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1st Session
42nd Parliament

Wednesday 21 October 2020

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 21 October 2020

Mercredi 21 octobre 2020

The committee met at 1530 in room 151 and by video conference.

MINISTRY OF LONG-TERM CARE

The Chair (Mr. Peter Tabuns): Good afternoon, everyone. We're going to resume consideration of vote 4501 of the estimates of the Ministry of Long-Term Care. There is now a total of three hours and two minutes remaining for the review of these estimates.

When the committee last adjourned, the official opposition had 15 minutes and 16 seconds remaining for their round of questions. Who will be going from the official opposition? Ms. French. The floor is yours and the watch is started.

Ms. Jennifer K. French: Thank you, Minister. I'm glad to have the opportunity to ask a few—more than a few—pointed questions today.

I have a question specifically about accountability licensing. What criteria have to be met for a long-term-care home to have its licence revoked? I'm wondering if any homes have met that criteria. I'm particularly concerned as we're watching outbreaks happen again, many in homes that are owned by the same operators that were responsible for some of the biggest outbreaks in wave 1. Of course, I live in Oshawa, in the Durham region. We have our eyes on homes like Orchard Villa, but in fact, there's a long-term-care home—that's my question, about licensing.

Hon. Merrilee Fullerton: It is not straightforward, so I would like to start by saying that all of our homes receive their licences; they are required to be compliant with the Long-Term Care Homes Act. Our inspectors are active, doing a yearly inspection and also any inspection that is prompted by a call to the action line or a report of some kind that would prompt swift action, usually within 24 to 48 hours, to respond.

We've seen an unprecedented situation in long-term care with COVID-19. Looking at what happened in the first wave, understanding the challenges that it posed for our homes, there are many variables that are taken into consideration when we assess the performance of those homes. So it's not just a check box. Looking at the mandatory management orders that we issued and the voluntary management contracts, it really is—the levers that the government has are to coordinate assistance for the home. Understanding that our homes have been at 99% capacity with wait-lists of 38,000, taking away a licence would really be a last resort. We would work with the home to stabilize them to address the needs, and often it's a staffing issue—

Ms. Jennifer K. French: With respect, I'm going to interrupt. I appreciate that there are things that the ministry is doing, but I'm asking specifically what the criteria about losing a licence would be and whether any have met the criteria. To my understanding, none have met the threshold for removing a licence during the pandemic.

Hon. Merrilee Fullerton: The mandatory management orders have created a response whereby a hospital will then manage the homes. But the licence—I'll let the deputy comment further on the details of that.

Ms. Jennifer K. French: I'll add one more question. You can answer that, but how many long-term-care homes have had their licences revoked in the past couple of decades?

Hon. Merrilee Fullerton: First of all, there are 13 mandatory management orders. There might be a couple of voluntary management contracts in there, but as I said, no—

Ms. Jennifer K. French: But no real revocations or any revocations?

Hon. Merrilee Fullerton: Well, because we would have to have a place for the residents to go. That would be the biggest issue—the capacity issues and the wait-lists.

I'll pass it to the deputy for the remainder.

Mr. Richard Steele: That's correct, Minister.

Certainly in COVID-19 times, since wave 1 of COVID-19, we have not revoked any licences. We have, as the minister notes, issued a number of mandatory management orders to put in, generally speaking, a hospital to manage a home, and also a number of voluntary management contracts, which really has the effect of somebody else managing the home.

The challenge with a licence revocation—which is a power that the ministry has under the Long-Term Care Homes Act. It is in the range and at the extreme range of compliance sanctions we can take. The challenge with a licence revocation, of course, is that the licensee does own the home.

Effectively, what a licence revocation means is, you're closing the home. In the current context that means, as the minister notes, we have to find somewhere for those residents to move, which is quite challenging. So the preference is always to ensure that the licensee is actually

meeting their obligations versus revoking the licence—or it is an option. In terms of—

Ms. Jennifer K. French: Can you confirm, though, that in the last 20 years, only two homes have indeed had their licences technically revoked? I'm not talking about the management orders that revoked. It's our understanding that only two—

Mr. Richard Steele: I would have to turn to my operations ADM, Sheila Bristo. In fact, we might have to go back and confirm the records. I certainly do know that it is not something that has been done frequently.

