie Scott): Thank you. I'm sorry. We're out of time.

We will begin the next round with the opposition. This is the four-and-a-half-minute round. I will defer to MPP

Singh. We've changed microphones, so hopefully it's clearer for all of you. Please begin.

Ms. Sara Singh: Thank you, Chair. There is still a bit of static, but it may just be me—but I see some head nods agreeing that there still is some static.

Anyhow, I am happy to pick up on a few themes that I think are really important as we wrap up here.

My first question is for Natalie.

I know, Natalie, that many staff are often very concerned about speaking up and speaking out against what's happening in long-term-care homes, and there's a need to strengthen whistle-blower protections.

Can you elaborate on the need to ensure that staff feel confident in reporting incidents of abuse or neglect and why whistle-blower protection is so important?

Ms. Natalie Mehra: Actually, it could be strengthened, and I hope that this is one area, if this act were to pass, that is strengthened.

There are recommendations and best practices for G8 countries on whistle-blower protection that include a way for whistle-blowers to access external places when whistle-blowing internally doesn't work. For example, as Briana and Audra outlined, staff in homes know when homes are tipped off about inspections, even what are supposed to be surprise inspections. So if you, for example, are a staff person and you call the ministry 1-800 line, but you have nowhere else to go, and you know the inspectors for your home are tipping off your home—where do you go? There needs to be a provision that enables staff to go to their MPP, to the media, to NGOs, to their labour union. There needs to be protection to go to external sources.

In addition, there need to be really clear requirements of the homes to stop with the illegal gag orders in employment contracts that have scared staff. You wouldn't believe the number of staff who were afraid to testify on the record before the long-term-care COVID-19 commission. The terror about retribution is very, very high in this sector. It needs to be addressed with accountability for the operators. And then, for families, there need to be much stronger protections against retribution for whistle-blowing about abuse and neglect and making complaints about inadequate care in the sector.

I want to highlight one other thing that has not been highlighted sufficiently here, which is that this act opens the door to for-profits, which have major, major problems in this area. That needs to be stopped. We're really at a juncture in this province. Some 46,000 new and redeveloped beds are going to be put into the system over the next five years, and at the moment, tens of thousands of them are being given to the same for-profit companies. I just want to highlight that this act should not be allowing that to happen.

Ms. Sara Singh: I think it's a really important point that others have brought up in previous delegations, but reiterating it is so critical.

I think Briana has a thought.

Chair, how much time is left on the clock?

The Chair (Ms. Laurie Scott): You have one minute and 15 seconds.

Ms. Sara Singh: Okay. Final word to Briana.

Ms. Briana Broderick: Thank you. The ability of staff to report on whistle-blowing or any other issues that they have with the home are fundamentally tied to the precarity of their employment. If you are a PSW and you make \$16 an hour and you have a 30-hour contract per month, that means that you are absolutely dependent on that money and you will not be reporting to any outside agency for fear of losing your job. That is fundamental.

Workers need to have enough hours in their contracts in order to sustain themselves, and they need to be paid an hourly rate that will allow them to have more than a couple of dollars in their bank account, if we actually want the abuse that goes on in long-term-care homes to be reported.

Ms. Sara Singh: Thank you all for sharing. So many more questions—but I thank you all for taking time to share your thoughts with us today.

The Chair (Ms. Laurie Scott): We'll now move to the government side for the next four and a half minutes. MPP Wai will begin.

Mrs. Daisy Wai: First of all, I thank all of you for coming out and sharing your comments. I share with a lot of your comments as well—we listen to your comments.

I would like to share a few things some of you have mentioned but that I want to clarify.

First of all, the Ontario Health Coalition is saying that the four-hours-of-care target can also be in regulation. Well, in fact, section 8.5 says additional targets can be set that are higher. Section 8.6 explicitly says that regulations cannot be used to alter the four-hours-of-care target.

Also, another thing some of you mentioned—and we did listen—I want to clarify that in fact we do have inspections; they are surprise inspections as well. The homes will not know that ahead of time.

1400

I want to share with you that before I became an MPP in 2018, I had already heard a lot of horror stories that we have in long-term care, which is one of the reasons why I put myself forward. I have to admit that when I became an MPP, it was really sad and upsetting to see what we're seeing in long-term care. It's like going into a broken home—everything is broken. We worked on it. Even before the pandemic, we already knew that we had to do extra work on it, and that's why we have a special ministry, the Ministry of Long-Term Care, to take care of this. I am the parliamentary assistant for the ministry for seniors; we are also working very hard on it. In fact, recently, we updated our regulations, and we are focusing on the best care, the best protection, the best quality of life during what should be their golden years. In fact, we're going to improve care for residents, enhance consumer protections and strengthen the authority that governs retirement homes. We are giving them the authority. We will go in there for inspections as well.

I thank Mayor McGarvey for your comments. I'd like to ask a question to either yourself or Monika. We are listening. Minister Phillips and, in fact, Minister Clark

have been going around and visiting, especially the municipalities. Maybe you can provide me with some perspective on how this legislation will make it easier for homes to get into the development pipeline and get shovels in the ground across the province.

Mayor, please?

Ms. Monika Turner: I can try to answer, if that's okay.

We're all looking at improving both long-term care and housing. One of the things that we at the municipal level look at is that there's an intersection between the health care system, that continuum—

The Acting Chair (Mr. Vijay Thanigasalam): One minute left.

Ms. Monika Turner: —and the housing continuum.

Am I finished?

The Acting Chair (Mr. Vijay Thanigasalam): No, you have one more minute.

Ms. Monika Turner: We are looking at this and we do see these long-term-care homes as homes. We don't want them to be acute-care institutions. As Councillor Best did say, we are legislated to provide at least one home under the act—every southern upper-tier, single-tier municipality is required by law. But most municipalities provide more than one. We are devoted to our communities and that's why we put in over 350 million of taxpayers' dollars to make—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. That concludes the time for today.

I want to thank all the presenters for being here and for your presentations.

I would like to confirm MPP Pettapiece. Please indicate that you are, in fact, the member and you are currently in Ontario.

Mr. Randy Pettapiece: I'm Randy Pettapiece, and I'm in Ontario.

The Acting Chair (Mr. Vijay Thanigasalam): Thank you.

REGISTERED NURSES'
ASSOCIATION OF ONTARIO
LONDON HEALTH COALITION
MON SHEONG HOME
FOR THE AGED
FAMILY COUNCIL

The Acting Chair (Mr. Vijay Thanigasalam): We are getting the 2 o'clock presenters. They are slowly coming into the room. Please bear with us.

Now we have the Registered Nurses' Association of Ontario. You have seven minutes for your presentation, and you may begin now.

Dr. Doris Grinspun: Thank you very much. It is our absolute pleasure to present to committee our response on Bill 37. Let me just acknowledge that with me today I have, first of all, myself—sorry—Doris Grinspun, CEO of RNAO; Matt Kellway, director of nursing and health policy; Christina Pullano, nursing policy analyst; and

Rene Dunkley, Web and social media editor—so we are going to make this committee famous.

I want to say that I wish we didn't have a need for committees and for much discussion about this topic, but the reality is that we had a tremendous and very serious and avoidable catastrophe during the pandemic and the preceding many, many years. RNAO has been speaking about this for the last 20 years. The COVID-19 pandemic exposed the fragility of Ontario's long-term-care sector; 4,000 long-term-care residents and 10 LTC staff members died of COVID-19 during the pandemic, and we dedicate this presentation to them. We hope that we will honour them; that at the end of this bill, when it is finalized and revised, we will be able to honour their lives and make things better for the residents. Some 16,000 long-term-care residents and over 7,000 long-term-care staff have contracted COVID-19.

The pandemic experience confirms the need of fundamental changes to long-term care in Ontario—and I want to stress “fundamental changes.” That need ought to be fully reflected in Bill 37, and it is in that context that we are providing our recommendations. The fundamental principle that we need to confirm in the act, that indeed a long-term-care home is primarily a home, must absolutely be strong, and it must recognize the complexity of care requirements of residents that must be met. That has never been the case with this act. The act speaks about the home. The act, in this revision, speaks about the home, and again the complexity of care is not being recognized.

The evidence of acuity is astonishing. The number of LTC residents with heart disease has increased by 14.3% since 2009; the number of LTC residents with dementias by 12.5% since 2009. The provincial CMI for LTC residents has increased by 20% since 2004.

RNAO has developed 10 recommendations, and I'm going to focus primarily on two recommendations related to staffing and skill mix; the full submission will have the 10, with all the background required. These two recommendations are at the heart of RNAO's nursing home basic care guarantee and the foundation upon which LTC needs to be built. We provided these recommendations to Minister Fullerton. We provided them to past ministers, to past governments. And as you may know, the commissioner adopted all of our recommendations.

We are basically asking for a minimum of four work hours of direct nursing and personal care per resident per day, rather than the targeted average. So while we are pleased that finally we will have the four-hour minimum in legislation, we want it per resident, not targeted by average.

The skill mix is equally important, given all the complications that I mentioned to you before that residents have, whether it's with cognitive impairments or whether it is with physical conditions and comorbidities. We are asking for 20% RNs, when we now have only 11%; 25% RPNs, when we only have 20%; and no more than 55% PSWs, with all the respect we have for them, and we have 69%. It needs to be a re-shifting, a rebalancing, because of the complexity of residents in long-term care.

We are also asking for one nurse practitioner per 120 LTC residents—and we acknowledge that Minister Rod Phillips already made that announcement. We are delighted. We are asking for more, and we are asking for one IPAC RN per 120 LTC residents.

An average of one hour—as opposed to what the bill is proposing—of care per day for allied health professionals, simply because if we are saying this is the home of the resident and we know their complexity, we need the right dose of regulated health professionals, including our allied health professionals.

1410

Other critical LTC recommendations we have: We want—and we have insisted for the last decade—to change the funding formula. The funding formula, right now, is punitive. It's a disincentive. It basically focuses on CMI, so it's only a lose-lose. Basically, if you do good practice and because of evidence, you decrease falls, you decrease pressure injuries etc., then next year you get less money; as opposed to a funding formula that accounts for complexity and for quality outcomes, so that when you achieve quality outcomes, you actually can keep that funding and reinvest into programs for residents—of course, not for shareholders, but for residents.

Not-for-profit care, for us, is the first right—

The Acting Chair (Mr. Vijay Thanigasalam): One minute left. Go ahead.

Dr. Doris Grinspun: First right of refusal for not-for-profits, for us, is a must. Some locations, not-for-profits may not be able to deliver, but we are asking that they have the first right of refusal and that we provide the supports they need to succeed.

Inspections: We need to align them with best practice, cultural safety, and quality care and continuous improvement.

I want to show you that it is doable to improve long-term care for residents. The proof is in the pudding. Our evidence-based guidelines that are right now in about 120 nursing homes produce results. They improve the care for people. But the runners of the nursing homes are telling me, “We do better; they claw back the funding for us.” So changing the funding formula, investing in staffing and investing in evidence-based practice will produce the results that—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time ends now.

The next presenter we have is the London Health Coalition. You have seven minutes for your presentation, and you may begin now.

Mr. Peter Bergmanis: Thank you, Mr. Chair, and to the members of the standing committee for affording me, as co-chair of the London Health Coalition, the opportunity to provide some input regarding the proposed long-term-care legislation, Bill 37, before the House.

With scant notice and less than 24 hours of acceptance of my participation in this preposterously abbreviated public consultation, the members of the London Health Coalition do wish to register our extreme displeasure with the disrespect of participatory democracy. In all my years

of testifying before parliamentary committees, never have I seen such a shoddy excuse for genuine public input on an important piece of public legislation. It appears as if a foregone conclusion is seeking legitimization.

To the matter at hand: The London Health Coalition vigorously objects to the evisceration of the preamble language to the existing long-term-care act. And as a Londoner, I'm very gravely concerned that there are only two non-profit long-term-care facilities in our municipality of almost half a million citizens. With the existing non-profits having over-two-year wait-lists for resident beds, thousands of our seniors are forced into the money-hungry arms of the for-profit industry—providers who have so publicly been exposed to have had such horrible COVID-19 pandemic-related outcomes.

The 2007 legislation exclusively favoured the promotion of non-profit homes in Ontario, the kind of homes that experienced the least deaths in the pandemic. Imagine the consternation at knowing some of the most lethal for-profit chains cannot only enjoy a virtual legal immunity for their misdeeds, but now they will benefit from government largesse in ongoing promotion, finance and bed allotment.

Adding promotion of mission-driven facilities in the preamble is a betrayal of the citizens of Ontario, the vast majority of whom have demanded an end to profiteering in the long-term-care sector. "Mission-driven" is a marketing phrase that does not differentiate between public or private, non-profit or profit. Not one long-term-care facility in the province lacks a mission statement. Tragically, not one life has been saved by mission-driven long-term-care homes either.

The worst were the for-profit providers, whose primary mission is maximization of profit for shareholders and not the welfare of their residents.

To the standing committee, I say return the preamble to its original intent, favouring investment in public long-term care, and drop the blah, blah, blah language of "mission-driven" business.

To address the public interest, the legislation must credibly deal with real, meaningful measures, not unenforced, malleable targets set for a distant future. Contrary to lobbying efforts by the for-profit providers, all long-term-care homes should be required to embrace minimum standards of care, with professional and highly qualified staff who enjoy well-paid jobs, full-time hours and benefits that befit the essential status they hold in our society. They should be given respect and personal protective equipment in accordance with the precautionary principle of safety first, without having to prove it.

During the pandemic, it was shameful to witness nurses having to take a for-profit home to court simply to justify permission to wear proper PPE.

How many cases of COVID-19 may have been avoided if only the proper PPE were available to staff without budget-conscious employer pushback?

Proper whistle-blower protections for these workers need to be in place so that regulations and reprisal against those workers for the common good cannot be invoked by

bad operators. Workers need to feel secure in their ability to disclose breaches of safety in a long-term-care home. After all, their conditions of work are the conditions of care of the frail elderly in their charge.

There must be real, concrete penalties for the bad operators. Doubling unenforced penalties is meaningless.

Ontario has the worst COVID-19-related death rate in long-term-care facilities of all the advanced economies in the world. It is no coincidence that our province is the most heavily commercialized in the sector, with the highest rates of death amongst the for-profit chains themselves.

Under no circumstances would Ontarians tolerate mass casualty events numbering in the thousands of preventable deaths. How does this government justify a free pass in this situation? The deadly embrace of the for-profit industry by our government must cease—no more intertwining of politicians and the profit-driven industry they were elected to regulate and control.

For Bill 37 to actually advance interests of providing more care, protecting seniors and building more beds—it would be best to scrap the entire piece of legislation itself. Bill 37 is little more than a privatization bill of rights that will destroy yet another generation of Ontarians as they enter their twilight years. Ontarians are paying for improvements to beds in long-term care; Ontarians should own and hold accountable that which they are paying for.

I thank you for your time.

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Our next presenter is family council, Mon Sheong Home for the Aged. You have seven minutes. You may begin now.

Ms. Helen Lee: I'm Helen Lee. I'm the honorary adviser for the family council at Mon Sheong Home for the Aged, D'Arcy, in Toronto, and with me is Luisa Cheng, the current chair of family council. We represent the families of Mon Sheong Home for the Aged, known as "D'Arcy"—both the current families and the bereaved families.

D'Arcy was one of the early homes that had an outbreak in April 2020, and we struggled with the lack of staff and PPE. Help was slow to come, and 33 residents died of COVID-19—with 10 excess deaths—within a span of less than two months. Forty-three out of 104 residents died. It is our hope that all those deaths will not be in vain, but that there will be systemic and substantive changes to long-term care.

First of all, I'd like to say, family, staff and residents in nursing homes during the pandemic have gone through very traumatic situations. Family members were not allowed in, and residents died alone, without family support—such as my grandmother, who you see a picture of behind Luisa. She was 111, one of Canada's oldest women, and a social activist. Some families even lost both their mother and father within the span of weeks.

We're greatly concerned about the speed at which this present government is trying to pass Bill 37. The current act actually doesn't need to be replaced; it only needs to be updated, as it has mechanisms for enforcement, which the province has never chosen to use. The current public

consultation and hearing process is too short for such an important piece of legislation and in light of the many lives that were lost in homes throughout the pandemic.

The minimum hours of direct care: We have concerns with the definition, the method of calculating and the timing. We want the increased number of hours, the maximum hours, to be fast-tracked so that the residents who survived the pandemic actually enjoy that. The bill targets four hours by the end of 2025, but we want to reach that maximum by the end of March 2022. The language of the bill indicates targets, not legislated minimum care standards. This is problematic and not informative. The method of calculating this average is across all long-term-care homes and is not transparent. We suggest a minimum average of four hours of direct care per resident per home with a staff mix appropriate to the residents, and the inspectors can audit this.

1420

We all know that working conditions are the conditions of care. Staff need to be paid for the value that they bring to the organization. The positions need to be elevated, not diminished. PSWs are the backbone of the long-term-care sector, and they merit better pay, equivalent to hospital rates; full-time status with benefits and pension; and should be provided the training for the increasingly complex work that they do. The government needs a proper HR plan to get where we need to go. Staff need to be properly trained and certified, and this needs to be enshrined in legislation—training in dementia, as well.

And the culture of the home—it should be a home. After the pandemic—the lives of all these people that have been lost—we should make that possible now. It requires effective leadership—homes whose sole purpose is care for residents—and teamwork and a political will to do that. I hope you will all join me in that.

Families need to be equal partners in the care team. Essential caregivers must have access at all times, including during the outbreaks—of course, with properly fitted PPE and training. They play a key role in providing the emotional well-being of the residents. These family councils and residence councils need to be consulted and interviewed and acknowledged as key stakeholders when the home is being reviewed and investigated. We need a holistic approach.

Bill 37 creates this long-term-care quality centre to support mission-driven organizations, and the COVID-19 commission recommended a compliance unit, so I hope that this new centre will have that as a mandate—the compliance area.

Transparent reporting, of course—everybody has talked about that—performance indicators reported, posted publicly, accessible at the home and on their website. There should be consequences if you don't report in a timely manner.

And of course, stronger whistle-blowing protection—inspectors need to be able to gather information from residents, front-line staff and family, along with the protections so that they can freely speak without fear of retribution, or fear of creative or constructive dismissal

like changes in shifts and scheduling of staff. Stronger whistle-blowing protection has to be there so that there is reporting of the concerns that is timely.

Lastly, on my section: If staff believe that there's an immediate risk to the health and safety of residents and staff, and staff have tried to report to the ministry hotline and they haven't gotten anywhere, it should be appropriate for them to disclose it to the public without retribution.

I'll leave the remainder of the presentation to Luisa, the current chair.

Ms. Luisa Cheng: Thank you. In regard to the residents' rights, we need to set staff ratios based on levels of needs of residents; increase the availability of linguistically and culturally appropriate nursing homes; increase the allied health professionals.

Our nursing home currently has a physiotherapist two days a week, part-time—total. That's not enough for residents. That is why residents' mobility declines so swiftly in long-term care.

In order to really have transparency and accountability and enforce the residents' bill of rights, the creation of a tribunal to address the gaps in enforcement is needed.

The inspection of the infection prevention and control program needs to be annual and unannounced—inspections and a reinstatement of RQIs. The infection prevention and control program should be headed by a registered nurse.

The act needs to include references—the precautionary principle to *[inaudible]* risk—

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Ms. Luisa Cheng: —and non-profit resident care. Our seniors' nursing homes deserve no less.

Lastly, we have serious concerns regarding the change of the preamble. "Mission-driven" is added with no clear direction of what this means. Remove "mission-driven." Leave in existing language. There should be a phasing-out of profit. Contracts should be awarded to more non-profit organizations. Make it easier for them.

While Extencicare long-term care in Saskatchewan is being transitioned back to the province, Ontario needs to take a similar bold step.

In conclusion, I want to ask, how many lives need to be lost before there are sincere, concrete system changes to the long-term-care sector, including delivery models and not building beds and warehousing? The current Bill 37 is severely inadequate, given the short consultation process and tragic losses Ontario has suffered in long-term care. It's such an important piece of legislation, and Bill 37 rushed through does not honour the 4,000-plus residents' and 10 staff's lives—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time has ended now.

Thanks to all the presenters.

Before we move to the questions, I'll go to MPP French. Please confirm that you are in fact the honourable member and that you are in Ontario.

Ms. Jennifer K. French: Yes, I'm Jennifer French, and I am live in my basement in Oshawa.

The Acting Chair (Mr. Vijay Thanigasalam): Thank you.

Now we'll move to the government side for questions, for seven and a half minutes. MPP Triantafilopoulos?

Ms. Effie J. Triantafilopoulos: Thank you very much to all of the presenters for being here today and for your very thoughtful presentations.

I'd also like to make a special thank you to Doris, who I met very early on as the parliamentary assistant for the Minister of Long-Term Care. I want to tell you how much I value your personal advice and the association's advice as we move forward in order to prepare what we think will be fundamentally improving and creating a new long-term-care sector.

I also have to acknowledge that nurses have been on the front line during this unprecedented, terrible pandemic this past year. They really are at the heart of our health care system, not only in long-term care but generally across the health care sector. Doris, I just wanted to make a personal thank you for all that your members have done over the past year and a half, or beyond that.

As part of our government's effort to be able to address our fundamental changes that we see as required in our sector, the government announced \$100 million to add 2,000 nurses to the long-term-care sector by 2024-25. We made this announcement particularly in two programs that would assist personal support workers to advance their careers, as part of the retention in that sector, in order to provide career-laddering opportunities.

One program is called the Bridging Educational Grant in Nursing, and this has been partnered with the Ministry of Health and with WeRPN. Eligible PSWs will receive \$6,000 a year to pursue further education to become registered practical nurses. These registered practical nurses will receive \$10,000 a year if they wish to continue to become registered nurses.

The second program is the Nursing Program Transformation in Ontario's Colleges. This, as well, is hybrid online and in-person learning models in practical nursing and a bachelor's of science in nursing programs, to provide students the flexibility to learn according to their own individual schedules. This is creating an additional 500 enrolments in bridging programs for the 2022-23 academic year. It's designed to give applicants the skills and credentials they need to move to the next stage of their career. These hybrid options will be available, as well, for the bridging programs. This has never been done before. This is all part of our holistic plan to improve the quality of care in long-term care.

Most recently, in the fall economic statement, the government announced \$58 million in funding to hire 225 new nurse practitioners. The minister told the committee this week that currently there are only 75 directly funded nurse practitioners in long-term care. This will quadruple the number over the next three years.

I would like to address this question to Doris: Could you tell us what the addition of these 225 new skilled nurses will mean for our long-term-care residents? And

how will it truly make a difference in long-term care in terms of improving the quality of care for our seniors?

Dr. Doris Grinspun: We absolutely appreciate the announcement of the 225 NPs. In fact, the minister yesterday told our NPs that this is just the beginning, that he plans to continue. Hopefully, whoever will be in government will continue. The reality is that nurse practitioners will make a significant change because they are there 24/7. They are located at the site.

1430

However, I want to go to what my colleagues Luisa and Helen said: You also need the rest of the regulated staff. You need the 20% RNs. You need the 25% RPNs. We are not completely off track. We have 11% RNs; we need to reach 20%. We have 20% RPNs; we need 25%. So we need to keep those moving too.

The other piece is that the bridging program is excellent because it gives the capacity to develop careers in nursing in Ontario in long-term care, and that's critical. One piece is missing. I spoke with the minister, and I will ask you to also help me push that. You spoke about PSWs to RPNs. We need to add in 20—absolutely, that needs to be so they have the entire career laddering. They come to long-term care because that's the sector they wish to work in and because that's their passion, and they have the capacity in the hours of work.

I will also add that we—of course, you know—support the call that it not be by 2025, in terms of the hours of care; that we fast-track to a 2022-23 maximum. Is it doable? I know you have asked me, and I say again it's doable. People want to work in long-term care. People have the passion, the love, the expertise. They need to be able to build their careers all along.

The other piece that is critical is what I spoke about: CMIs. We cannot continue to fund the homes only based on case mix index, because it's a lose-lose for the homes. If they do well, as you know they do with our evidence-based guidelines program, then the funding gets clawed back—meaning, if they don't fall, if they don't have pressure injuries, if instead of restraints we are working with residents in a way that they have quality of life, next year they get less money. Let them give the money not for shareholders, but to reinvest into programs.

Yes, a first priority of refusal should be for not-for-profit. We have said this for many, many years. We need to rebalance that significantly, and they need the supports to be able to succeed in their applications. That's the other piece. They need the support to succeed.

You will be happy to know that our board of directors passed a motion that all the undergraduate nurses will need to do a clinical placement in long-term care—all of them. That's where we are moving in the RNAO.

We are also moving, as you know, to embed evidence-based guidelines into every single home, so not only the 120 that we're working in but all of them benefit from the coaching, from the engagement, from the person- and family-centred care, from aspects that the family council colleagues were speaking about, from the aspect that the

coalition was speaking about—engagement—so people regain their passion.

You did not create the mess completely; you inherited a big mess of decades, but now it's in your hands to help us fix it, and we want to fix it with you.

Ms. Effie J. Triantafilopoulos: A further question I'd like to ask, perhaps not only to you, Doris, but to the other presenters—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. I'm sorry; your time has ended.

Next, opposition members, you have seven and a half minutes for your questions. MPP Singh?

Ms. Sara Singh: Thank you to all the presenters here today. I really appreciate you taking time to shed some light on your perspectives. I think Peter really encapsulated how we all feel about this. It's a bit of a rushed process and very limited time, I think, for that feedback.

I'll try to keep my questions as directed as possible. I'll start with Doris.

Thank you so much, Doris, for being here. I know you've been a staunch advocate for reform in the long-term-care sector, and especially the supports that are needed for your members.

We have heard, from many presenters throughout this experience, the concerns that they have and the challenges around the four hours of direct hands-on care that are needed and outlined here in this legislation.

Can you explain why it is very concerning to you and your members that this government will not meet the targets intended here, but also that the average itself is fundamentally flawed—and perhaps a moment in terms of the staffing ratios that are actually needed to provide this hands-on direct care that residents so desperately deserve.

Dr. Doris Grinspun: There are two aspects.

Thank you so much, MPP Sara. The last time I saw you was in a park, doing a video with MPP Kusendova and me about politics, and I was targeting both of you, so apologies for that. Thank you so much for the question.

The issue of staffing has three components. It has the component of the hours of care; on that, we are pleased that finally we will have in legislation four hours of work. This is my understanding. Do we want them in 2025? No, we want them now. We wanted them 15 years ago, quite frankly.

The second thing is the issue of the skill mix. The issue with the skill mix is not that we don't value all health care providers; we absolutely do. PSWs are core to the system, especially in long-term care, but we have an excess of PSWs and we have a deficiency of regulated care. We have 11% RNs; we need 20% RNs. We have 20% RPNs; we need 35% RPNs. We have 65%, I believe, PSWs; we need 55%.

Then there is the issue of other allied health professionals: I believe the deal offered 0.64; I'm not sure. We are asking for an hour of that care, because those are the types of residents—my colleague Luisa and her colleague said you decondition if you don't have the recreational therapies, if you don't have the physio, if you don't have

speech therapies to be able to eat properly, if you don't have the social worker. It's the whole thing.

And please note that the announcement that was made is critically important, because they are on-site. Those homes that added nurse practitioners during the pandemic did significantly better because they were on-site—not like our colleagues in medicine, who are very needed, but they come and go. They are on-site. They add to retention. They add also to quality of care, and they add, of course, to early diagnostics and treatment of residents and for the families' peace of mind.

Ms. Sara Singh: I really appreciate you highlighting the need to have a mixed ratio of care providers in homes. I know others have spoken to the need for specialized training, for example, in dementia or Alzheimer's care, or people with intellectual disabilities—as we know, more and more are being moved into long-term care as a housing solution.

I want you to pick up on some points that I think everyone raised in terms of the punitive approach that is being taken here in long-term care. As Peter aptly outlined, what the government has done has actually provided legal immunity, and as Helen and Luisa outlined, existing legislation already put in place enforcement mechanisms that were just not acted upon. And so, creating this culture of fear through this bill, I think, has left many in the sector grappling with concerns about what this is going to mean for their homes, but also that there aren't enough coaching or learning opportunities to address concerns in those homes.

Perhaps we can start with Helen—and then, Doris, feel free, as well as Peter—to elaborate on the punitive approach and why this is not going to be helpful, for example, to help build capacity in the not-for-profit sector, which is what we need to be doing right now.

Ms. Helen Lee: From an HR perspective, you do need metrics and you need enforcement, but you also need to create a condition where the work environment is healthy and grows and there's a camaraderie among workers. If you don't have that, that is an issue. We saw that during the pandemic. This is critical to do, and I think that it has to come with the proper messaging from some of the government, like, "We're there to support you and provide the support and work with you. This is not just your problem; this is our community problem." We've had it for 30 years.

With the number of deaths now, it's time that we really work together, band together and focus on the residents first. The people are there. The families love the residents. People who want to serve in long-term care have a passion for that, but there are so many barriers, so many other things that would turn them off. And they take great risks as well. So when they ask for PPE, it should be given to them. It shouldn't be said that, "We have to wait until the test comes back that it's COVID-19-positive." Or it shouldn't be, "Well, we only have five kits from public health, so we can't do it for you." It has to be a team approach.

1440

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Dr. Doris Grinspun: If I may add to it, inspections need to be a mix of what's wrong and also what's right. If all you can expect—and you and I spoke about that when you were in the office with Christine back then. I said inspections are necessary, but they need to say what's not working so you improve, and also what's working so others learn from you. They also need to be publicly reported so people can actually learn from best practices, one from another.

We have offered—the homes that we work with, we have the coaches. If we embed our guidelines in EMRs and the coaches will come and train, not only—we train everybody. We train PSWs with a great degree of success. They all work as—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time has ended now for this round.

Next, I will go to the government members for a seven-and-a-half-minute round of questions.

Mrs. Daisy Wai: Randy will be speaking.

The Acting Chair (Mr. Vijay Thanigasalam): I don't see him. Are there any government members who would like to ask questions?

Mrs. Daisy Wai: Sure. I think she was asking a question just now, so I will let her continue with her question.

The Acting Chair (Mr. Vijay Thanigasalam): MPP Wai, go ahead.

Mrs. Daisy Wai: I also want to say thank you to all the presenters just now. We have been listening to you attentively and, as I say, we will listen to what you're saying. If you see this act, Bill 37 has made a lot of changes addressing the concerns that you have. A lot of you are mentioning concerns that you already see that are actually from the previous government—that a lot of things have not been done. We're working on it. I know that it's not completed yet, but we have been listening to all the things that you have been mentioning.

I would like to, at this time, pass the time to MPP Triantafilopoulos so that she can continue with the questions she was asking a little bit earlier.

The Acting Chair (Mr. Vijay Thanigasalam): MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: One of the questions I also wanted to pose relates directly to the palliative care philosophy that our government is now enshrining in this legislation. I think it's a departure from what used to take place in previous years. Can you address specifically how you think this will add to the quality of care and, more importantly, the quality of life for seniors in long-term care, as a result of this change?

I'll start with Doris.

Dr. Doris Grinspun: I go back to the fundamental notion of, "this is your home." That's one piece that we are insisting be clear. "This is your home. You're not a visitor here." And that goes together with having the family present, that Helen also spoke about—not shutting

families out. We all were a part of it at the beginning. Ontario actually was one of the jurisdictions—we need to acknowledge that—that enabled families to re-enter the homes. And I take a lot of credit. RNAO pushed for that big time, with families.

We need to remember that people in nursing homes live for a relatively, unfortunately—or fortunately—short time. I say "fortunately" because they live in the community for much longer than before. And if we would fix home care, they would live even longer in the community. But once they enter the home, their time is limited.

The philosophy of RNAO for palliative care is not the last few days, the last few months; it's the last years of life, whether you have a condition that is cancer or whether you are aging and at an age that you know that passing away is approaching. So we don't take it as an illness; we take it as living till the last minute that you live. That's why it's so important to also have the one hour of allied health professionals as well as the regulated staff, because if you don't have the regulated staff—and NPs will help very much, Effie, there, because they can pain-control. NPs can prescribe, but then you need to have the RNs, you need to have RPNs and the allied health professionals and have the education, as colleagues mentioned.

The guidelines, again, embedded in the homes will help, because there is a whole guideline on palliative approaches to end-of-life care in nursing homes. So that, with the coaches we have—we are confident that we will be able to improve issues significantly.

Ms. Effie J. Triantafilopoulos: Maybe I could also ask this question of Luisa and Helen. Particularly in the environment where the cultural environment is so important for residents as they age, and if English is not their first language, end-of-life care becomes all the more important. Perhaps you might be able to comment on that question as well.

Ms. Helen Lee: The first nursing home my grandmother was at was one where there was only one Chinese resident, and she could not communicate. So we had to make laminated charts of keywords so that she could communicate with the staff there: "I'm hungry"; "I have pain"; "The water is too hot"; "I'm thirsty." The staff used that to communicate. This is what we did to bridge the gap, but the gap shouldn't be there. She should be able to be provided with the services that she's accustomed to and so that she can communicate her needs clearly to the people who are in charge of her care. I think it's very important, culturally and linguistically, that the resident needs are paramount. We encourage the government to do more homes that incorporate that, for sure.

The second home she was in was Mon Sheong, and of course, that was a culturally appropriate, linguistically appropriate home. Unfortunately, she did decline a bit, but she was about 111, 109 when she came in. But she was excellent for that. You wouldn't think so. You would think that she was 80. But yes, she couldn't take advantage of the meals as much as she would have liked to, and that was a shame, because we had to wait long for it.

So, yes, I encourage the government to have that and to expand that.

Ms. Effie J. Triantafilopoulos: I understand. In my own case, my background is Greek. There are two long-term-care homes in the GTA that are able to support people of Greek background, both in terms of culture and faith and also the cuisine, which is so important. And my aunt, who I had been the principal caregiver for, had entered the long-term-care home, I think, at the age of 86 and was able to live there with the proper cultural supports until she was 96. I could tell that her quality of life was truly extended by the kind of care she got in her own language.

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Ms. Effie J. Triantafilopoulos: So I think that what our government is in fact doing to expand culturally appropriate homes in our communities is very, very important in terms of ensuring that. We've got an aging demographic. We've got a very diverse population in our province, so it's so fundamentally important that we're able to care for them in their latter years. Thank you all very much for your comments on that aspect.

Ms. Luisa Cheng: Yes, and I have to echo that, because my mom was originally in a non-Asian home first, and then when she was transferred to Mon Sheong, immediately my mom had a lot of laughter, reactions, stimulation. It was unbelievable. Definitely, the language and the culture is very important for each and every one of us.

The Acting Chair (Mr. Vijay Thanigasalam): The time has ended for this round.

Before we move on to the next round, MPP Bell, please confirm that you are in fact the honourable member and that you are in Ontario.

Ms. Jessica Bell: I'm Jessica Bell. I'm the MPP for University-Rosedale. I'm at Queen's Park, Toronto, today.

1450

The Acting Chair (Mr. Vijay Thanigasalam): Thank you.

Next are the opposition members. You have seven and a half minutes for your questions. MPP French?

Ms. Jennifer K. French: Thank you very much, Chair. I'd also like to say, there seems to be a lot of static out of the committee room. If you can give that feedback to your tech folks—I see a head nodding; I don't think it's just me.

I apologize to the presenters that I came a little late to the game.

I will say, though, I regularly meet with nurses. I fully and totally appreciate them, and we are working hard to ensure that we take action on that appreciation. A thank you won't suffice, and we know that. I'm sure that you laid out a number of concerns on behalf of your members and workers and staff.

I'd like to address my first question to Dr. Grinspun, as you had said that we can't continue to fund the homes on case mix index. What would basic language look like if we were looking for it in this legislation? If you could just answer that—and then I have a few follow-ups.

Dr. Doris Grinspun: We have provided this language, just so you know, for the last, I think, at least eight years or so. It basically needs to be accounting for complexity and for quality outcomes—because you will not be able to avoid complexity. The reality is that 85% of residents need extensive 24/7 daily assistance. One third of residents have severe cognitive impairments, so complexity will be there, plus all comorbidities that I spoke of before—heart conditions etc. When you have that level of complexity and you introduce evidence-based practice with coaching, with engagement of staff, engagement with families, what happens is, you start to reduce that complexity. You have less falls. You have less pressure injuries. You have less escalation of outburst behaviours—because, as our colleague said, if you provide service in their language and in a way that is engaging, you have less of that.

What happens now? You do better. Complexity case mix index goes down. Next year, they yank funding. This has been forever. This is not new—forever.

We are saying it needs to be that and quality. If I do well, I keep the funding that we saved on pressure injuries and falls, and I use that funding to reinvest into programs—recreational programs, staffing programs etc.

Ms. Jennifer K. French: Just so you all know, full disclosure: I have a 100-and-a-half-year-old grandma that we're making the transition now, unfortunately, from—

Dr. Doris Grinspun: You all have good genes.

Ms. Jennifer K. French: Oh, God. Well, I don't know about that—but transitioning to long-term care. So that's something that our family is going through, and I'm well aware of the care needs and hurt where she is now. But certainly, all of us hear it on a regular basis from our constituents.

I know the parliamentary assistant was thanking you for the input that you've been giving through the years. I know that you've been giving that input for years, and I would have liked to have seen more reflected in this piece of legislation, frankly.

I did want to address a question to Mr. Bergmanis. You were talking about whistle-blower protections. I am interested in that, because I know that there is language in the legislation about whistle-blower protections, but what I keep hearing—much like what you said and what Helen had said—is, it's not sufficient. If you could give a bit of feedback to us on what would be better—because the language is not enough to hold water and certainly not enough to protect folks and encourage them to come forward.

Mr. Peter Bergmanis: I'll address part of this as well. Quite frankly, it's a case that this sector has been so under wraps, and because the staff feels so threatened, they are desperately open to all kinds of manipulations and possible threat from their employers.

We have yet to really see anything here about addressing retention strategies. I believe that whistle-blower legislation would address that.

So, you'll have to forgive me if, with 24 hours of notice, I didn't come up with the in-depth legislative amendments that would be required here, but broad strokes would be: It's because we have an abused workforce that needs this.

They're precarious work, they're non-full-time, and they don't have the protections of even the employment standards. In this kind of a setting, you would have to have the bare minimum—something akin to, say, the landlord and tenant tribunal system, where an appeal could be taken forward by an employee if there is no satisfaction at the level of the employer. It could be addressed in some sort of adjudicated fair process. Labour relations could lend something to that. But where it is now? No, it's an exploitative model. It depends on a lot of free labour from volunteers and underpaid staff. We need something there to give these people a voice. They're the backbone.

Ms. Jennifer K. French: If I have a bit of time, Chair—how much longer?

The Acting Chair (Mr. Vijay Thanigasalam): One minute and 16 seconds.

Ms. Jennifer K. French: Okay, I'll take it.

Helen, I'll address my question to you.

I have a full appreciation of the need for culturally appropriate and responsive care and what that could look like from a language perspective, from a food perspective and all across the board. And while I'd love to have a full conversation on that, I'm not going to ask you about that.

What I would like to talk about are the minimum hours of care. You talked about fast-tracking. That's on the record. We have concerns about the language not being about minimums and being about targets—I feel like that's kind of weasel words, frankly. How do you know when you hit a target and what is—a minimum of four hours, it could be more; whereas, if they're aiming for four, it could be less, and that would be fine as an average. Could you speak to that, please?