Ms. Jennifer K. French: If a licence were to be revoked, is there an opportunity to substitute management in that home on a temporary or permanent basis?

Mr. Richard Steele: Essentially, if a home is closed, then there is a closure plan that has to be put in place. So potentially, if a licence was revoked, there would have to be some kind of a transition plan put in place.

Ms. Jennifer K. French: Okay. A licence revocation, then, you're saying, is synonymous with closure, so you can't revoke a licence without, necessarily, closing a home. Is that correct?

Mr. Richard Steele: Effectively, because the licensee owns the home. Unless it could be arranged for the licensee to sell that home to a different operator, then effectively, a revocation would translate into a closure.

Ms. Jennifer K. French: So there's the opportunity for a transition plan or to arrange management or selling of the home—but there are opportunities.

Mr. Richard Steele: I'm sorry, could you say that again?

Ms. Jennifer K. French: In the event of a revocation, there could be, as you said, a transition plan, there could be selling the home, or management or something like that.

Mr. Richard Steele: Having not been through a revocation, I can't speak in great detail to what the process would look like, but of course we would be looking for an orderly closure of the home. We would need to ensure that there was an alternative location for the residents to be moved to.

Ms. Jennifer K. French: Okay.

Hon. Merrilee Fullerton: I'll just add a comment.

Ms. Jennifer K. French: Quickly, please.

Hon. Merrilee Fullerton: I think, ultimately, it depends on what you want to achieve. We're taking a very resident-centred approach. If we want to achieve the care for the resident that is needed, then we need to understand whether that revocation of the licence would actually improve a staffing level, would improve an infection prevention and control level.

What we saw in COVID-19 was homes where the staffing was getting affected early on—fear, illness or, really, just having to self-isolate. A lot of the conditions we saw were because the staffing was an issue. So if you actually think you'll improve the care that people get by revocation—I would just suggest that you need to understand many variables, including how we support homes in a crisis situation with COVID-19.

Ms. Jennifer K. French: But predating COVID-19, there was no discussion of revoking a licence, there were no bad actors that were enough in violation or had violated enough the criteria, then, is my understanding—because there have been two in the past 20 years. But I am moving on.

In addition to that, I'm interested in fines. How many fines has the Ministry of Long-Term Care issued on failure to uphold the Long-Term Care Homes Act? How many "bad apples" have been fined so far?

Hon. Merrilee Fullerton: I'll just start by giving some context to this, which is—

Ms. Jennifer K. French: I would like an answer to that: How many homes have been fined?

Hon. Merrilee Fullerton: I'll pass it to the deputy.

Mr. Richard Steele: I don't have that information. We can certainly provide that to you.

Ms. Jennifer K. French: Okay.

Hon. Merrilee Fullerton: I do think the context is important to understand. The homes receive envelopes of funding, so if you start fining, then you're actually taking dollars away from residents.

Ms. Jennifer K. French: Are there disincentives, then, for the home? Are there any penalties that have been issued or levied against the homes that have continued to be "bad apples," as I'm quoting, from the ministry? Are there any deterrents to bad behaviour, whether it's fines, licence revocation, or is it just business as usual?

Hon. Merrilee Fullerton: If you look at the Long-Term Care Homes Act, the wording in it is actually fairly punitive. What we've seen with that act is that it has not necessarily improved the conditions or the care in long-term-care homes.

We take very much an understanding approach to understand what the issues are in the homes. We coordinate support for the homes, and that's what we did with COVID-19. A fine does not solve the resident-care aspect, and I think that's what we have to keep in focus.

Ms. Jennifer K. French: However, the penalties, as you say, punitive measures, that are opportunities for the government that are in the act, to your knowledge—right now, the ministry is not able to provide the number of homes that have been fined. So, thank you, we'll watch for that answer, but I'm going to move on.