Ms. Helen Lee: Yes, it's not a target—it should be a minimum per person. And it should be recorded by homes as well. It's very important that it is not a target. A target? What's a target? I think those are, as you say, weasel words.

In legislation—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. The time has ended.

Next, we have the government members. You have four and a half minutes for your round of questions. MPP Triantafilopoulos?

Ms. Effie J. Triantafilopoulos: I was continuing down a line of questioning that dealt with what we think really should be at the centre of care for residents in long-term care. We've all talked about quality of life. We've talked about quality of care.

I think it's fair to say that in the past, for reasons that, frankly, escape me, the previous government did not invest and did not make long-term care a priority. You've all heard about the accelerated builds that we're doing in terms of increasing the capacity in long-term care. When we came to government, we inherited a long-term-care waiting list of 38,000. We know that aging demographics in our province are only increasing, and therefore the need for long-term care is going to be increasing. From the years 2011 to 2018, the previous government built only 611 net spaces in long-term care.

I can tell you, just a few weeks ago, Minister Phillips came to my community and together we announced in Oakville two long-term-care facilities with a total of 640 beds. In that long-term-care facility, there will in fact be culturally appropriate floors that are going to be meeting the needs of Sikh and South Asian Hindu communities. We're a very diverse population in Oakville North-Burlington, and so having that kind of need met is very important.

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I'd like to ask you all—I'm not sure if I've missed someone on the panel; if I have, perhaps they could speak to this: What additional things can we do around the culturally appropriate long-term-care facilities to be able to give our residents truly a quality of life?

Doris, I'll start with you.

Dr. Doris Grinspun: I hear you say “the government of the past.” Unfortunately, I've been—or fortunately; I'm lucky—very long in this job. So I go to the government in the past—even Mike Harris, because this started long, long ago, the disdain for long-term care. And it talks about ageism. We still have societal ageism, and that's a reality that we need to talk about.

But there has been another issue. There has been an issue of ongoing expansion of for-profit care. We know that. We know that if we don't respect—from the homes that have been announced, out of 220 long-term-care facilities, 140 of these, 64%, are for-profit. I know we cannot do away with that, but we are asking first right of refusal for new ones. The reason we are asking is because the research shows the results. I don't need to tell you, because you know that I was deeply involved with Orchard Villa. In my view, Orchard Villa should have been closed. This is where the issue is.

We will never do away with these types of homes or those types of homes, but we need to set parameters so that whichever homes need to have the standards in hours of care, in skill mix, in language capacity, in other types of workers to help.

And on the issue of funding models, I go back to the same: If you do well, you keep the funding for quality improvements—not for shareholders; for quality improvements. This is how we will go from where we are to better, and next time to better. It will not be fixed in a year, I am sorry to say to everybody. It will not be fixed in five years. It will take a generation to help the homes, and that means also new construction—not these mega homes only. You look at Europe. I know we have different, whether villages—people will want and expect different than what we have now. In that sense, no government that I have worked with has done a truly transformational look at how nursing homes need to be part of primary care and community care, not linked necessarily to the hospitals, as we are doing, but community care—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. The time has ended.

Next are the opposition members. You have four and a half minutes for the last round. MPP Berns-McGown?

Ms. Rima Berns-McGown: Thank you to each and every one of the presenters. I know you didn't have a lot of time to put this together, and we're really grateful for what you had to say, and you should know that. Of course, there are themes that have developed, and you're generally speaking in concert.

I have a very short amount of time and a couple of questions.

My first question is for Helen and Luisa. Clearly, when you have situations where you have bad actors and no whistle-blower programs that are safe because of the precarity that folks were speaking about and no surprise inspections, the role of family becomes even more important. But I know that sometimes families are afraid to speak up because they're afraid of how their loved one might be treated when they're not there.

What do you think the bill might be able to have in place in order to enable family members to speak out when employees can't, and when there aren't surprise inspections?

Ms. Helen Lee: An anonymous complaint process would help a lot. I think that is very important. And it is true that families are fearful to speak out because they have loved ones in the home. That's just natural. So family councils need to be empowered to bring those actions across as well. But I do think that the anonymous complaint is something that is key for people to be able to whistle-blow.

Ms. Rima Berns-McGown: Peter, do you have any thoughts on that?

Mr. Peter Bergmanis: I would also add that I'm not in the same camp as Dr. Grinspun, thinking that we can't remove for-profits—which are really the core issue here because of their mixed priorities and the primacy of profit over care. I am definitely in the camp where, if you can remove Extendicare, a well-known for-profit corporation, out of Saskatchewan in the blink of an eye, by a government that has the political will to do it, then I'm pretty darned sure a big province like Ontario could do the very same thing. We're not to be held hostage by the lack of beds. It doesn't matter if it's public or not; we are still paying for these beds. So let's remove that profit equation. We could do it. A big provider, Extendicare, was discredited in the United States 20 years ago, and we're still dealing with it here in Canada. I don't understand it.

I'm pretty darned sure that if we put our minds to it, we could remove the profit issue, and then we can definitely enforce real standards of care that are accountable to the people of this province.

Ms. Rima Berns-McGown: A question for all of you: Who do you consider to have best practices in Canada in this area, that we should be following?

Dr. Doris Grinspun: Rima, we can even take you to places that are best practices. There are lots of them, in not-for-profit; there are some in for-profit. I'm not preferencing for-profit—by no means. I don't want to be spun out of it, to say that I'm saying that the profit model—legally, for chains, you are correct: Their first obligation is the profit. But for small entities, that's not the

case. What I am saying is, you still will need good staffing, you still will need good, evidence-based practices, and you still will need families involved—because if not, you're not going to get good care.

Staffing, evidence-based practice, person-centred care, family involvement and staff who stay there—I think you hit the nail when you said “full-time employment with good conditions, with good training, with good work environments that people stay around and want to make a career in and want to make their contribution in that home.” That is what will create real change on the ground.

Ms. Rima Berns-McGown: And on that point, there seems to be complete agreement, regardless of where people are coming from—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. My apologies; the time has ended.

I would like to thank all the presenters for being here and for your presentations.

FAMILY COUNCILS ONTARIO
SIOUX LOOKOUT FIRST NATIONS
HEALTH AUTHORITY
ONTARIO NURSES' ASSOCIATION

The Acting Chair (Mr. Vijay Thanigasalam): Now we'll move on to the next set of presenters. Next, we have Family Councils Ontario. You have seven minutes for your presentation, and you may begin now.

Ms. Sam Peck: Good afternoon. I'm Sam Peck, the executive director of Family Councils Ontario. We lead and support families of residents in improving the quality of life in long-term care across Ontario. My goal today is to amplify the calls from our service users to transform the sector, so it's my honour to share recommendations on enhancing Bill 37, many of which are informed by the dedicated individuals living, working and caregiving in long-term care.

We have identified six overarching issues that should be prioritized in legislation to effectively fix long-term care:

(1) Embed equity as a foundational principle in the legislation. Equity is one of our foundational values, but it's only used three times throughout Bill 37, and only in reference to the Pay Equity Act. Including the term “equity” would emphasize the sector's and the government's commitment to delivering individualized and high-quality care plans, and also acknowledge the dynamic, layered experiences attached to the thousands of residents, caregivers and staff in long-term care. Embedding it as a foundational principle will aid in supporting inclusivity, belonging and diversity in all its forms, and we believe it will help with the retention and recruitment of staff in the sector, as they will be supported as whole human beings.

Further, more needs to be done to support the delivery of culturally specific care. Residents living with dementia often revert to their first language. With an increasingly diverse population, it's often not English, so homes need to have staff on-site who can communicate in a resident's

preferred language, connect them with the culturally specific supports they need, and provide them with the food, care and activities that are culturally appropriate. What this will do is, it will increase the quality of the care delivered to residents. For example, someone who is not used to eating a standard American diet would have access to the foods that are culturally appropriate for them. Therefore, they'll maintain their weight and they will have a higher quality of life, as one example.

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(2) Reimagine compliance and enforcement for long-term-care homes—this is under part 5, compliance and enforcement for inspections. Legislation should enable homes to improve quality. While monitoring performance is essential to holding long-term-care homes accountable, providing supports such as specialized coaching for homes to improve care delivery should be prioritized. What we've heard is, inspections should also provide examples of best practices and learning so that homes can actually correct the issues from inspections. Inspections shouldn't be just about the bad things they're doing or the areas of non-compliance. Whether we call them inspectors or coaches, whether it's part of inspections and compliance or a new branch, these people should be able to assist, guide, support or coach homes in changing their practices from violations to best practices.

(3) Acknowledge caregivers as the essential care partners they are. These are unpaid caregivers, families, friends. The term "caregiver" is mentioned in the preamble and part of the residents' bill of rights, but we firmly believe that the new legislation should acknowledge caregivers in a stand-alone section or otherwise highlighted as the essential care partners they are. Family caregivers invest hundreds of hours on an ongoing basis for residents with chronic and acute conditions. Due to perpetual staffing shortages, unpaid caregivers are critical to meeting the daily needs of residents and psychosocial and emotional needs. Even in a perfectly staffed system, there will still be a need for residents and caregivers to maintain a relationship, and it's time for legislation to acknowledge that.

(4) Competent and sustainable workforce: Bill 37 cites the commitment to having a diverse, qualified and empowered workforce, but there needs to be more to define the roles within the scope of allied health professionals and for there to be increased onus on legislation to support homes in addressing gaps in care continuity, resident-specific supports and safeguards for staffing shortages, and specifically, to require homes to have a social worker on staff to support the needs of residents, caregivers and their staff peers. Our research has identified that the supports provided by social workers improve resident well-being, communication between the home and caregivers, and can reduce conflict that may lead to complaints being lodged with the ministry.

(5) Modernize infrastructure and delivery methods. Modernization is more than the financial commitments and creation of care spaces. It also means upgrading room designs, implementing models of care, enhancing IPAC

measures, and increasing the accessibility of technology supports. As part of this, "mission-driven" needs to be defined in the legislation. Is this the definition as per the long-term care COVID-19 commission report? Families acknowledge the role of for-profit corporations in the building of infrastructure but maintain that the delivery of care must be mission-driven, not profit-driven, regardless of tax status, and homes need to be able to implement emotion-based models of care and have the funding and flexibility to do so—so if a resident wishes to skip breakfast or eat later than 8:30 a.m., then that is supported and enabled.

(6) The institutionalization—these are homes of people. They're not primarily medical institutions.

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Ms. Sam Peck: So we need to de-institutionalize the perception of the sector, policies, practices and language. It's a place people call home. The culture of aging needs to be dignified, humane and person-centred.

FCO continues to be a strong pillar for family engagement in care and decision-making, as well as a conduit for channelling that information to decision-makers.

Today, I thank you for your attention to the points I have brought and your respect for the caregivers who have provided input to what I have shared during this committee meeting.

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Next, we have Sioux Lookout First Nations Health Authority. You have seven minutes for your presentation.

Mr. James Morris: [*Inaudible.*] My name is James Morris. I'm the president and chief executive officer of the Sioux Lookout First Nations Health Authority.

Something about us: We work with 33 First Nations in northwestern Ontario, in Treaties 3, 5 and 9. Twenty-five of these communities are only accessible by flying or with [*inaudible*]

The Acting Chair (Mr. Vijay Thanigasalam): Mr. Morris, we cannot hear you clearly. Could you please speak louder? Thank you.

Mr. James Morris: Okay. Can you hear me now?

The Acting Chair (Mr. Vijay Thanigasalam): It's quite better.

Mr. James Morris: Okay.

The population in our area in northern Ontario is approximately 35,000, roughly going. This is a map of the area that we serve in northwestern Ontario. Many people have said that it's an area equal to the size of France, for comparison.

We are basically talking about our elders, who are very important to us in our culture. They are the keepers and teachers of our culture. We call them knowledge keepers. They have maintained our identity, traditions, skills and also the language, the Anishinaabe language that we speak. We feel that the eldest must stay in the communities and receive care as close to home as possible. Our elders deserve meaningful change in the current health care system.

The communities we serve have always asserted that they have a treaty right to health care. The province of Ontario was a direct signatory to Treaty 9. Medicine, rights to health wellness and health care were critical elements that were woven into the treaties. Treaty rights are portable also, meaning that they also apply to off-reserve members.

The communities served by SLFNHA have an inherent right to self-determination, including their right and responsibility to have their own health care, health and wellness program services, which includes the inherent right to control their own health services.

With poor health outcomes with complex health needs due to factors including historical and intergenerational trauma, colonialism and discriminatory legislation practices, there are poor social determinants of health in all of our communities: overcrowding; lack of housing; lack of access to infrastructure, such as running water and power; and boil-water advisories. The trauma of residential schools engages fear and mistrust of non-Indigenous health professionals and institutions.

The majority of these communities, however, do not have their own long-term-care facilities or other similar homes. Some communities do have elder complexes with piecemeal funding sources, and they also have fragmented community services.

Palliative care is generally not possible in the community. That is done in hospital-based services outside the community. It separates patients from their family members at the end of life. There is a 20-bed facility in Sioux Lookout, where we're headquartered, for the 28 communities that are served by the Meno Ya Win hospital. We are still waiting for provincial commitment to another 76 beds.

The 2018 seniors' care and housing strategy reported a four- to five-year waiting list at the long-term-care facility in Sioux Lookout, resulting in impacts that have devastated the seniors and their families. The complexities of overlapping responsibilities and jurisdictional barriers between the federal and provincial governments result in a complicated and ambiguous framework.

There was a 2018 northern seniors' care strategy that was commissioned by the Sioux Lookout Meno Ya Win Health Centre and reported the following main gaps: in dialysis, respite care, palliative care, rehabilitation services, and mental health.

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This is our position at the health authority regarding Bill 37: It fails to address the long-standing barriers to health care for our elders, who require trauma-informed care, provided in the language, that is based on Anishinaabe values, traditions, food and medicines. It fails to fit the context of northern Ontario, which is comprised of small communities in an economically deprived region. It represents a lost opportunity to effect meaningful change for northern First Nations communities by addressing the colonial structural barriers and resolving the long-standing jurisdictional issues between the federal and provincial governments.

Direct hour targets: The proposed targets for direct health care will significantly impact the health care workforce. Bill 37 does little to protect workers during a time of health care crisis, when professionals are burnt out and leaving the profession in droves—which is what is happening in northern Ontario and in other regions in Canada now, for those people who want to check it out. These shortages will even be more pronounced in northern and remote communities where compensation models do not reflect the unique context of care in our regions.

The continued privatization of long-term care has eroded the health care system for the elders and has contributed to the current state of crisis. To us, privatization is a breach of treaty obligations and responsibilities. A privatized system is not viable for northern Ontario, comprised of small communities in an economically deprived region.

Part IX limits the establishment of long-term-care homes to communities of over 15,000 people. That makes care closer to home impossible, as the entire region is comprised of municipalities and First Nations with populations far less than 15,000.

While the proposed residents' bill of rights is positive, it fails to include culturally appropriate care and address long-standing issues of anti-Indigenous racism. Further, there is nothing in the bill to ensure enforcement and provide actual protections—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time has ended.

Next, we have the Ontario Nurses' Association. You have seven minutes for your presentation, and you may begin now. Please introduce yourself before you start your presentation.

Ms. Cathryn Hoy: Good afternoon. My name is Cathryn Hoy. I'm a registered nurse and the president-elect for the Ontario Nurses' Association, the largest nursing union in Canada. I'm joined today by Vicki McKenna, ONA president; Beverly Mathers, ONA CEO; and Etana Cain, government relations manager. We represent over 68,000 registered nurses and health care professionals working in every sector in our health care system, along with 18,000 nursing student affiliates.

Our members have all been affected by COVID-19, but none more so than our thousands of members in long-term care and, more importantly, the residents they care for. For decades, our members have been sounding the alarm bells about the conditions in their sector. For decades, they've been the canaries in the coal mine, consistently raising concerns about understaffing, underfunding and calling for an end to for-profit care.

I'm here today, once again, to raise concerns regarding Bill 37, the so-called Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. Honestly and frankly, it's a little too late. My remarks today will focus primarily on registered nurse staffing, infection prevention and control, and the need to protect and expand non-profit long-term care.

When considering our recommendations, I really urge you to think of the thousands of residents who died of

COVID-19. Think of the health care workers who died, including one of our very own members, Brian Beattie. We all have borne witness to a grave humanitarian crisis in long-term care. What is it going to take to make changes that are so desperately, desperately needed? And if not now, when?

To start, we need to put a stop to profit-making and greed—plain greed—in long-term care. A glaring sign that this government has not learned the lessons from COVID-19 is the proposed change to the preamble in Bill 37. The existing act has a clear comment to promote “the delivery of long-term-care home services by not-for-profit organizations.” Bill 37 proposes language that effectively waters down this commitment to non-profit care by adding “mission-driven,” which is not defined and could mean anything. The preamble is the language and the lens by which the entire act is interpreted. This change is not insignificant. We reject this change. The commitment to non-profit care must remain.

It is alarming that this government continues to award new bed licences to for-profit homes, including some of the worst offenders and even chains that were named in a military report. Nurses know that the government must put quality care, including staffing levels, over profit, a position that is shared by the vast majority of this province and country.

I also want to emphasize to MPPs that staffing, the work environment and quality resident care are all connected. Dr. Pat Armstrong said it best: “The conditions of work are the conditions of care.” The reality in homes is that the staffing levels are unacceptable. Working conditions are unacceptable. Many of our members in non-profit homes have had their wages cut by the government’s Bill 124, fuelling an even worse retention crisis.

Bill 37 does not go far enough to address the critical issues. The legislation introduces a commitment to a target of four hours of direct care by nurses and PSWs by 2025 province-wide. This is not what ONA and other stakeholders and families have been advocating for. Four hours of direct care must be a requirement or a minimum care standard within each nursing home, not a provincial or ministry target. This staffing standard must be increased as quickly as possible—not in five years, after the election, but starting now, with greater improvements.

Where are the details about how the four hours will be delegated? ONA’s recommendation is 20% RNs, 25% RPNs and 55% PSWs, and one NP for every 120 residents. Further, the legislation standards of having at least one RN in the building, 24/7 hours, should depend on the size of the home. Larger homes require more than one RN so that our members can collaborate and share the load when needed.

The long-term-care commission echoed ONA’s skill mix recommendations in recommendations 44 and 46. The commission also recognized the need for more registered staff, including NPs, given the complex care needs of residents, including continuing declines in mental conditions.

Finally, it should be no surprise to MPPs that there must be firm commitments to full-time jobs and wage parity

with the hospital sector. This is essential for both recruitment and retention of staff. It is also an equity issue, as racialized nurses and health care professionals are more likely to work for the for-profit sector and are more likely to hold multiple jobs. These groups were impacted by the pandemic and worked in the hardest-hit homes. They want to know, MPPs, when this government will finally act.

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Ms. Cathryn Hoy: Infection prevention and control is another area where there are many lessons that can be learned. In congregate settings like long-term care, applications of IPAC measures are key to preventing the continual spread of infections. We should know this by now.

ONA is recommending that Bill 37 be amended to require homes to have a stockpile of PPE for a three-month period in accordance with precautionary principle. The stockpiles need to be maintained and should be part of the annual inspection of the Ministry of Long-Term Care.

We’re supportive of the creation of the IPAC lead in all homes, which is outlined in Bill 37.

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I should also say that all IPACs should be educated with Canadian-endorsed courses.

Further, we recommend that IPAC leads have the reprisal-free authority to make effective decisions about infection prevention.

Whistle-blowing needs to be stronger in Bill 37. Nurses and health care professionals—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time has ended now.

Thank you to all the presenters.

Now we’ll move on to our questions. The first round of questions goes to the opposition members, for seven and a half minutes. MPP Berns-McGown.

Ms. Rima Berns-McGown: Thank you to all the presenters. These were very strong and powerful remarks.

Mr. Morris, I want to give you an opportunity to continue. You talked about the reasons that Bill 37 does not work for First Nations. I wonder if you could give us some thoughts on what you would like to see there in order to have it work.

Mr. James Morris: We need to address our staffing crisis by achieving rate parity and equitable compensation models, because the First Nations are complex. We need to amend the regulations to develop standards that are obtainable for First Nations communities while also ensuring equitable and safe care for our elders. You have to keep in mind that the elders basically come from a different culture than even what you’re used to down south.

We need to create one funding mechanism that combines federal and provincial funding and provides stable, predictable, long-term funding for capital projects. Too many times, the federal-provincial jurisdictions are used as an excuse to do nothing. We need to get rid of that approach.

We need to include mandatory cultural sensitivity training and anti-racism training for staff where our elders go. All of our elders currently go to homes in the south.

The people who look after them need training to know how to deal with elders from the north.

We need a clarification of roles and responsibilities between federal and provincial governments to address jurisdictional barriers for home and community care, palliative care and long-term care. And we need to establish a Jordan's Principle that goes to elders—that means when an elder comes to you, you look after him or her; you worry about the funding issue later. You provide for this person.

And we need to support a unique model that moves from an institutional model to one that is a social, community-based model. Rather than sending people to homes that are in a city, we need to direct models to our communities, from our community. And that requires more resources—

The Acting Chair (Mr. Vijay Thanigasalam): Mr. Morris, my apologies to cut you off. Could you please come closer to the mike? We still have a hard time hearing you.

Mr. James Morris: We need to remove the barriers to the provision of traditional healing and traditional foods as part of a holistic continuum of care. This is called for in the Truth and Reconciliation call to action number 24. It calls on those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal persons, in collaboration with Aboriginal healers and elders, where requested by Aboriginal patients and Aboriginal elders who live in long-term-care homes.

Ms. Rima Berns-McGown: These are really powerful remarks on how it's important to incorporate an Indigenous lens into every piece of legislation that we put forward.

I'd like to ask a quick question of the folks at the ONA. This has come up a number of times—this question of whistle-blowing. It feels to me as though this is really crucial—that there be a safe whistle-blower protection outlet, particularly in a world in which inspections are not a surprise and right now employment is precarious. What would you see as a safe and secure whistle-blower program? What recommendations would you have? What needs to be in there?

Ms. Cathryn Hoy: Members who work in long-term care need to know that they're protected for whistle-blowing. Could you imagine if they were protected and could have come forward to the ministry with what was happening in long-term care, where management locked up PPE and it wasn't available to them? Where did they have to go to if they called the ministry and the ministry came in and did an investigation? They weren't protected. At the end of the day, with that PPE being locked up, it put not only our members at risk—all the health care professionals—but it put the residents at risk. They need to know that they're safe and they can come forward.

Long-term care has become far more complex than it ever has been. They're basically like medicine units in hospitals. Sometimes they're providing care that may be far too much for that home—or, if you only have one RN

in a building, how are they providing the proper care for those residents, meeting their college standards? They need to know that if they speak out to the ministry and say that the care isn't appropriate at this level, that residents need to go to hospital, they're going to be protected—simple things like ensuring that there are air conditioners in for-profit homes when the temperatures in the rooms are unrealistic in the summertime, leading to heatstroke of our members.

It's all about patient care, and the whistle-blowing is to keep the residents safe.

Vicki, do you have anything else to add?

Ms. Vicki McKenna: Absolutely. Currently, for our members, as they describe it—the nurses out there in the homes—because the inspections are not a surprise, they are very closely monitored during inspection periods, so there isn't really an opportunity to speak in confidence. Sometimes the inspectors, quite frankly, will flip them a card to say, "Call me," but I've got to tell you, it's a bit of cloak and dagger—it's not the inspectors; it's the process. I think there needs to be a way for the inspectors to be able to have that information and to clearly understand what's happening.

We have some great homes out there, but we have some that aren't. There has to be a way for people to be able to speak up without fear of reprisal or losing their income. That happens. That has happened with our members. So, there has to be a way for that to happen.

I'm thinking that the procedure could be pretty easily done if there's a willingness and some courage on the ministry side to make that happen.

Ms. Rima Berns-McGown: Sam, I saw you nodding. Is there anything you would like to add?

Ms. Sam Peck: I echo very much what Mr. Morris and ONA said: that culturally appropriate care for Indigenous elders is essential—and to have long-term care be delivered closer to communities to ensure that we have person-centred but community-connected care so that people can actually be supported as their whole selves.

Whistle-blowing protection for nurses and families—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. The time has ended; my apologies.

Next, we have the government members for seven and a half minutes. MPP Wai?

Mrs. Daisy Wai: Thank you very much to all the presenters for coming in and sharing with us. I want to especially thank Mr. Morris for coming in and sharing with us.

It's listed in the preamble of this bill that we "recognize the role of Indigenous peoples in the planning, design, delivery, and evaluation of culturally safe long-term-care services and care in their communities."

I am happy that you are sharing this with us today as well.

Could you tell us more about the benefits of having people from similar communities providing care to residents so that we can ensure that this is running in a way that is good for communities and that is culturally suitable for them?

Mr. James Morris: The first thing, to the member, is that the people who live in our area—we call ourselves Anishinabek. We have our own culture. We have our own language. The customs and the traditions and the language that they have in those communities are very different from what you have in the south.

If you really want to know the difference between a long-term-care home, say, in Toronto and what we call a senior citizens' home, say, in Big Trout Lake—and you should go take a look for yourself. That was a lesson that was learned by one of your ministers during the NDP government. I invited her to come up north and take a look for herself. What she discovered while she was up there was a great eye-opener, shocking in some cases.

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We know how to look after our old people. We know how to look after our elders. We know the language. We know the food that they eat. We know what they require. When they have to be sent to a home down south, they lose all that, and they're essentially put into a foreign environment. The biggest complaint they have is one of loneliness, because they have no access to their support systems, like they had back home. We need people who understand their culture and know how to look after them to be their caregivers.

I have nothing against the professionals who work in long-term-care homes up north, but they are not trained to look after our elders, and I think they should be. Meegwetch.

Mrs. Daisy Wai: We definitely want to partner with you, and we know that this is something you want us to do together with you. We will definitely continue to work together on this.

Now I would like to pass my time to MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you, MPP Wai.

I would also like to address my question to Mr. Morris. What you said, particularly about the loneliness of seniors and not having access to their families and their support system, really resonates with me. I think it's very important going forward that we're committed to ensuring that the support system is there for all seniors.

Our government has recognized the unique challenges of supporting Indigenous seniors, as you were mentioning, in remote communities. That is why we have approved 10 Indigenous projects, with 735 new beds and 205 upgraded beds which are in the pipeline now. I know that in Sioux Lookout Meno Ya Win long-term-care home, 76 new beds were allocated.

In addition to supporting the additional beds and capacity, could you share with us, Mr. Morris, what additional things we can do, perhaps on the staffing side?

Mr. James Morris: We're still waiting for that commitment of those 76 beds for the Meno Ya Win Health Centre in Sioux Lookout. We were told that it was on hold. I guess one of the things we're looking for is some answers about when that commitment will be approved so they can move ahead. That's just one step forward to bringing our elders a little bit closer to home. Increasing the number of

beds will only bring our elders a little bit closer to home. Currently, they go as far as Kenora, Thunder Bay—I don't know where else—to access them. That's too far. Sioux Lookout is perfect because there are large numbers of native families living in that town who play a big part in visiting the elders when they are in the homes.

But what we really need is to find a new way to be able to keep elders in their own communities. They need increased resources to build better housing for the elders, and they need more resources for personal support workers to make sure that these elders are looked after on a regular basis. My grandma passed away last year. She stayed in the community for as long as she could, but she went blind because of diabetes and it was a constant worry to us, how she was managing—

The Acting Chair (Mr. Vijay Thanigasalam): One minute.

Mr. James Morris: —to live alone in the community. We need more resources, personal support workers to keep track of these elders on a 24/7 basis.

Ms. Effie J. Triantafilopoulos: I have a question for Ms. Peck. Particularly since family councils are so critical to getting the advice and feedback we need to support our seniors in long-term care, you'd be interested to know that our government has increased funding to Family Councils Ontario by approximately 50% in 2021. The legislation also mandates that the minister must consult at least annually with Family Councils Ontario, although Minister Phillips, to date, has been doing so more frequently, on a quarterly basis. So I wonder if you could speak specifically to that in terms of—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. The time has ended.

The next goes to the opposition members—seven and a half minutes. MPP French.

Ms. Jennifer K. French: A couple of things: I'd like to ask the committee if some of the presentations that we've seen, specifically that of Mr. Morris—if that can be made available to committee members, please. Also, the sound continues to be really staticky and awful.

However, moving on: I'll start with Ms. Peck. I was doing my best to take notes while you were speaking, and I know that you had seven points. I didn't get all seven. Is that something that you could also share with the committee, so that we do have your points outlined? You talked about a competent, qualified workforce—was that number (4)?—and (5) was modernize? Could you just outline the last few?

Ms. Sam Peck: I can recap, yes. Number (4) is a competent and sustainable workforce, including allied health professionals and social workers. Number (5) is modernization of infrastructure and delivery models, so physical plant, mission-driven versus for-profit—the definition there—models of care. Number (6) is the institutionalization, so really looking at culture change and ensuring that the language used in the legislation is person-centred and reflects that long-term care is primarily the home of residents. And yes, I will make that available.

Ms. Jennifer K. French: Okay. Was it just the six, then? I thought it was seven. I got those six. I'm glad.

Ms. Sam Peck: Six and then a recap. I will make this document available.

Ms. Jennifer K. French: Thank you. We had been talking about whistleblower protections, and I'll stick with you for a quick second because while I wanted to talk to the other presenters a bit about that, you said, "and families." Certainly, I know that New Democrat offices, on a regular basis, hear from families with concerns. We have been hearing that there are new channels that are problematic, that redirect families and their complaints back to the for-profit operator, rather than the ministry sorting them out themselves, and that is obviously of concern. If you have thoughts on what an accountable either whistleblower or complaint—and I'm not saying those are two of the same things. What could that look like—to put it in the appropriate place that's accountable and protected?

Ms. Sam Peck: I think that for complaints that either cannot be resolved at a local home level or are such that a family or a family council feel uncomfortable bringing it to the attention of the administration regardless of operator type, at a ministry level, there needs to be a way to make anonymous complaints that are followed up in a timely manner, that are triaged appropriately, and that there is accountability—having some sort of dedicated phone line for the ministry, where it doesn't take many days for a family or a caller to get a response back; where, if there is a concern about abuse, neglect or something else that affects the well-being of all residents, it is dealt with rapidly and that it's fixed; and that there's accountability and follow-up, so it's not just going into a home—"This is a problem; fix it"—but an inspector actually comes back and ensures that it's either resolved or an action plan is put in place.

1550

Ms. Jennifer K. French: I'm going to piggyback on that—either Cathryn or Vicki. Where inspections are concerned, I've been hearing that there are some perhaps unfounded concerns about the nature of the inspection. I currently have a written question on the order paper asking the government if the criteria will at least be the same as the RQIs, what would trigger an inspection and the specific details of these inspections. We've heard concerns that it could be a five-point inspection, or specific like, "Inspect these things," rather than a comprehensive inspection.

Do you have comments on what you at least hope that those inspections would look for and where that would go? I know that everything has to be publicly recorded, but it's a maze. I look for it, and I know what I'm looking for, and I can't find reports on the homes. Certainly, a family looking to make the best decisions for their loved ones wouldn't know where to look. Can you speak about inspections, please, and what you would hope that those would look like? The government is championing more inspectors—but inspecting what?

Ms. Vicki McKenna: Exactly.

I'll start and maybe Bev can jump in as well.

What they should inspect for is a really good question. What we have been calling for is standards in each home that need to be measured and need to be measured over time. Inspectors have told me that when they go in, they do have a list of things—and not to minimize it, but including the temperature of food; it goes on and on. But at the end of the day, it is about the care that surrounds the resident, as well. That has to be their priority.

They've told me they get caught up in the logistics of things around housekeeping, for instance, which is important in regard to IPAC, to which we would say, "Yes, check." IPAC assurance and training needs to be done throughout. But the safety of residents and the care quality that they are receiving—and yes, to interview residents and families, but it's got to be a confidential process.

Families tell me—I have family in long-term care, and people and relatives are afraid to say anything. So when I hear relatives afraid to speak up—and I know nurses are afraid to speak up, because it is a really difficult climate in some homes. So it has to be clearly identified what the standards are and how those will be measured, so it's fair. It needs to be a fair assessment.

Inspectors have to be able to coach some as well—because somehow that seems to not be provided, and I don't know why. There's some failure on that side. I don't think it's all the government's job to do coaching. I think it might lie better in some of the associations that they belong to, as well, that could assist in some of the coaching side of it. But aside from all of that, we need inspectors in there who look at how people are able to live and be cared for safely.

I'm just speaking from the viewpoint of some of the members, the nurses we know who are trying to speak out and have suffered as a result of it, and who also say the inspectors are so tied up in a whole big, long list that they don't actually get to: "What's the staffing? What vacancy rates do have? How many hours of care are you actually able to provide?" That has to be keystone. I've said to many government officials of the day, this is like—

The Acting Chair (Mr. Vijay Thanigasalam): Thank you. Your time has ended; my apologies.

Next, I will move to the government members for seven and a half minutes. MPP McDonnell?

Mr. Jim McDonnell: I want to thank the presenters for coming out today.

A question to the family councils about our bill of rights: Our legislation makes certain important changes to the residents' bill of rights in long-term care. The first is aligning the bill of rights with the Ontario Human Rights Code to ensure residents are not discriminated against while in long-term care. As well, the role of caregivers in care for residents is strengthened and properly recognized. Do you support these changes to the legislation? Could you speak to their importance—particularly in recognizing the importance of caregivers and residents' enhanced rights to receive care from their caregivers?

Ms. Sam Peck: What we saw during the pandemic is that when caregivers were shut out of long-term-care homes, residents suffered. I think we can take that as truth.

We can also take as truth that locking caregivers out had a negative impact on staff, on morale, on support for them and so on.

The changes to the residents' bill of rights, in that the alignment with the Ontario Human Rights Code is important, and recognizing the inherent humanity and protection of such for residents, and the right to be treated with respect—I think where we could see opportunities for improvement is to be more clear that it's not just a right to receive a caregiver, or not just the right to have a caregiver attend any meeting with a licensee to receive safe and ongoing support, but really that this right doesn't depend just on context. By that I mean:

—that if there is another crisis or emergency—climate change-related, pandemic illness, what have you—the caregivers won't be locked out;

—that in day-to-day life, but also, more importantly, in a crisis, residents need to have ongoing support, including in person, from their caregiver, because “ongoing and safe support” could be interpreted to mean that phone and email is sufficient, when we know that it's not; and

—that caregivers provide a lot of care and support to residents, and this needs to be maintained at all times.

Mr. Jim McDonell: Certainly, the hours of care, the majority of care for the residents, has been called into question. We've taken strong action to try to rectify that, and that takes years. You've got people through education—PSWs are more than a year's education, and nurses are up to four years and longer, and nurse practitioners even longer—so that help doesn't come out of thin air. That's something we're trying to do as quickly as we can.

We're looking at meeting those targets of four hours by the end of the first quarter, which is March 2025, so considering the lengths of time of those education requirements, we're actually filling them in less time than it takes to get a degree. It's certainly a challenge ahead, and we're looking forward. I know that we've increased quotas at universities, post-secondary and colleges—in the case of Queen's, by 25%, and I'm sure some of the others even higher. These are steps, but it all takes time.

The minister has indicated that this bill will hold the system accountable by measuring the quality of care and the quality of life for residents of long-term care. Ontario will track a number of different indicators at homes across the province using home-by-home annual surveys of residents, families and caregivers. These results will be made public for residents, future residents, families and the general public to review.

What advice would you offer to help the government ensure that these results will give people the information they need, whether it's for the resident to decide on a long-term-care home or for the family to see that excellent care is being provided?

Again, that's back to the family councils.

Ms. Sam Peck: Measuring satisfaction is important. It's how we get at, “Is this a good place for people to be?” When it comes to measuring those metrics, I will say I'm on the ministry's quality framework tables, providing input there. When it comes to home-level surveys, I think

we need a mix of standardization, so as to be able to compare and contrast different homes, regions and so on. And I think, above all, that we need to ensure we're measuring what matters, and to know what matters we have to ask families and residents. My role is to provide input to the quality framework development, so we're getting at those metrics.

So ask families and residents, look at data from other jurisdictions, and then ensure that we can measure across sites, because that gives us a picture of what's working well and what's not, and can we learn from what's working well to apply it to areas of improvement. But above all, ask your residents and your families.

1600

Mr. Jim McDonell: I know there has been some talk about the inspectors, and of course, we're doubling the number of inspectors.

One system inspection that we have been incorporating over the last couple of years is to publicize a number that any family member or any resident could call to report an issue, which would then have inspectors sent to verify or check out the issue. That seemed to be well under way. I guess we're looking at 350 inspectors, but they don't have 350 sets of eyes; you have thousands of eyes looking at it—

The Chair (Ms. Laurie Scott): One minute left.

Mr. Jim McDonell: What do you think of that type of system to continue—where you actually make the homes very aware that the residents and family members are expected to report any deviations or issues they see?

Ms. Sam Peck: I think it's important for residents and families to have a mechanism for reporting complaints and concerns.

I also think that the role of inspectors could be more proactive, but also done as a way for what has been called coaching for compliance, so that there is another set of eyes that comes from a more expert lens and can be more proactive and, through part of that process, interview families and residents so that small issues don't escalate to the point of needing to go to compliance. Ideally, a proactive compliance, coaching for compliance support system would reduce the number of calls, therefore reducing issues at a local level—

The Chair (Ms. Laurie Scott): Thank you very much. That's all the time we have in this round.

We would now go to four and a half minutes to the official opposition. MPP Mantha, go ahead.

Mr. Michael Mantha: Mr. Morris, I come from an area where there are 37 municipalities, 22 First Nations. Everyone understands the needs, and everybody respects the roles that each and every organization, long-term-care home and hospital has to play in sensitivity and also knowledge about the importance of why we need to get the training in anti-racism, why we need to understand Indigenous culture, why we need to understand the practices, the ways, the means, the treatments, the history, the story.

I do want to share with you that I have seen it first-hand. I was part of opening up the new grandmother home in

Wiikwemkoong First Nation. It's a beautiful home. Everything there is First Nations culture, practice. It has a room for everything.

The reason I wanted to say that is that I want you, for the rest of the committee members, to stress the importance of what that anti-racism training would mean to Indigenous homes and what it's going to bring as far as benefits to those who are going to be staying in those homes.

Mr. James Morris: As I said earlier, the elders who we're talking about from northern Ontario have their own culture, the Anishinaabe culture. They live in that culture, and they speak the language, and they eat the food, and they have the customs. When you move these people into a foreign environment, you need people who understand that at their new homes. I'm not so much concerned about the bricks and mortar of what we call long-term-care homes. Our interest mainly is in the program, a program that's designed to look after a client. In our case, we're talking about people who, from your perspective, come from a foreign culture, a foreign environment, and who speak a different language. They need to be looked after in that context, because otherwise, you end up with elders far away from home who have no connection to your culture, your language and even your food.

It's pretty basic, but you guys don't understand that.

Mr. Michael Mantha: I do. I do understand—because your environment is the wellness that you're going to receive. Again, a lot of the presenters said that the care that you provide is going to be the care that you're going to be receiving and the results that you're going to be getting. We've heard that numerous times from previous presenters.

Mr. James Morris: You need staff who have some what we call "sensitivity training," who understand the values that the elders respect.