In terms of hospital management, or just management generally, can the minister confirm how many long-term-care homes have a voluntary or mandatory order issued?

Hon. Merrilee Fullerton: I believe that we are at 13 mandatory management orders, including potentially one new voluntary management contract, but I would have to double-check those numbers to be absolutely sure. I believe some of the hospitals have finished their work in the homes and they're no longer in the homes. But the running total would have been about 13.

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Ms. Jennifer K. French: Again, I'm interested in specifics in terms of criteria. What is the criteria that brings hospital management into the homes? Is this criteria

public? Is worker safety included in the criteria that would involve and bring in hospitals?

Mr. Richard Steele: I'm happy to speak to that.

Obviously, it's somewhat situational. The circumstance in which we brought in hospital management in wave 1 and have continued to do so in wave 2 is generally in the circumstance where we believe that the licensee on their own is not in a position to contain the outbreak quickly enough or rapidly enough and could use additional management help and additional resources, in terms of either infection prevention and control or staffing that a management contract can provide.

Typically, what would determine whether it's a voluntary arrangement or a mandatory management order would be one of two things—either in circumstances where we believe that speed is really of the essence, the mandatory management order would generally get us to a contract quicker, so there is a speed element there that would determine a mandatory management order; or, in certain circumstances, if we believe that either for capability or for some other reason the licensee isn't going to move quickly enough to agree to a voluntary contract.

Ms. Jennifer K. French: I appreciate hearing a bit of that process. That's helpful. But that is in the wake of, once it has been decided that there be involvement with the hospital—whether you pursue voluntary or mandatory.

Again, the criteria that would bring in hospital management, either in a voluntary or a mandatory capacity—you said it's situational. Is it indeed public?

Hon. Merrilee Fullerton: I can add some information to that. I have some numbers for you. Out of 626 homes, 15 have needed temporary management—

Ms. Jennifer K. French: So that's a correction to the 13—

Hon. Merrilee Fullerton: Yes. There has been a total of 15, and of those homes, 11 have had the hospital move out. So they've been there, they've stabilized the home, and then they've moved on. My understanding is that there are three remaining under temporary management.

Ms. Jennifer K. French: A further breakdown to that—just because now I'm thinking of voluntary and mandatory. Do you know, of those 11 that have had hospital management—were they all voluntary; were they all mandatory?

Hon. Merrilee Fullerton: The majority were mandatory—and we work with the homes to understand. I think the deputy would agree that that's the case.

Ms. Jennifer K. French: So the criteria, then, that the ministry is monitoring and then they decide, "We need to bring in hospitals or"—we'll talk later about others. You've said it's situational. Is it subjective? Where does that come from? And can the public have access to that criteria to have a better understanding of those thresholds?

Hon. Merrilee Fullerton: To be clear, it is done through the IMS table. There are multiple people at that table. That allows a broader understanding of the issues. You've heard me talk about the colour-coding so that we can understand which homes might be getting into distress, to make sure they're on the radar and—

Ms. Jennifer K. French: Is that public yet?

Hon. Merrilee Fullerton: Well, we're very clear with the numbers, and we publicize those on a regular basis. When we see the staff testing positive, we know that is a flag, and we've seen that from the beginning. So that's what happens at the IMS table—they start being active in terms of getting into the homes, activating public health.

You should be aware that the medical officers of health also have levers. So when the deputy has explained, in terms of the process, what the mandatory management orders or the voluntary management contracts, that the medical officers of health in each public health unit—they also have levers to use through the Health Protection and Promotion Act. In some instances, they've been faster. Orchard Villa would have been one of those homes where it was the medical officer of health who initiated.

Ms. Jennifer K. French: I had also asked, is worker safety included in the criteria? So there aren't criteria, but there are recommendations or broader interpretations or whatever from the table. I will admit that I'm concerned that there aren't specific criteria, so I want to make sure that worker safety is included in the deliberations.