Let me give you a quick example before I go. I've worked with First Nations people going to outside institutions for about 30 years now. They never complain about the medical care that they receive.

The Chair (Ms. Laurie Scott): Forty-five seconds left.

Mr. James Morris: Most of the complaints centre around how they're being treated—that in the course of people doing their work, that translates itself as elders feeling that they're not being respected. That's the most important thing that they complain about. They don't feel respected or valued.

Mr. Michael Mantha: Nahow. Baamaapii. Meegwetch.

Mr. James Morris: Meegwetch.

The Chair (Ms. Laurie Scott): We'll now move on to the government, which has four and a half minutes. MPP Ghamari, please go ahead.

Ms. Goldie Ghamari: Thank you, everyone, for your presentations.

Mr. Morris, thank you for taking the time to join us today to talk about long-term care and the programs that are being provided to First Nations elderly in Anishinabek Nation, in that area. I think what you're talking about is

very important, especially since—my mother works in a non-profit that provides services to seniors, mostly underprivileged seniors. Their organization, in the past 15, 20 years, has continued to grow and expand in terms of diversity. For example, she is responsible for the division that deals with seniors who are from an Iranian background. There is an aspect of cultural competency that I think everyone needs to learn about. A lot of times, people focus on immigrants coming in from different cultures and backgrounds, but sometimes, especially in the past, the focus hasn't been given to First Nations communities and diversity within First Nations communities. So thank you again for sharing that. As my colleagues MPP Wai and MPP Triantafilopoulos said, we look forward to keeping that dialogue open and working together to see what we can do to improve services for Indigenous seniors.

I have a question for the ONA. I want to follow up on what you were speaking about with regard to LTC funding. During the recent federal election, the Liberals committed to \$9 billion worth of long-term-care funding. However, there was no mention of this funding in their throne speech. What would Ontario getting their fair share of this funding from the Liberal government mean for long-term care in this province?

Ms. Vicki McKenna: I asked Minister Phillips not long ago about the funding that's available to long-term care, prior to the federal election, and asked why Ontario wasn't negotiating with the federal government and said that I didn't want Ontario to leave money on the table for long-term care. So I've raised this with the minister.

I do believe that, certainly, the federal government has a role to play in providing support for long-term care. It's a tragedy, what has happened, and there is opportunity. I don't know why Ontario isn't at the table on this. Other provinces have already made deals on the long-term-care monies available from the feds, so I'm not sure what—I don't really understand.

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Ms. Goldie Ghamari: My understanding is that—

The Chair (Ms. Laurie Scott): Final minute.

Ms. Goldie Ghamari: Thank you, Madam Chair.

My understanding is that the minister is currently negotiating, working on this in order to get a fair share for Ontario. Ultimately, at the end of the day, we have the biggest population in the country. We have a growing number of seniors across the province, and this is something that we need to focus on—

Ms. Vicki McKenna: Yes, agreed.

Ms. Goldie Ghamari: Yes, and oftentimes getting the best deal isn't necessarily getting the fastest deal.

Ms. Vicki McKenna: Well, I don't think it's about speed. I've been contacted by the press on numerous occasions, because they've been saying to the feds that we weren't even at the table. Minister Phillips was just in, and he said he was going to be working on it, so I'm glad to hear that. Whether it's enough or not—I don't know the quantum, but I will say this: Any dollar that we can get, we should, and we need the—

The Chair (Ms. Laurie Scott): Thank you very much. The time is up.

I thank all the presenters for being here this afternoon.

ADVOCACY CENTRE
FOR THE ELDERLY
ONTARIO ASSOCIATION OF
RESIDENTS' COUNCILS
HOME CARE ONTARIO

The Chair (Ms. Laurie Scott): We'll move on to the next group of three presenters. The three that will follow for the next hour will be the Advocacy Centre for the Elderly, the Ontario Association of Residents' Councils, and Home Care Ontario. Each presenter will have seven minutes for their presentation, and after we've heard from all three presenters, we will have 39 minutes of questioning divided into two rounds of seven and a half minutes and one round of four and a half minutes for the government members, as well as two rounds of seven and a half minutes and one round of four and a half minutes for the official opposition members.

I will ask you to state your name for Hansard, and you may begin. I will give a one-minute warning near the end.

Ms. Jane Meadus: Good afternoon. Thanks for us being allowed to present on this important piece of legislation. My name is Jane Meadus. I'm a lawyer at the Advocacy Centre for the Elderly, a clinic for low-income seniors that has been in operation for 37 years, where I've been a staff lawyer and institutional advocate representing the rights of residents of long-term-care homes. With me today is Graham Webb, who has also been a lawyer at ACE for 26 years, with the last six years as executive director.

The legislation entitled the Providing More Care, Protecting Seniors, and Building More Beds Act, 2021, we submit, has a flawed approach from the beginning, as it states it's there to protect seniors. Long-term-care homes are open to admission to persons 18 years and older, and while the vast majority are seniors, many people younger than that live in long-term care. While many of these residents should be in other settings, the current reality is that that doesn't happen, and therefore the legislation has to recognize all residents, not just seniors.

We also have an issue with the fact that we must "protect" residents. We feel this is ill-placed. The paternalistic sentiment which we've seen through the COVID-19 pandemic, where we saw over 150,000 residents of long-term-care homes and retirement homes illegally detained and families and caregivers barred from entering long-term-care homes is just one example of this. This resulted in residents having increased anxiety, depression and likely death from enforced solitary confinement and a lack of access to caregivers who had been supporting residents and advocating for them. We submit that the legislation should be focused on promoting the rights of long-term-care-home residents, and that's going to be the focus of my remarks today.

One of our biggest concerns about the proposed legislation relates to the palliative-care philosophy contained in right number 25 and section 12, which mandates a palliative care philosophy for all residents, which we oppose. While we agree that amendments are needed to ensure quality palliative care when necessary, it's not always appropriate or required for every resident. My friends from the Ontario Association of Residents' Councils will be speaking to this more fully. However, I do have a couple of comments with respect to this, which include the issue of level-of-care forms or advance directives as part of the care plan.

Presently, long-term-care homes are often asking residents or their substitute decision-makers to sign level-of-care forms on admission, where they are treated as consent from then on. These documents are not legal, and they contravene the Health Care Consent Act and can result in poor care. The Health Care Consent Act in Ontario does not allow for advance informed consent. Wishes can be expressed by a capable person, but not their substitute, whose job is to interpret those decisions when a decision has to be made. This does not occur when these documents are signed. What happens is that the home treats them as consents and no informed consent is obtained. This occurred during COVID-19, when residents were not sent to hospital by the home, based on "no hospital" being ticked off on a form that they signed when they were admitted to the home. How could a prior capable wish or decision exist for a disease that did not exist at the time? We've been arguing for years that these forms have to be eliminated. And our fear is that the new palliative care philosophy, instead of ensuring that people have the right to consent and access to care—are going to be relied on these documents even though they contravene the Health Care Consent Act.

I now turn to a different issue: section 203, which is the amendment section with respect to restraining and confining a resident. It's unclear why these are in the amendments, but we presume that's because they're going to be enacted at a different time. We urge you to make changes to these sections and enact them at the same time as the rest of the legislation.

Today, anyone who is being prevented from leaving a floor in a long-term-care home or going out the door in Ontario is being illegally detained, as we have no legislation. In law, people can only be detained or restrained in accordance with legislation, and that must comply with Canada's Charter of Rights and Freedoms; specifically, sections 2(d), 7, 9, 10, 12 and 15. We've had many clients who were prevented from leaving long-term-care homes without accompaniment simply because they live there, not been allowed to go to Tim Hortons for coffee or home for Christmas, just because the home has the policy. Long-term-care-home residents do not lose their civil rights and freedoms just because they're admitted to care.

We recognize many residents do require some kind of confinement, but this has to be done in conjunction with appropriate legislation, so we're asking you to make those

changes today. That will not only protect the residents but will also protect the homes from unwanted litigation.

Another issue would be the confinement sections in the legislation. They indicate that competent residents can be confined. This is contravening law. You cannot confine a competent person.

We also ask that all of the suite of appeals that appear in the Health Care Consent Act in part III.1 are included for residents who are in long-term care. Currently, they can only challenge substitute decisions, and there is no help with respect to the other issues regarding the various findings of incapacity and challenges to those.

With respect to retirement homes, the confinement sections were there. They've now been repealed, and we urge you never to put them back. Landlords should never be allowed to confine tenants.

The Chair (Ms. Laurie Scott): Last minute.

Ms. Jane Meadus: With respect to enforcement, we have one issue that we're going to talk about today, which is section 143. We want that amended to ensure that the annual inspection is a whole-home, proactive inspection and not just simply an annual inspection. That's where we got into trouble in the past.

Finally, we also want to comment on the lack of alternatives for people in long-term care and retirement homes. Only the rich can afford retirement homes; it's out of reach for many. Young people should be in supportive or attendant housing, as should many people who are older. We need to have cheaper options for people who might like a retirement home but cannot use them.

We also need to have a limit on the amount of care in long-term care. There is no upper limit at the current time, and homes are forced to take people they cannot care for, because chronic care facilities and psychiatric facilities—

The Chair (Ms. Laurie Scott): Thank you very much for the presentation.

We'll now move on to the Ontario Association of Residents' Councils.

Ms. Dee Tripp: Good afternoon. My name is Dee Tripp, executive director for the Ontario Association of Residents' Councils. We are the conduit between the voice of long-term-care residents and government. Devora and Carolynn will be speaking with me.

Devora?

Ms. Devora Greenspon: I am 89 years old. I have been a resident in a long-term-care home for 10 years. I have had multiple surgeries and have learned to walk again. I am an adult, and I don't like to be patronized or talked down to; I definitely see red when someone does this. I am a resident leader of my home's residents' council. I am part of creating solutions to the challenges in my home. I advocate for residents who cannot speak for themselves. It is important that they have a voice.

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I have known heartache, and I have known joy. I am a widow, a mother, a grandmother and a great-grandmother. I am a teacher and taught into my seventies. I love ginger, naan, ice cream, chocolate, opera and live theatre. I am not

done yet. I am still here, and I am whole. I am Devora Greenspon.

Ms. Dee Tripp: Residents are not passive recipients of care. As full citizens, residents are not plucked out of community. Residents want to be part of the solution. Words matter.

Our first comment today speaks to one of the new residents' rights. It's number 25, which reads, "Every resident has the right to be provided with care and services based on a palliative care philosophy." Residents have a reaction to that, based on the language that has been used.

Devora?

Ms. Devora Greenspon: I may be 89 years old, but I still want to live. I didn't move into long-term care to die. I moved into long-term care because I couldn't walk, and I needed a hoist to move me. But guess what? I got better and am now walking. People have the wrong image of residents who live in long-term-care homes. We are just like everyone else. We have emotions and feelings. We want to laugh and dance and have fun and go out and do all kinds of activities that will provide us with a better quality of life.

Ms. Dee Tripp: When we're talking about long-term care, the culture, the law, the policies all need to be life-affirming. We cannot frame a resident's right in the context of palliative care as a service or an act done to residents. A palliative approach focuses on meeting the resident's full range of needs every single step of the way, and it embraces self-determination and choice. We have a solution for how to reword that resident's right, number 25, and I am happy to share that later.

The second point we wish to emphasize is the interconnectivity of quality, residents' councils and communication. During the pandemic, communication was terrible. Residents reported feeling in the dark and punished. They didn't have the information nor the communication channels they needed as residents' councils fell silent. Residents' councils provide peer-to-peer support for residents, and they provide management with consensus, decisions and suggestions that absolutely inform quality from the residents' lived experience. Residents' councils are the main driver of communication between residents and the management of their homes. So we're asking for the following: that residents' councils are declared essential, linking directly to legislation on quality; that residents' councils are continuously supported; that licensees must allocate dedicated human resources to support residents' councils well.

I want to mention the resident and family caregiver experience survey. The current act reads, "The licensee shall seek the advice of the residents' council ... in developing and carrying out" and acting on survey results. But Bill 37 removed the word "developing," so that means that residents' councils do not need to be involved in developing the very survey that measures their quality of living. This change is not acceptable.

The last item we wish to address today relates to the staffing crisis in long-term care.

Now I would like to have Carolynn speak for a moment.

Go ahead, Carolynn.

Ms. Carolynn Snow: I am Carolynn Snow, a resident in long-term care in Keswick.

We residents feel that the role of a resident support ambassador or aide should be embedded in this legislation. Their duties include assisting with visiting programs and screening, quartering residents to and from activities and the dining room—

The Chair (Ms. Laurie Scott): Final minute.

Ms. Carolynn Snow: —assisting with meals, answering call bells and routine non-medical care, reading and playing games etc. with residents, and helping recreation staff with the programs. These activities free the nurses and PSWs up to provide physical care to the residents without having to be rushed through it.

Many of the behaviours exhibited by residents with dementia occur because their care is rushed and the PSWs don't have time to explain step by step what they're going to be doing with them.

The Chair (Ms. Laurie Scott): Thank you very much. I'm sorry; the time for the presentations is over.

If we could now move to Home Care Ontario, please.

Ms. Sue VanderBent: Good afternoon, everyone. Thank you very much for the invitation to speak to the standing committee today. I'm really grateful that you took the time to listen to us.

My name is Sue VanderBent. I'm the CEO of Home Care Ontario. I consider my members and their staff to be the hands and heart of the home care sector. They provide over 59 million hours of care to Ontarians every year. They employ 28,000 professional home care staff who provide high-quality home care to over a million people annually. To put this in perspective, home care now touches more Ontarians than many other parts of the health care system.

Home care delivers a range of professional and specialized services. A lot of people don't know that, but we have specialized services: nursing, personal support, physiotherapy, occupational therapy, speech therapy, respiratory therapists, infusion pharmacy, home support services, dietetics, and many more, including medical equipment and devices that come into your home. A key point for this presentation about these services is that they all support our seniors who are living in retirement homes across the province, and this in turn allows them to receive a wide range of the supports they need so that they can continue to age with dignity and independence in their own retirement homes and dwellings. I think that Mrs. Snow and Mrs. Greenspon talked a little bit about that. If they needed a physiotherapy visit or they needed some infusion therapy, it's the home care staff who could bring that into their retirement home for them. A key point is that the retirement home is the person's dwelling. It is their home. We provide this wide range of services to help all of our retirement home residents to continue to age with dignity and independence in their own retirement home dwelling.

It's helpful for you to know that I am here today to speak in support of Bill 37, which is an important step forward in integrating the provincial health care system

and supporting our residents in retirement homes and in long-term care.

Home Care Ontario supports modernizing the Retirement Homes Act in a way that maintains choice and quality for seniors through continued access to all these vital home care services. By way of context, it's important to note that retirement homes are considered an individual's own residence, where they can receive either home and community care support services, previously LHIN-funded, or family-funded home care services to help them age independently and in place. In fact, home care has been providing additional supports in retirement homes for decades, and this support has taken the form of additional hours to supplement the personal care to residents that homes deliver, as well as giving them access to the integrated health professional teams to establish goals for health, wellness and functional rehabilitation.

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In addition, retirement homes have increasingly called upon home care providers in recent years to support higher-needs residents who wish to stay in their own homes, with specialized care teams to ensure that they continue to receive high-quality care as their needs increase. The increased demand for these services from our aging population, along with COVID-19, have demonstrated that home care services are more important than ever before in helping every Ontarian age where they want and where they feel safe: in their own homes, wherever they might choose that to be.

The good news is that Ontario's home care professionals are trained and prepared to support our loved ones safely in their homes.

We're pleased that the government has recognized the critical role that home care plays within retirement homes and has maintained the current service delivery model that provides high-quality care to residents in a way that supports their independence. It will be critical that this commitment is maintained and sustained in the regulations—and that's one of our recommendations—to ensure that the vision becomes a lived reality.

I want to conclude my remarks by highlighting the need for government to review the lessons learned through COVID-19, particularly in terms of IPAC practices; that is, infection prevention and control protocols. Home care providers worked very, very diligently with our retirement home colleagues to develop many shared IPAC practices, resulting in the lowest amount of transition of virus of any part of the health care system. The home care staff did come in and did support patients and residents everywhere and had a very low—in fact, the lowest—infection or transmission rate. These were developed, as I said, directly between retirement homes and in concert with retirement home staff. We recommend that that also be standardized throughout the province and that joint IPAC leads are appropriately trained and credentialed.

I want to also add that it will be important for essential visitors, including home and community care staff, to continue to provide all of these services, especially during any kind of future pandemic, to preserve the health and

safety of all residents, which we know can be done safely and well with proper IPAC controls.

I want to conclude by saying thank you very much for the opportunity to speak to you today.

Finally, I believe that Bill 37 is an important piece of legislation and will help establish a system for the 21st century that can deliver more and better home care services within retirement homes in our province.

I would be very happy to take any questions. Thank you so much for your attention.

The Chair (Ms. Laurie Scott): Thank you very much. That was the final presentation. You were wrapping up, and I didn't get my final-minute warning in there, so thank you for finishing right on time.

The first round of questions will go to the government, for seven and a half minutes. MPP Wai will begin.

Mrs. Daisy Wai: I just want to take this time to thank all of the panellists who came in and shared with us your specific comments. I specifically want to take a moment to thank the front-line heroes for the work you all have done in protecting the seniors not only in my riding of Richmond Hill, but across Ontario.

My question is for Sue, for Home Care Ontario.

Before I ask the question, I just want to say that having our seniors aging at home is one of the pillars, one of the strategies that the Ministry for Seniors is operating on. That is why we, the government, have provided additional funding for home care services—actually, \$549 million for the home and community care sector.

With that, I would also like to get your ideas, because I know with the experience that you have, you have a lot of great ideas that you can share with us.

My question is, how will the proposed legislative changes help Home Care Ontario's commitment to provide quality care services across Ontario?

Ms. Sue VanderBent: Thank you very much for that question.

Home care definitely needs to grow. That's certainly something that Home Care Ontario has been advocating. I think most people on this call would know that there is not enough home care to look after the citizens of today, and certainly not the citizens who will need home care in the future. I'm not just talking about our seniors; I'm talking about people of all ages and all stages who need home care, for many different types of conditions and problems that they might need care.

We are very grateful to the government for the recent investment. We think that it is very helpful. We're very supportive of government supporting the home care integrated team being able to be a part of the services that retirement homes need to keep people healthy and safe in their retirement home dwelling.

Mrs. Daisy Wai: We look forward to working in partnership with you as well.

I would like to follow up with another question now. Could you please share how the proposed legislation amendments would help protect residents in retirement homes from potential financial abuse?

Ms. Sue VanderBent: Clearly, we want to make sure that there are adequate and enough publicly funded

services for people to access in their own homes, and also that if they choose to supplement the publicly funded system, that they are able to choose organizations that are reputable and that support good practices for good patient care. Home Care Ontario represents both of those types of members. This is a critical juncture, I think, in terms of the demographic that we face: It's a growing elderly population that needs both publicly funded and family-funded supports.

Mrs. Daisy Wai: I really appreciate the experience that you have and the comments and all the insights that you just shared with us.

Is there anything else that is in what we have in our legislation that you can advise or suggest for us to do?

Ms. Sue VanderBent: I suppose I would be remiss if I did not speak to the increasing wage disparity in our sector between home care and long-term care and acute care, and the need to ensure that we close that wage disparity gap in order to help make the home care sector a place where people, of all of the staff I talked about, want to work and really feel good about delivering care to all Ontarians. We don't want them to have to make an economic decision to leave the home care sector just at the time when we badly need them as a society.

Mrs. Daisy Wai: Our government listens.

One last thing to ask is, how can we ensure that the wait-lists are shorter for seniors waiting for spaces in long-term care? I know you have a lot of experience, whether it's social work experience, all kinds of experience in caring and the different boards, so we would love to hear from you what your suggestions are to ensure that the wait-lists are going to be shorter.

Ms. Sue VanderBent: Thank you for that question.

There are a number of really interesting programs that are starting now: the new High Intensity Supports at Home program and the short-term medical care at home programs. What they do is, they give someone the equivalent of the kind of care that they would receive in a long-term-care home, but in their own homes. There has been some amazing research done by our rehab specialist to show that with the right kind of intensive care, a person can actually rehabilitate and be able to go back home and not actually go forward into a long-term-care bed. So that has been remarkable, and I think the government has really shown a lot of leadership—

The Chair (Ms. Laurie Scott): Final 60 seconds.

Ms. Sue VanderBent: —in the new, high-intensity support programs.

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Mrs. Daisy Wai: This is exactly the direction our government is taking, whether it's with long-term care or with the Ministry for Seniors.

We will be continuing to work in partnership with all of you, and if there are any other suggestions, please feel free to discuss that with us as well.

The Chair (Ms. Laurie Scott): We now move to the official opposition to do their seven and a half minutes. MPP French, please go ahead.

Ms. Jennifer K. French: I want to thank all of the presenters.

I will make it personal for myself. When I'm finished this evening at 6, I'm headed to the hospital where my 100-and-a-half-year-old grandma is recovering from surgery, and then we'll be making the move from her retirement home into long-term care. I'm her registered essential caregiver, so throughout this pandemic, I have been up close and personal and have appreciated the work put in by a caring staff all along the way.

Dee, I'm going to begin with you. I know you said that later in your presentation you were going to suggest rewording for the palliative care piece. If you want to get that on the record, I would value that, please.

Ms. Dee Tripp: I'm glad my hook worked, so thank you for this.

I have two suggestions. The resident's right needs to be about a living philosophy, not a dying philosophy or a dying interpretation. The first version is this: Every resident has the right to live each day, supported through a palliative care philosophy that affirms and maximizes their self-determination and quality of life. The second iteration would be something like this: Every resident has the right to live in comfort, dignity and self-determination in their home at all times, at every stage of life, recognizing that a palliative care philosophy is a philosophy of empowerment and living. It's not about the last couple of days of your life.

Ms. Jennifer K. French: I appreciated Devora's comments and Carolynn's comments definitely reaffirming that folks in long-term care are there for care in the long term—and still dancing, I think Devora said.

Dee, I'm going to ask if you could submit that in writing to the committee. I didn't type fast enough, and I don't want to use this time to have you repeat that. Thank you.

Jane, I appreciated that you crammed a lot into that presentation. Thank you. I did my best to keep up.

I'll say that I live in Oshawa, near Courtice, and so the White Cliffe retirement home with the confinement and whatever—I followed that very closely. So I appreciated, certainly, your suggestions around language. Is that something that you have submitted to the government? Is that something that they have consulted with you on—on detention language or confinement language in this bill? Is that something you've already been able to give them that they're considering?

Ms. Jane Meadus: We haven't provided anything specific, I think, on the bill. This is a conversation we've been having with government for 20 years. The existing legislation was put in through submissions that we made. It wasn't the wording that we wanted, and things were left out. It's something we certainly have made very clear as often and as loudly as we can, no matter who was in government—that confinement in long-term care, hospitals, elsewhere, cannot be done except under very strict legislative oversight. That is just not being done for long-term care, and so you have people illegally detained. It will be in our written submissions, but we haven't specifically discussed it recently.

Ms. Jennifer K. French: Further to that, and building on what Dee just shared in terms of the language around palliative care and her suggested wording: You highlighted for us that the folks living in long-term care—while we welcome Carolynn and Devora, there is a range in age and life stage in long-term care. So for the wording to reflect the care needs of everybody living in long-term care, would you add to her recommended wording, or is that—

Ms. Jane Meadus: I think what we would like to see is something to say that people have a right to quality palliative care if and when it is required. To be admitted to a home and hear, "We're going to treat you with a palliative care philosophy" could be the most jarring thing, because it's telling you that when you come in, we're going to determine how you die. That should only happen when that process is taking place.

There isn't enough palliative care. They need more care and access to the right kind of care—but it's the access and the right to that care.

Palliative care philosophy sometimes means removing treatments and stuff—and not everyone wants it, even at the end of life. So it has to be based on the rights and the request and the consent of the resident or their substitute.

Ms. Jennifer K. French: I appreciate that. I'm my grandmother's substitute, so we live it, and we do our best to find a balance that she is very involved in.

I found it quite interesting when you were discussing or reminding me, maybe, about those documents that you are wanting to do away with that are signed when they first move in. Is that across the board in long-term-care and retirement homes?

Ms. Jane Meadus: We don't see the level-of-care forms too much in retirement homes, although we probably will be seeing it more if this happens.

Definitely, it's a document that is often handed to you by office support staff, and they say, "Sign this level-of-care form." There's no context.

We have had people who tick the box saying "No hospitalization," thinking, "If I'm dying, I want to die in my home." And then they have broken hips, very serious UTIs or other kinds of things happen, and the home says, "Well, two years ago, you signed a form. We didn't even bother telling you to go to a hospital because you signed it." That's actually what happened with COVID-19, when people were not sent to hospital because they signed a piece of paper two years ago.

Ms. Jennifer K. French: And that is something that we heard from families around that specific example—

The Chair (Ms. Laurie Scott): Final minute.

Ms. Jennifer K. French: Okay. I think my colleague Rima is going to ask some questions in the next round, and I'll maybe jump on the last one.

I would like us to think about inspections—a whole-home proactive inspection. My concern around inspections is that we're leaving it up to this government to define what they are, the parameters. I have a written question on the order paper asking for specific criteria—at least, to be like an RQI. Do you have thoughts on what those inspections need to be, how they need to be outlined?

Ms. Jane Meadus: I think they need to be looking like an RQI. Obviously, the meat and potatoes have to be in the regulations, how many protocols. My understanding is that they are going to be lessening the number of protocols than what we have now. I think that's wrong-headed. We really need to be looking at that whole home and not limiting time or the number of protocols they can look at, or the number of people, if they need more. But I think one of the key elements is having it in the act. Right now, it says "an annual inspection," and that's where we've gotten into trouble, because the governments change what that means.

The Chair (Ms. Laurie Scott): Thank you very much for that allotment of questions.

We are going to move now to the government for another seven and a half minutes of questions. MPP McDonell.

Mr. Jim McDonell: I want to thank the presenters for coming out today—because it certainly is a very important side of what we're seeing in this long-term-care bill.

My question is for Sue of Home Care Ontario.

First, I'd like to thank you and your members for, as you said, being the hands and heart of the care.

I was hoping you could share how the work of your Home Care Ontario members across the province could help seniors receive culturally appropriate and geographically relevant care in our retirement homes.

Ms. Sue VanderBent: Thank you very much for the question.

Again, I think it goes back to the access to the professional and specialized services that home care can deliver. I rhymed off a number of professions: nursing, personal support, physiotherapy, occupational therapy, speech and language therapy, respiratory therapists, social work, infusion therapy, home support services, medical equipment and devices, and more.

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I think the previous speakers were speaking to this issue, which is that we want to ensure that our services can support people living in either a retirement home or long-term care—but for retirement homes, that is considered their own apartment; this is their home, and they should be entitled to all of these services. Regardless of age or stage of life, all of these services could enhance their care. It could help them live more comfortably. It could prevent them from having pain and symptoms related to some of the issues they're facing. For instance, respiratory care—to have access to oxygen and treatment for breathing disorders would benefit and improve the quality of life of persons living in their own home, in a retirement home. To me, that's the kind of support that the home care system can really provide—be an add-on support to our retirement home colleagues.

Mr. Jim McDonell: I have a question for Graham from ACE.

I know in my time as an MPP, especially in the opposition, I'd never heard of the ACE group. But as I say, we quickly found that when local residents came in with an issue or were trying to find or get access to a home—although we didn't, I guess, get a chance to talk to the

group very much, we certainly knew we got results. It just seemed when we forwarded something to you, there was never anybody who ever came back with a further issue. It got so that we were asking some of the family members to come back and give us some feedback, because they all seemed to be positive.

I've been listening to your presentation. I really do appreciate all the input you have provided to the committee.

Can you please let us know how you see this bill protecting those who choose to live in a retirement home?

Mr. Graham Webb: I think there are some important aspects of this bill that allow the RHRA to directly contact residents, which are not in the present legislation—also, the prohibition against loans from retirement home residents.

We are concerned about issues of confinement that had been in the Retirement Homes Act, that were repealed by operation of statute. We're very concerned that those confinement provisions should never be again re-enacted towards retirement homes.

I think those are our major concerns with the Retirement Homes Act.

Thank you for your kind comments.

The work with long-term care really falls to my colleague Jane Meadus and other staff lawyers who have worked with her presently and throughout the years. I can tell you, it's a very important need, because there are very few other avenues for access to justice for long-term-care-home residents who need actual legal advice from a lawyer.

Mr. Jim McDonell: Usually, when somebody came to us, it was after many tries or many disappointments, so it was interesting that you always seemed to come through. For an office that seemed to always face a brick wall when we went through the ministry to try to get some solutions, the ACE group—and I know that in many of the cases, in talking to our clients, they'd be somewhat apprehensive in contacting you. We'd just say, "The success rate has been very good—and if you could come back and speak to us about your experience." So it was nice to have that resource, because it always worked, and it was certainly something of a real plus for our side in trying to advocate for our residents.

The increased enforcement measures in this legislation should create a better long-term care system in Ontario. Can you let us know how you see this helping those living in long-term care—the different avenues that we put in this legislation?

The Chair (Ms. Laurie Scott): Final minute.

Mr. Graham Webb: Thank you for those comments.

I'd like to refer that question to my colleague Ms. Meadus, who has extensive expertise on that.

Ms. Jane Meadus: Thank you. Again, the regulations we're going to see in there, just exactly how the fines are going to be enforced—I think that we definitely need very strong enforcement. I'm encouraged that the minister says that the inspectors are now going to be provincial offences officers. That's a really important part of the legislation. The last provincial offence that was prosecuted was, I

think, in 2009. Having it there doesn't help unless someone could actually lay the charges. We've seen not a lot of enforcement.

Getting rid of the voluntary plan of correction is such a good idea, because it was very unhelpful; it didn't really do anything. To get these new inspection plans that are going to be reviewed by the ministry—I think that's the way to go. That's the way they used to do it, and I think that's a great job.

The Chair (Ms. Laurie Scott): That ends the government round of questions.

We'll now move to the opposition for the next seven and a half minutes. MPP Berns-McGown.

Ms. Rima Berns-McGown: I'd like to continue to probe into this whole question of the way that the palliative care issue is framed. I think that the framing you talked about, Jane, makes a lot of sense, and I think that's where Dee's wording was heading as well—although slightly different. I understand, from the perspective of the resident, why those differences would feel very different—why the rewording and the reframing would feel very different.

I wonder if Jane—and then you, Dee, if you would like—can talk about why the reframing is important from a care provider perspective. I'd really like it if you could go into some depth on this, and also discuss why you think that those changes, that reframing you were talking about, aren't in the bill at the moment, and what we need to do to make sure that it gets into the bill.

Ms. Jane Meadus: I'll be quick, because I'd like to let Dee have some really good comments on this.

I think that if you're framing everything as this being a palliative care philosophy and that every plan has to have palliative care, you're really pushing the fact that everyone is going to die. That really has been some commentary that we've heard through the legislation and in the debates—about how this is somewhere people go, and it's only 18 months, and that most of them are going to die. No wonder the stats are so high that people don't want to go to long-term care. If you were told, "Here's a place where you can go to die," most people wouldn't want to go there for very long either.

We have to make these facilities places where people want to go and live. Just like my daughter was thrilled to go live in a dorm at university, I want seniors to be thrilled to go to a long-term-care home because they get to live out their life—not go in and be inundated with things that are asking questions about how they want to die.

Ms. Rima Berns-McGown: Dee, do you have anything you would like to—

Ms. Dee Tripp: [*Inaudible*] the most important for this, for this term. I read the new residents' right number 25 to a number of residents, and not one reacted positively from the get-go. I heard everything from "Well, that's doom and gloom," or "I didn't move into long-term care to die. I got better. I actually stabilized." Devora said it herself: "I didn't move into long-term care to die. I need some help."

This is about culture change. It's about social change. It's a bigger picture. If we're talking about palliative care

from the general public standpoint—these are residents' rights. These are not rights of care providers. These are residents' rights, and if residents are not identifying with those rights or feel that they support their lived experience, then we have to reword them. Residents' rights are not a document to support care delivery from a provider perspective; they are what residents can look towards—look on the wall, look at their education, and look at the law and say, "This is what is important to me." And residents have said, "That resident right rubs me the wrong way."

Devora, over to you.

Ms. Devora Greenspon: Well, I have to tell you, I phoned my son about the new change in the act, and he had two words—he said, "Mom, that's insulting and insensitive."

Ms. Rima Berns-McGown: Thank you so much to all three of you. It feels to me as though this encapsulates something that all of you have been saying, which is that this should not be a paternalistic way of providing a beautiful home for people who need the level of care that is there in long-term-care homes. This reframing strikes me as really important, and I hope the government members are hearing everything that you're having to say.

The other thing that I think is really important about what you were talking about today, Jane, is that question of people being held against their will. That seems to me to be so fundamentally wrong, and we did see that playing out again and again during the pandemic. I wonder if there's anything else you'd like to expand on there and what we need to do to change that.

Ms. Jane Meadus: Certainly. I guess this again goes to that—

The Chair (Ms. Laurie Scott): I'm sorry; I'm going to have to interrupt. There is going to be a vote in the House, so I have to suspend the meeting for 30 minutes. We'll resume shortly after the vote—if you could all hold that response. There will be two minutes and 12 seconds left when you come back from the vote. I'll just please ask everyone to stay connected. It will be shortly after the next 30 minutes that we'll resume. I am gavelling out.

The committee recessed from 1702 to 1731.

The Chair (Ms. Laurie Scott): Thank you, everyone, for your patience. We are going to resume committee. There are roughly two minutes and 12 seconds left. I don't know who was about to speak, but you probably remember, so carry on. I think someone was replying.

MPP Berns-McGown?

Ms. Rima Berns-McGown: Yes, Jane was about to let us know what needs to be done to fix the question of people being held involuntarily—involuntarily confined.

Ms. Jane Meadus: Thank you very much. As I said, I'm sort of making this my life's work. Last time I was before committee, I actually brought a resident who had been illegally detained for two years.

What we have to do in order to prevent illegal detention is to ensure that people who are determined to be unable to leave, so incapable or some other format—advise them that they can challenge that at the Consent and Capacity Board; have someone authorize it on their behalf, but have

the full ability to go to the Consent and Capacity Board around challenging either the defining of capacity or the decision of the substitute decision-maker or a bunch of other things that are in that legislation, and also the right to advice. Parts of those are in this legislation, but not all.

Ms. Rima Berns-McGown: So there is more that needs to be done in this legislation, is what you're saying. It needs to be fixed in here.

Ms. Jane Meadus: Right. Funnily enough, these are amendments to a piece of legislation that has not been passed yet, so what we really need is for them to be actually enacted at the same time as the rest of the legislation—

The Chair (Ms. Laurie Scott): Final minute.

Ms. Jane Meadus: —from 2010.

Ms. Rima Berns-McGown: I trust that the government members are listening to that. It doesn't make any sense to carry these systemic flaws forward when we're busy trying to fix systemic flaws.

On the home care front, I think that it is absolutely fabulous that we're trying to enable more people to be able to live their full lives at home. I think this is really important. We've had experience with that in my family as well, and I can give you the examples of many friends and neighbours.

Are there any other things you would like to see in the legislation?

The Chair (Ms. Laurie Scott): You only have seven seconds left, but go ahead—I don't think they're going to let your mike go on, so maybe in the next round you could finish. You guys can sort it out.

The government side has four and a half minutes in our final round. MPP Triantafilopoulos, please.

Ms. Effie J. Triantafilopoulos: I'd like to begin my comment and question by thanking all the residents who have actually joined us on the panel today. We all need reminding that the long-term-care homes are in fact your homes. I've been listening very closely to what you've said about that. It is a place to live, it is a place to be able to nourish relationships and friendships, and it is a place where it's important for your essential caregivers to be able to come and support you, both emotionally and in other ways. So I want to thank you all very much for being the voices for the many other residents who live in long-term care.

I want to move to our plan to fix long-term care—this is to the second pillar of our plan, and that is protecting residents through better accountability, enforcement and transparency. The proposed legislation would actually update the residents' bill of rights to address recommendations we have received from third-party reviews, like the long-term-care commission's. Residents will have the right to be supported by a caregiver, and the role of caregivers will be strengthened and clearly recognized going forward. The proposed legislation would align the language in the residents' bill of rights with the grounds of discrimination in the Ontario Human Rights Code and make the residents' bill of rights easier for residents and

family members to understand. It would allow the government to establish new requirements for resident and caregiver experience surveys and establish emergency planning provisions that include planning for pandemics. It would also enable the minister to create a long-term-care quality centre.

I wonder whether you might comment on what I've just talked about in terms of our second pillar and if you've got any further feedback and suggestions on how to improve what we've got here.

I'll leave it open to whoever on the panel wants to jump in.

Ms. Dee Tripp: I'll jump in initially.

Hi, Effie. Thank you for that wholesome question.

The residents' bill of rights, the one that speaks not about palliative philosophy of care—let me just start with that one first. That residents' right does conjure up some confusion, so I appreciated you saying that the revision to the residents' bill of rights is aimed at causing less confusion. But because the term “palliative care philosophy” is used in there—to the general public, to non-medically-trained people, “palliative care” or “palliation” equals “close to death.” There's a difference between end-of-life care and palliative care, but for the vast majority of people, “palliative philosophy of care” means, “Oh, my goodness. I'm about to die, or people think I'm about to die.” So there's education needed. If the wording absolutely cannot be changed—I don't know why it couldn't—there would have to be a definition in the interpretation section of the bill to address that.

The quality centre is a good addition. Our recommendation would be to harness the strengths and skills and scope of practice of the CLRIs—

The Chair (Ms. Laurie Scott): Final 30 seconds.

Ms. Dee Tripp: —to be that centre of excellence or to be that centre of quality.

Jane, I'm not sure if you have something you would like to add.

Ms. Jane Meadus: I have two things. One is that the inclusion of all those rights from the Human Rights Code suggests that the Human Rights Code didn't apply in the beginning, and what I think people don't recognize is that there's nothing special in these residents' rights. Residents have all these rights, with or without. The problem is that we put them in rights because of the lack of enforcement of those rights. People should understand that residents' rights are there because they have been trampled on, and residents have every single one of the rights of a citizen. They don't have to be in these rights.

The other thing is that I disagree with Dee a little bit. I think that the quality centre should have no affiliation with any long-term-care homes presently providing care. It should be absolutely separate and independent, and the CLRIs are not such—

The Chair (Ms. Laurie Scott): Thank you so much. The time has been spent.

I now turn the next four and a half minutes over to the official opposition and MPP French.

Ms. Jennifer K. French: Actually, Jane, what you were just saying—could you finish that thought?

Ms. Jane Meadus: Yes. The CLRIs are—I understand it's Baycrest, Bruyère, and one other facility that escapes me at the moment; I think it's one of the Schlegel homes. They are ongoing facilities that have ongoing care. I don't know what makes a quality centre—we don't know what that means—but I don't think it can be affiliated with anyone who provides care. It has to be something that supports the sector but that is independent of the sector so that it can provide criticism as well as support when it's needed.

1740

Ms. Jennifer K. French: I'm going to return to Dee. Earlier, you said that the word “developing” was removed, regarding the surveys; that rather than involving residents' councils in “developing” the survey, that that word has been taken out. Is it specific to that word? Is there a section taken out? Is this accidental? Is this purposeful? If you have it handy, could you point me in the direction of where I would find it in the bill, so that we can point to that for the government? I hope that they haven't left it out purposefully.

Ms. Dee Tripp: It reads exactly as it currently does in the Long-Term Care Homes Act, except that one word is omitted. It's in part III, “Quality,” under the “Advice” subheading: “The licensee shall seek the advice of the residents' council and the family council, if any, in carrying out the survey and in acting on its results.” It used to say “developing, carrying out and acting.”

Ms. Jennifer K. French: Well, that seems intentional. That's too bad.

Jane, different folks have come before the committee and spoken specifically about the need for whistle-blower protections. I've been working on a private member's piece of legislation about long-term-care accountability, then this bill came up. I'm still working on it, though. There's still the need, unfortunately. Where whistle-blower protections are concerned—even as I'm working with the legislative drafters—there is language in legislation suggesting protections, but the reality is that people are not feeling protected or being protected.

Maybe we don't have enough time today, but I would love to know your thoughts on what whistle-blower protection could look like in legislation. What would we need to see either in statute or regulation?

Ms. Jane Meadus: I think that there's certainly the enforcement part. It is in the legislation, but very often, for residents or family members who ask the ministry to enforce that, it doesn't happen. This is often specific to trespass orders, which cannot be made against visitors, but which happen all the time and are enforced. People are afraid they're going to—

The Chair (Ms. Laurie Scott): One final minute.

Ms. Jane Meadus: And so, making it very clear—I know that Voula's Law did that somewhat, but I think it has to be set out in legislation that “trespass to property” cannot be used for visitors, and with residents, they have to have a way of getting it enforced. Part of what we would

be looking at under this legislation that I didn't talk about was potentially having a stand-alone tribunal of some sort, where things like that could be brought to it—and also elements of care issues, where they would have an independent tribunal where you could bring evidence, as opposed to relying on inspectors.

Ms. Jennifer K. French: As it goes with all presenters, if there's anything further you would like to submit to us, we would be glad—whether it can make it with this ridiculously quick turnaround for amendments, or just going forward, to continue to bring voice to the specifics. I would certainly value your expertise and input.

Chair, do we have much more time, or is that it?

The Chair (Ms. Laurie Scott): Five seconds, so basically no.

Ms. Jennifer K. French: Okay. Thank you.

The Chair (Ms. Laurie Scott): Thank you very much to all the presenters of this group for presenting. We'll let you go for the rest of the evening.

MS. MAUREEN McDERMOTT
ONTARIO ASSOCIATION OF
SOCIAL WORKERS
DR. HUGH ARMSTRONG

The Chair (Ms. Laurie Scott): The next group of presenters are being let into the room. I'll just remind them that they have seven minutes for presentations. We're going to start with Maureen McDermott, the Ontario Association of Social Workers will follow, and then Hugh Armstrong.

I would ask Maureen, if she is ready, if she could start the presentation, please.

Ms. Maureen McDermott: Good evening. I want to begin by thanking everybody for this opportunity to come in and speak with you about the long-term-care act and long-term care itself.

I am a caregiver. My mother resided at River Glen Haven in Sutton, Ontario, for two years. She just passed this May. I'm also still a caregiver, actually, for her roommate there, so I'm very much involved.

I want to thank you for allowing me to talk about this. I had some notes written down, but I'm going to skip them—because I watched some before.

I do want to start off by saying I think it's a really unfair advantage—to the fact that we had 24 hours to prepare a seven-minute presentation and a written component. So I would like it noted for the next time that more time is definitely required—as well as more than seven minutes.

I'm just going to go right into it. You know that she was at River Glen. River Glen was one of the first homes to be taken over with a mandatory takeover back in the first wave. Thirty-six residents died in this home. The reports that are out there about what happened in this home are in fact actually still happening.

Let's jump right into enforcements and licences. I appreciate the fact that in this new bill, you are actually talking about doubling down on fines. That's fantastic, but

I'd like to know, when was the last time there was actually a fine invoked? As I heard earlier—I have to laugh—two times zero is still zero. Not one single fine has happened during this pandemic.

We don't have to go through all of the information that has been given out there—it's widely known through every single report—and the fact that this actual home is now being considered for a 30-year extension and an extension of beds. The long-term-care act needs to put through these enforcements before anything can go forward—that is with regard to critical staff shortages, IPAC shortages, anything that came to light, and why they lost their licence. These things need to be fixed before any further funding can go through.

Sorry, just give me one second here.

I'm going to talk about the residents' bill of rights, with regard to being able to visit. There were 169 days I was locked out from my mother in her home during the first wave. In the residents' bill of rights, it clearly states that they do have these rights to be heard; they have rights to see who they want, to visit who they want. We know, obviously, that that's not true.

Sorry, it's really distracting. Are you listening? I'm being really distracted by—you're all over the place there. It's a little unnerving to be here today, and I just appreciate the attention.

Back to the residents' bill of rights: They have the right to have a conversation in privacy. There is no privacy in a four-person ward room, which is what my mother was in. Residents would sit there and watch us cry and hug. Any conversations that had to be had with residents, especially with my mother—she was hard-of-hearing, so my voice had to be amplified, and there was no privacy. With regard to the bill of rights, those things are not happening. Again, that needs to be addressed before any further amendments are done to that.

The More Than a Visitor Act would definitely solve the fact of keeping families locked away—when we're back to the bill of rights here. They had the right to see family. They had the right to be cared for by family. Putting through the More Than a Visitor Act and including it in the long-term-care act would definitely solve this problem.

I want to talk about the accountability, transparency and enforcement—the other pillar that you talked about: Again, this is a toothless section. There is no enforcement that has been happening. In fact, I went and researched River Glen that had been taken over because of the gross neglect. There are supposed to be yearly inspections. They actually haven't had one since 2018. Thirty-six residents died, I'll remind you, during that first wave, and there still has not been an inspection. Its licence was revoked. Southlake took over. We were promised that there was going to be a microscope on this. Well, there's no microscope, there are no inspections, and there are certainly no fines.

1750

Critical staff shortages absolutely have to be fixed under any licensing is going to be considered going further.

The Chair (Ms. Laurie Scott): Final 60 seconds.

Ms. Maureen McDermott: Thank you. That's a quick seven minutes.

Putting my mother into long-term care, in fact, was worse than the day that she died. This government needs to hear those words and make sure that that is taken into consideration. This long-term-care act could improve long-term care. If you are 50 years and over and live in this province and you plan on aging—then that needs to happen. The bill of rights needs to happen. The quality of care needs to happen. The minimum four hours cannot wait until 2025, because it's too late for this one, and in fact, it's too late for the residents who reside there now. So 2025—

The Chair (Ms. Laurie Scott): Thank you very much. I'm sorry; your allotted time is up.

I now call on the Ontario Association of Social Workers, please.

Dr. Deepy Sur: Thank you, Madam Chair, Vice-Chair, and the members of the Standing Committee on the Legislative Assembly for the opportunity to speak with you today. My name is Deepy, and I'm the CEO at the Ontario Association of Social Workers. With me is Vanessa Rankin, senior policy adviser.

OASW is the voice of social work in this province, representing nearly 8,000 members. As the largest regulated profession providing psychotherapy in Ontario, many of our province's registered social workers—20,000 ORSWs, in fact—can be found working across the continuum of health care in urban, rural and northern communities. We're delivering vital psychosocial and mental health services, including within the province's long-term-care homes.

OASW certainly welcomes the intent of Bill 37 and the focus particularly placed on providing culturally safe and emotionally focused care, delivering comprehensive palliative care, and the acknowledgement of the complex physical and mental health needs of residents. We know that our residents here in Ontario who enter long-term care are extremely vulnerable and living with complex needs, including mental health concerns and dementia.

The successful outcome of the intent of Bill 37 is premised upon the delivery of proactive psychosocial care. When I say "psychosocial care," I mean care that addresses the psychological, social, emotional and behavioural needs of residents. This includes mental health, psychotherapy, dealing with caregiver distress, addressing the cultural needs of residents, and supporting palliative and end-of-life care. Prior to the pandemic, 44% of residents in long-term care had a diagnosis and/or symptoms of depression, and now we're dealing with even more additional trauma incurred from COVID-19 specifically. This puts all of our residents at risk of worsening mental health, and we're concerned that this could be directly linked to the lowered quality of life that we've seen in many research outcomes. They need our help.

Despite evidence pointing to the significant mental health care needs of our residents, there's a notable lack of attention to this in Bill 37; now is the time to make bold changes to ensure this is proactive and that we include

psychosocial and mental health care for our residents. Their families and loved ones expect and depend on this. To achieve the care residents desperately need, we must ensure that social workers are in every home in this province, delivering that care.

Therefore, we respectfully recommend that Bill 37 be amended so that: (1) psychosocial care be added as an aspect of care covered under the “Plan of care,” and as a distinct program of care under “Care and services”; (2) the provision of social work services by a registered social worker be mandated in all long-term-care homes; and (3) every licensee of a long-term-care home ensures that a registered social worker is on-site for a minimum of 30 minutes per resident per month to provide direct social work services.

Part II, section 6(3), of Bill 37 refers to the aspects of care under a plan of care. However, it does not include a reference addressing the mental health of residents within that plan of care. Imagine our residents who are experiencing social isolation, depression, and/or anxiety, or all three, not having ready access to the counselling and mental health care that they need and that is required to be built in right from the start of an onset of a plan. Our members have shared that the lack of inclusion of psychosocial care within the plan of care has resulted in this being entirely absent or only added after a mental health crisis has struck. Therefore, we recommend the addition of psychosocial care as a required aspect of the “Plan of care” within the new act.

Additionally, part II of Bill 37 refers to the programs of care and services available to long-term-care residents. This section includes services like recreational and social activities and dietary services. However, it does not make mention of the mental well-being of residents.

Including psychosocial care as a distinct program of care under “Care and services” is critical. This type of program is actually included in long-standing models in the United States and has been recognized as a best practice and quality standard by Health Quality Ontario for those living with progressive and life-limiting illness. Therefore, we do recommend the addition of psychosocial care as a distinct program of care under part II, “Care and services.”

I’ve had the opportunity now to speak to you about the need to include psychosocial care in the “Plan of care” as a program, but in order to achieve this, residents need to have access to services in a timely way. Every licensee of a long-term-care home is currently worded so that we ensure a written description of social work service is available in the home and that the needs of the resident are met. The current wording in the Long-Term Care Homes Act, 2007, should be amended to include the provision of social work services by a registered social worker—RSW—and that it be mandated by all long-term-care homes. In reality, long-term-care homes are not actually mandated to ensure that social work services are provided. RSWs are uniquely trained to deliver this care within homes, and the absence of them creates a gap that is attempted to be filled by other professionals, such as

registered nurses, registered practical nurses and PSWs, who are not specifically trained.

In fact, the preamble of Bill 37 intends to acknowledge—

The Chair (Ms. Laurie Scott): Final minute.

Dr. Deepy Sur: Thank you—that residents have diverse physical and mental health needs. To enable that we are proactive and efficient, we also recommend that every licensee of a long-term-care home ensure that a registered social worker is on-site for a minimum of 30 minutes per resident per month to provide direct social work services.

Now is the time to implement a vision for comprehensive care. As a direct practitioner myself and a leader in the industry for a number of years, I know that including and addressing the well-being of our residents is paramount. Making this important change will signal our commitment together for a positive impact on the quality of life of residents and caregivers across the spectrum and life span of care.

Thank you for the opportunity to share the recommendations.

The Chair (Ms. Laurie Scott): Thank you very much for your presentation.

I’d now call on Hugh Armstrong.

Dr. Hugh Armstrong: Hello. Let me begin by thanking the Chair and members of the committee for according me the opportunity to present my perspective on the draft long-term-care act. I’ve been researching and publishing on health care for over 30 years and, during the last decade, have conducted numerous and intensive ethnographic studies of long-term-care homes in Canada and in five other countries: the US, the UK, Germany, Norway, and Sweden. During the pandemic, I have continued conducting and analyzing transcribed phone interviews with staff, residents and families in Ontario.

The act is of vital concern to long-term-care residents, staff and families and, indeed, all citizens. Your obligation as a committee is to conduct meaningfully on it—a heavy obligation. The draft is complex. It contains a number of admirable provisions, including many items from the former act—I guess it’s still the current act. But I will address here just two of the draft’s troubling features.

1800

The first is the use of the terms “mission-driven” and “mission statement.” The concept of “mission-driven” came to prominence last April with the final report of Ontario’s Long-Term Care COVID-19 Commission. In the report, mission-driven organizations were distinguished from dividend-driven organizations. The commission was very skeptical of the latter, arguing that providers should be focused on care, not profit.

This distinction is maintained in the draft Bill 37 preamble, which adds mission-driven organizations to not-for-profit organizations as ones that are to be promoted according to the act. The draft act then proceeds, however, to obliterate the distinction in its section 4, which declares that every long-term-care-home licensee must provide what is now termed a mission statement. This

means the inclusion of all for-profit homes. They are all in fact instructed that they must declare that they are driven by the primary goal of providing quality care. No home will declare to the government or, indeed, to the general public that it is dividend-driven, notwithstanding the fiduciary responsibilities of its directors. This shift to include all for-profit homes is not only in conflict with the commission's position; it also flies in the face of the overwhelming body of evidence that not-for-profit and public homes—in Ontario, this means municipal homes—usually provide better care than do for-profit homes. Criteria such as death, comorbidity, hospitalization and verified complaint rates are systematically employed by researchers in reaching this conclusion.

The public understands this. When given the choice, prospective long-term-care residents and their families disproportionately favour not-for-profit and municipal homes, leaving the less desirable for-profit homes with shorter wait times for admission.

This brings me to my second point. The contrast between the staffing of for-profit and not-for-profit homes was only intensified and made more visible by the pandemic. As with the other differences noted just above, there is a distinct pattern of lower staffing levels in for-profit homes.

Meanwhile, insufficient staffing was almost universally viewed as a crucial concern pre-pandemic; it became deadly once the pandemic hit. The government recognized this issue in raising PSW wages temporarily, restricting regular staff to working in a single home, and expanding educational opportunities for nurses and PSWs.

The need to move towards an average of four hours of actual, direct care per resident per day is recognized in the draft act. The hours are to be provided specifically by RNs, RPNs and PSWs, which is all to the good—even if the benchmark of four hours was developed in the United States 20 years ago, when acuity levels, that is resident needs, were much lower than they are today. The devil, however, is in the details. The move to the four-hour level is far too leisurely, as has just been pointed out. Most residents now in our homes will have passed away before the 2025 date at which the four-hour level is projected to be reached.

The proposed legislation has other shortcomings on the vital issue of staffing. The draft's commitment to appropriate levels is unacceptably inadequate. It repeatedly uses the term "targets" when the term "requirements" is needed. The draft lacks the sense of acute urgency that is called for. This is no time for the government to let itself off the hook with vague target commitments.

Equally important, the calculation of hours is based on averages over all 625 homes taken together.

The Chair (Ms. Laurie Scott): Sorry; final 30 seconds.

Dr. Hugh Armstrong: Thank you. This renders the calculation useless for it means no accountability of the individual homes and no enforcement of any failure to meet these low levels. The averages should apply and be publicly reported for each home at least annually.

To conclude, delete all references to "mission-driven" and "mission statement" from the draft. As the commission and most other independent observers make clear, we should be moving in the direction of not-for-profit and municipal ownership and operation of our homes.

The Chair (Ms. Laurie Scott): Thank you very much. Your time has ended.

I will now go to the official opposition, for seven and a half minutes of questions. MPP Berns-McGown will begin.

Ms. Rima Berns-McGown: Ms. McDermott, you said, "Putting my mom into long-term care was worse than the day she died," and that you felt it's critical the committee hears that. I wonder if you can expand on what you meant by that. I think that's really important.

Ms. Maureen McDermott: Thank you very much for asking that question.

It's hard to do this without the emotions because they're so heavily implanted. I was from a very large family. I had four siblings, brothers, and putting Mom into care was just never going to be an option between all of us—we would figure it out, whatever happened to her; she just simply wouldn't be in care. Life happened, and I lost all my siblings, so I was on my own caring for my mom, and I was not going to let that care go.

You can see in my home here behind me, I have lots of stairs. We brought her home for about three weeks, I think we lasted. With dementia and Alzheimer's, the needs just exceeded what I could safely do for her. There was absolutely zero choice for home care in Ontario. We had the odd PSW in so I could have a shower; that was about it. So I hung on for dear life to care for her, to the point where it was becoming unsafe for everybody.

So, to hand that care over, I had a lot of expectations about what was going to happen. Unfortunately, I was completely naive, because it was a crisis situation, so I really didn't know between for-profit and not-for-profit. When I brought my mom into the home—it was the very home, actually, that we used to joke about, "Well, we know you're not going to end up there"—it was the first bed to come up. At the time of a crisis, you're just focused on solutions.

I guess, again, I was really naive to think that there would be some support for me as well, handing that care over—that that would be considered.

I found out very quickly, within the first hour of being into that care, that the main priority was the money. They kind of took my mom away, took me into a basement, and it was all about the money: "When are we going to get payments, payments, payments?" And there was nothing for me—"Okay, you're done. We don't want you to see her again. Out the door." I cried outside that door for four hours and wanted to bring her back, and I didn't care if it killed me at that point to care for her. It was so bad.

COVID-19 happened, and then I was locked out from her. She was all I had and my absolute everything, and I was resorted to caring for her outside of a window and on broken Skype calls. I would phone when she got COVID-19, and I got hung up on six times by the home. At that

point, I started to pray that she was going to actually pass so that we didn't have to endure this pain of neglect, because I had pretty high standards of care for my mom—and it was not being met, it hasn't been met, and it's not being met for the residents who are in there.

1810

So when I say putting my mom into long-term care was worse than the day that she died, that's why. The day that she died was relief—it was relief that we didn't have to do this anymore.

Ms. Rima Berns-McGown: Thank you so much for sharing that. I know that was really difficult.

I think that what we've been hearing today over and over again is why this particular act doesn't actually fix the issues that you are discussing.

Dr. Sur, I wonder if you could please give us some concrete examples of how the psychosocial care that social workers give improves the lives of all residents of long-term-care homes and why it should be mandated, as you suggest.

Dr. Deepy Sur: I'm going to let Vanessa Rankin, our senior policy adviser, take this.

We absolutely contribute to the care for the team and the caregivers as well.

Ms. Vanessa Rankin: Thank you, Deepy.

In answer to your question: We understand psychosocial care to actually be the premise of the successful delivery of all care in long-term care, including medical care.

In hearing Ms. McDermott relay her experience and what she encountered, I am viscerally upset for her.

I'm upset that there wasn't a social worker who met you at the door, and I'm upset that there wasn't somebody who walked you through what was going to happen, and that what you had to deal with was discussing money. That shouldn't be the experience for anyone entering long-term care, nor their caregivers or family members.

I think primarily what attention to psychosocial care does is that it protects the mental health and psychological well-being of both residents and caregivers. We focus on the trauma that can occur when a caregiver is bringing a loved one into a home. We know from family members—and Family Councils of Ontario has done a ton of great research in this area—that it is some of the worst moments when this occurs. There's immense guilt that individuals feel and face. You really do need someone there not just addressing physical care needs and asking about funding; you need someone addressing those impacts.

The Chair (Ms. Laurie Scott): Final minute.

Ms. Vanessa Rankin: Additionally, once a resident is in long-term care, we know that their mental health care significantly impacts their social functioning and their physical health. They're intricately linked. If we were actually to really focus on delivering a high quality of care for our residents in long-term care, it must include a focus on psychosocial care, and a big portion of that care is looking at the mental health care needs of residents—delivering both individual and group psychotherapy and

counselling, as well as psychosocial education and support for caregivers and residents.

It also helps alleviate pressures on interdisciplinary care teams who can be set up to focus on what they do best: physical care. So leaving psychosocial care to social workers who are experts in the delivery of this care also helps to improve flow within homes and allow folks across the interdisciplinary team to practise to their full scope.

The Chair (Ms. Laurie Scott): We'll now move to the government side for seven and a half minutes of questioning, MPP Wai.

Mrs. Daisy Wai: I would like to start off with expressing my condolences to Ms. McDermott. I fully understand what you're going through because my mother-in-law is going through this exact situation. She's 92. I understand—when you say your mom was 93—what you have gone through. With our family, we understand that it will be difficult for us. We've gone through the whole pandemic time. Especially when you just put your mother in during the pandemic time, not being able to visit her at that time, it is difficult. We understand that. We go through the window visits and all that. But I guess among our family members—we encourage each other, knowing that if we bring her outside from the home just for a few minutes, it may be dangerous for her; not so much for us. So we have endured that. She has got her vaccine, and we have got our vaccine, and we are now being able to visit her. Even so, it is not the pandemic that is the concern—she just got checked into the hospital last night because of some other complications. It is hard for all of us, any one of us, with our loved ones inside—whether it's our own home or in a nursing home or long-term care or whatever. It is hard to see our loved ones going through this hard time. Luckily, I think they are giving her some medication. She might be able to pull through it. But realistically, with her age, when we make her pull through it at this time, there may be other challenges for her. It is a very difficult situation for us to go through, as well.

I thank you for sharing your emotions today. I think that can be one of the grieving processes we all have to go through. By hearing what you just expressed, to me especially—it prepares me and my family down the road on how to go through, or manage, my own grieving process. Something I was encouraged to do is that if you have some concerns, just express it out—if you want to cry, just cry; it's okay. That is a way to go through those grieving periods. All I can say is, I share your concern. I hope you can go through that grieving process and that will go away soon, especially when you have your loved one, your mom, so close to you.

I also have to share one other thing. My mother passed away. For 10 years, I was not able to cry. I was at her deathbed; I was not able to cry. For the past 10 years, I can't even cry. These can be feelings and emotions suppressed in us—so by all means, express it. Unfortunately, the pandemic is something that no one wants to have happened, and we are all experiencing different kinds of challenges in different ways. I hope that you go through

the grieving process sooner and faster, because it's not good for your health, either. We all understand that.

That's all I would like to express for Ms. McDermott.

I would also love to say to Vanessa, thank you very much for coming in to share with us.

I serve as the parliamentary assistant for the Ministry for Seniors, and this is an area where we've been encouraging our partners, whether it's different organizations in the community—this is an area where we would love to support our seniors. Whether it's the long-term care or the seniors—our government is putting extra funding just to support that.

When you shared about the psychosocial work—that is extremely important. In fact, I know that the pandemic has given a lot of challenges to our seniors, especially when they are isolated. Whether they are at home or whether they are in long-term care or retirement homes, they all experience this. We will be happy to partner with you.

Are there any other suggestions that you see, where we can work further with you—because you are trying to sing to the choir; we totally believe that, and we are here working with you. It's not just the nurses and PSWs that are a team; you are part of the team with us.

Ms. Vanessa Rankin: I really appreciate that, and your acknowledgement and commitment to mental health care for seniors in the province.

Certainly, long-term care is just one area where we see the need. We do know that poor mental health care should not be a predetermined outcome of aging. Depression is not supposed to come with age. This is an issue that we need to address. Whether you're living in a community or you're living in long-term care, you still deserve access to appropriate mental health care and support.

1820

A few things I can share with you that I think are appropriate to know, beyond what we've shared about just the domain of long-term care—

The Chair (Ms. Laurie Scott): Final minute.

Ms. Vanessa Rankin: Certainly, within home and community care in Ontario, social workers are present, delivering critical mental health care system navigation and case management to seniors in their homes. However, there are not many of us doing this work, and I think if we were able to increase the support in community, that would go a long way to supporting seniors and their caregivers to stay safe and well at home, which is largely where everyone wants to be.

I think we also need to look at shoring up our mental health supports in the places where our community members go for help—so looking at primary care, looking at family doctors' offices, and where else we can provide easy and ready access to mental health support. There are 20,000 registered social workers across this province. We are in rural and urban communities, and we are here to work alongside you to support the mental health of our seniors in community, long-term care, wherever it is they're residing.

The Chair (Ms. Laurie Scott): We'll now move to the official opposition for seven and a half minutes, please. MPP Mantha.

Mr. Michael Mantha: I'm MPP Mantha. I'm in northern Ontario. Don't be surprised; as a northern MPP, this is my office, in my vehicle. This is how I get around. This is where I work.

I listened to everything that the panel had to say and to offer. I want to see if you share the same frustrations that I have.

Just a couple of weeks ago, this piece of legislation came on the floor of the Legislature. We debated it very quickly, over the course of a few days. You've been all provided today with seven minutes to bring your ideas forward—amendments, frustration, concerns—highlighting all of the issues, that you're hoping that this legislation will be revised and will be amended by this government in order to get change.

My fear and my frustration is that a decision has already been made and a lot of the mission statements that we want to see revised, a lot of the targeted social care, psychological care that we need have already been decided. The fact that we're going to fast-track for-profit modelling has already been decided.

Do you share the same frustration that I'm feeling right now—that decisions have already been made? We are going through a process right now, and we are just expressing our frustrations, but the decision has already been done.

How do you feel about that, Ms. McDermott?

Ms. Maureen McDermott: I'm just going to be really honest: I have nothing else to lose. The thought crossed my mind when I was doing so much scrambling and preparing and rearranging schedules and everything with my 24 hours' notice, with my seven minutes. Truly, what it felt like is that it was going to ring on deaf ears.

I apologize, Laurie, but it was incredibly distracting, when I was trying to speak from the heart and control my emotions, and you were talking to someone else.

That's how it feels that this is going to happen—that it's just going to fall on deaf ears again. It's a process that the government is going through because they're mandated to. I hope I'm wrong.

I was told that everything that we say today will go down in the history books, and it's going to be part of the Legislature. So we can be hopeful.

But let's be honest: For the last two years, this government has been promising an awful lot. And what has happened? Absolutely zero. What we see inside long-term care right now: one RN for three floors; two PSWs on a floor where residents are immobile and require two people for a lift—I can go on and on and on. We've been doing that for two years. What we need is action.

The four years is not going to cut it. That needs to happen immediately. The staffing needs to be—I don't know where you're going to get them from. It's not a desirable place to work.

When you start taking words and changing them, like "requirements"—when somebody says to me, "You're

required to do something,” that sounds like that’s not negotiable; I have to do that. To change that word now to “targets”—“targets,” to me, is like a wish, a hope, a dream. And if it’s not reached, what are the consequences? Nothing. So it’s language like that that also has to be changed and addressed here.

Thank you for people like you and in the opposition who can keep this going.

Mr. Michael Mantha: COVID-19, the whole pandemic, has really highlighted problems that have been there for a very, very long time.

What really frustrates me is, how can we expect you to put everything in seven minutes?

And for us as individuals who are trying to develop legislation and amendments—which, by the way, we have to turn over within a couple of days, by next week, and bring in these amendments into legislation, to have something with teeth, something that’s going to matter, something that’s going to change somebody’s life and our future of this province in regard to how we’re going to deliver care to our seniors. This is the frustration that I’m feeling as a person who actually develops and builds legislation.

I want to go to Mr. Armstrong. You said in your comments that you extensively looked at long-term-care homes globally. I’m very curious to find out from you: What have you seen as far as models that have worked outside of North America, particularly in the Scandinavian countries? Is it big homes? Is it smaller homes? Have you experienced other models? And would you be in a position to make recommendations?

Dr. Hugh Armstrong: I’d be happy to try. I don’t particularly use the term “models.” I certainly don’t use the term “best practice.” The reason is that while we should be learning from other places—and we have learned from every jurisdiction we have been in, including other provinces in Canada—there is no single best way. It depends on the context. You’re from northern Ontario. If we were to design a place that works in Attawapiskat, it wouldn’t necessarily work very well in Scarborough.

We need to share ideas, and we have spent a lot of time developing and articulating ideas worth sharing. We use the term “promising practices.”

We have learned a lot from, for instance, Germany. It was in Germany that we learned—

The Chair (Ms. Laurie Scott): Final minute.

Dr. Hugh Armstrong: —that we should consider lives worth living, not simply the length of time.

And we’ve learned from Norway that we should combine long-term-care facilities with other community resources, for the benefit of family members, for the benefit of residents, for the benefit of workers.

The only thing we are absolutely certain about—there are two things: one is to get profit out of the way; the other is that the conditions of work are the conditions of care. If you want good care, provide good work. And we’re clearly not doing that now.

Mr. Michael Mantha: I’m—

The Chair (Ms. Laurie Scott): We only have 10 seconds left, MPP Mantha. Sorry.

Mr. Michael Mantha: Well, you just used my 10 seconds. Thank you.

The Chair (Ms. Laurie Scott): We’re going over to the government side for seven and a half minutes. MPP McDonell?

Mr. Jim McDonell: I want to thank everybody for coming forth for this night. It’s a little late tonight because of the bells, but it is very important.

My mother passed away in 2014, and she had a twin brother and a younger brother who were in long-term care in the 2000s, not too long before she died. Anyway, she made us promise that we would never put her in a long-term-care home. We have a large family. She developed dementia near the end, but we lived in a rural area on a farm, and she was certainly able to survive. We had a lot of family around. We all took turns taking meals down to her, but it was something that, as we got later and later in her life, became a little more difficult. Again, my eldest brother said, “I promised that we wouldn’t put her in a home”—but it just speaks to the way things are, up until now.

COVID-19 certainly made a big difference in that. We have a couple of sisters who are nurses. They talked about being in long-term care and that things weren’t all that rosy—so if something happened, they may not be found until the next morning. There were a lot of things to be concerned with.

Anyway, I know that plays a lot on the workers and the mental health. It is a tough place to work, and it takes a special type of person.

1830

We talked to the Ontario social workers about the role they played. I know our government has committed to an unprecedented \$5 billion over four years to hire more than 27,000 front-line staff, but on top of that, we’ve also committed to over \$12 million over two years to expand mental health and addiction supports for front-line health and long-term-care workers. That’s on top of the \$194 million in funding for mental health that the province provided at the start of the pandemic.

I think as we’ve moved through the last five years—probably a little more than that—we’ve realized the role mental health plays in all our lives, not just in long-term care.

I know locally, during the pandemic, a number of young farmers took their lives. It just speaks again to how mental health is so important, because if you don’t have it, you really don’t have your health.

This question is for Vanessa. Do you have any comments on moving ahead and where we need to go with some of the extra services that you would provide?

Ms. Vanessa Rankin: I think that what’s critical here is really shoring up the support. We are out there. Social workers exist in these spaces, and if we think about our strategic deployment and ensuring that there are enough of us to meet the need, we have the numbers in the workforce to do this. We are 20,000 strong in the province. There are

approximately 1,000 registered social workers joining the workforce annually in Ontario, and we bring the unique skill and expertise to support the mental health concerns you're listing.

Certainly, the farming community has been deeply hit by the pandemic, and it's not a community that's often discussed, so I thank you for raising that as well. We certainly do have seniors in Ontario working in farming as well.

I think what's key is looking at where we are placed and increasing those resources—so additional funding to support mental health care in the places where a community locates that care.

Within long-term care—that's a key piece within our health care system, as I mentioned. Home and community care and primary care, even so far as into our schools—our students and parents have really struggled. Social workers are in those settings, and we can certainly use more of them.

What we're hearing from our members that's helpful for some context, particularly in long-term care, is that—again, the current act does not mandate social work services in long-term care. It only mandates a description of social work services on record in the home, so we don't necessarily have the warm bodies providing this crucial mental health care. What we're often seeing is one social worker who is spread between multiple homes, and during the pandemic, that was a huge issue, when you think about homes locking down.

What we're also hearing is that our members are not able to provide the direct mental health care they need to provide to residents and caregivers because they're being pulled in multiple directions to provide services that fall outside of their role. So we're really not using our expertise to the fullest extent we can be. We really feel that if we can increase those resources—and the funding dollars are excellent—we can champion mental health care and long-term care in a space where it's desperately needed.

We can also, as a corollary to that, support the mental health of our interdisciplinary team members. As you mentioned, they are struggling. Nurses, in particular, are at high risk for PTSD right now in long-term care. Although social workers can counsel their fellow nurses in care, that would be a conflict of interest. What they can do is act as champions for mental health care in the home. They can tap their colleagues on the shoulder and say, "Here are some supports you can access." So we can really start to change the culture in long-term care, so that both the workplace mental health and psychological safety are increased, and the provision of vital mental health care to residents in long-term care is increased. I think what's critical is ensuring we have enough registered social workers in place to do so.

Mr. Jim McDonell: You talked about the shortage of mental health practitioners. I can recount a story: The former government created, basically, a hub site in Cornwall for our region for mental health. I truly think it was a great idea. I was there at the opening, when they

were talking about all the services—bringing them all in the same building, and if you came in with an issue, there would be somebody there who would be able to look after them. He went on quite a while about the merits of it and the idea—

The Chair (Ms. Laurie Scott): Final minute.

Mr. Jim McDonell: Good. Maybe I'll just quickly go through it.

One of the parents who was there raised his hand after he finished speaking. He said, "Do you mean that if I call up tomorrow, I can get a psychologist for my son?" And he just stopped and said, "No, we can't. We just don't have any. There are none in eastern Ontario."

I think that same problem is mirrored right across the province. There's a shortage of mental health practitioners. I know we're putting a lot of money into it, but part of it is developing that staff, as you were talking about.

Ms. Vanessa Rankin: Yes. With 20,000 of us across the province and approximately 3,700 psychologists, registered social workers are certainly available and ready to support. We just need to create the spaces for them to do so.

The Chair (Ms. Laurie Scott): We'll now move on to the opposition for their four-and-a-half-minute round. MPP Berns-McGown, please.

Ms. Rima Berns-McGown: I want to say that I think that empathy is very important, but it's not as important as making the changes to this legislation that it really needs. We have been hearing all day the kinds of things that Mr. Armstrong has been talking about: the fact that the "mission-driven" phrasing is really problematic, that the evidence tells us that we need to get away from for-profit care and that—you phrased it so well—the conditions of work are the conditions of care.

I wonder if you could go back to discussing—I'm so glad that you taught me this phrase—"promising practice," and which jurisdictions you think, from your research, you would draw on to put together something in Ontario that would work for both urban and rural. Farming communities are very different from urban ones. And of course, we were hearing earlier about First Nations and the fact that First Nations care and Indigenous care, whether it's urban or on First Nations, has to be very different as well. The scope, the framing of the legislation should be able to take into account the realities of everybody who needs it, including all the culturally competent framing that should be there as well.

Anyway, I would really love to hear your thoughts.

Dr. Hugh Armstrong: We have gone around several countries and several provinces, in part because there were a lot of good ideas out there.

There were even good ideas in Texas. It has the worst rating of any state, but we were in a home where there were a couple of good things. Each manager was assigned a few residents who that manager had to keep close track of, and that manager was available to all of the family members outside. That's from one of the worst of the jurisdictions.

I'll give you an example from one of the best. It's really important that food be prepared on-site. What we don't want is bad airline-type food delivered on a tray at a set time and then taken away. I spent a good deal of time in a Swedish home where residents would get up when they chose. They were relatively small units—a dozen or so residents. They would arrive at the little kitchen area, and one of the staff would help them prepare their breakfast when they wanted, what they wanted.

I was in a Swedish home where everyone has their own room—and of course, we don't want triple and quadruple beds in our rooms. In the Swedish home, every home had its separate toilet—they were all en suite. They had a washer-dryer—every home, every room.

1840

The Chair (Ms. Laurie Scott): Final minute.

Dr. Hugh Armstrong: This meant the support worker could do the laundry—delicate, if need be—while also doing other things, and the clothes didn't get lost.

We've written widely on this stuff—four little booklets that are available for free from the CCPA on promising practices and on the tensions in them.

There are no real definitive answers beyond a couple of them that I've already mentioned: get more staff, get them better-trained, get profit out of there.

Ms. Rima Berns-McGown: Thank you so much for all your presentations today. They were really important.

The Chair (Ms. Laurie Scott): We'll now move to the four and a half minutes for the government side. MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: I'd like to start by thanking all the presenters for the wonderful presentations and very substantive points that you made on ways in which to improve long-term care.

My question is directed to Mr. Armstrong, and it is on this issue that you talked about in terms of mission-driven organizations. I wanted to point out that the language that's in the new draft legislation is taken directly from the long-term-care commission's report. The commission stated, "Currently, there are not-for-profit, for-profit, and municipal homes. The characterization of homes based on their tax status is not helpful. It is more pertinent to consider if the owner is involved in long-term care as part of its mission or in order to profit. Some owners whose tax status is for-profit operate as mission-driven entities. Others have shareholders and owners whose motive is profit."

The long-term-care commission further indicated that the "real issue ... is the philosophy and actions of the operator rather than its corporate structure."

Our government's approach to enforcement and inspections will, in fact, ensure that all operators, regardless of proprietary structure, have resident-centred care as their primary motive.

So I'd like to have Mr. Armstrong's comment on what the commission actually said in its report.

Dr. Hugh Armstrong: You're right; the commission did make the distinction between mission-driven and dividend-driven—for-profit driven—and it used that distinction in a helpful way to say that the facilities could

be built by for-profit companies, just as is the case with hospitals. But the commission was very clear that they should not be owned and operated on a for-profit basis, because for-profit is not helpful. They say—let's see if I can come up with a quote or two of my own—they should be mission-driven rather than dividend-driven. They should have a separate bill. The commission says it's difficult to understand why for-profit firms are suitable for resident care. They're clear: It's okay to build them that way, the way we build schools and hospitals, but it's not okay to operate them that way, either directly or indirectly, with contracting out.

The evidence—all kinds of evidence, going back over 20 years—is that you get better care if it's not-for-profit or if it's public; you get worse care if it's for-profit. This is true in Canada. This is true in the United States. This is true in Europe, where there have been a few incursions of for-profit care, although they don't have nearly as much as we, in Ontario, do. And residents and citizens and staff are fighting back, most successfully in Norway, where the for-profits are disappearing because they're so bad.

The Chair (Ms. Laurie Scott): Final minute.

Dr. Hugh Armstrong: It's not that we need to let the public sector build them—but we cannot have the private, for-profit sector own and operate them.

Ms. Effie J. Triantafilopoulos: I think we may actually agree, Mr. Armstrong, on this. The commission is basically saying that what's really crucial here is that the owner is involved in long-term care as part of its mission and that the real issue is the philosophy and actions of the operator, as opposed to what the corporate structure is. What we're trying—

Dr. Hugh Armstrong: The problem—

Ms. Effie J. Triantafilopoulos: Continue.

Dr. Hugh Armstrong: Sorry.

Ms. Effie J. Triantafilopoulos: Go ahead.

Dr. Hugh Armstrong: The problem with the draft legislation is that it doesn't do that. By saying every home will have a mission statement that focuses on the quality of care—that's a useless piece of paper. I could cite from Revera, Sienna, Chartwell, Extencare—they all have mission statements that talk about how important their residents are. It's a good marketing strategy—but they don't do it. If you actually look at what happens—and I don't mean every home—

The Chair (Ms. Laurie Scott): Thank you. I'm sorry, but the time is up for today.

Thank you to all the presenters—and the members, for asking the questions.

Just a bit of housekeeping: The Clerk has distributed committee documents virtually through SharePoint. The deadline for written submissions on Bill 37 is 7 p.m. on Thursday, November 25, and the deadline for filing amendments to Bill 37 is 12 p.m. on Friday, November 26.

That concludes our business for today. The committee is now adjourned until 9 a.m. tomorrow.

The committee adjourned at 1846.

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