Hon. Merrilee Fullerton: Well, it has to be, because without staff we can't care for residents. So it's very clear that staff and residents are the government's priority. Also, the Ministry of Labour has had—

The Chair (Mr. Peter Tabuns): I'm sorry to say, Minister, that you're out of time. My apologies.

Before I go to the official opposition, we have a number of MPPs who have joined us on Zoom and I would just like to ask them to confirm their identities and their locations.

MPP Hogarth, could you confirm you are who you are and where you are?

Ms. Christine Hogarth: It's Christine Hogarth, and I am in Etobicoke, in the province of Ontario.

The Chair (Mr. Peter Tabuns): Thank you so much. MPP Bailey?

Mr. Robert Bailey: I'm in the legislative precinct in Ontario—Bob Bailey.

The Chair (Mr. Peter Tabuns): Thank you so much. MPP Parsa?

Mr. Michael Parsa: It's MPP Parsa, and I am in Ontario.

The Chair (Mr. Peter Tabuns): Thank you so much. MPP Armstrong?

Ms. Teresa J. Armstrong: It's MPP Teresa Armstrong. I'm in Toronto, Ontario, in the Legislature.

The Chair (Mr. Peter Tabuns): Thank you very much. With that, we will turn to MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Minister, we have heard a lot about hallway health care in the province, and I know that the Premier is very committed to ending hallway health care. I've heard you say before that one of the challenges facing our health care system is the length of time hospital patients wait to be discharged into long-term-care homes.

We also know that currently there are 38,000 seniors on a waiting list to access a long-term-care bed. In a report

last year by the Financial Accountability Officer, they confirmed that the previous Liberal government ignored the sector. Indeed, between 2011 and 2018, the number of long-term-care beds in the province grew by only 0.8% while the population of those 75 years of age and older grew by 20%.

I was very, very pleased to hear about the pilot project with North York General Hospital to give vulnerable patients direct access from hospital to long-term care. Minister, can you speak to us about how this project will help address hallway health care, and can you also expand on how this front-door-and-back-door flow helps improve the quality of care for residents and ends hallway health care?

Hon. Merrilee Fullerton: Thank you for all your good work on behalf of Ontarians for long-term care.

I've been very clear that our government made a commitment to seniors and their families to improve long-term care in Ontario. I'm sure you've heard me say that many, many times. That's something we began when we were made a stand-alone ministry in the summer of 2019. We quickly got to work with Justice Gillese's report, addressing the staffing crisis that had been pre-existing and looking at the wait-list of 38,000 and how we were going to develop capacity and create innovative programs, such as the community paramedicine program, to assist people staying in their homes even longer. All of this makes a difference to ending hallway health care, and we've been working on this steadily since the beginning. It's absolutely critical to understand long-term care as an important piece of the solution for ending hallway health care and for our alternate-level-of-care patients in hospital.

This direct access bed pilot is an example of how government, together with our long-term-care partners, is using innovative measures and ideas to solve what has really been a long-standing problem with that growing wait-list, particularly over the last number of years.

What we see with alternate-level-of-care patients is that they can't go home; they're at a level of care where they really need more support. They really can't go home, so there has to be another way to allow hospitals to keep the flow of patients going so that they can provide elective surgeries and urgent care that people going to hospital needing acute care require.

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In June 2020, 51% of alternate-level-of-care patients in Ontario hospitals were waiting to be discharged to long-term care. That's just over half. Some of them can be discharged to other settings, but 51% really need long-term care. It also speaks to the level of complexity that we're seeing in the long-term-care applicants as well. Their complexity has really grown in the last number of years.

Progress reports for the North York General Hospital collaborative effort on direct access beds will be completed at six months and 12 months. I think we have to continue to learn through these efforts and through these pilots what's working well, what we can do to make it work better, what might make it work in a replicable way for other hospitals to be assisted and for people ultimately to get the care they need when they need it—whether it's people going to hospital needing acute care or whether it's people and their families needing the support that long-term care can provide. All of this has to work together in an integrated and a coordinated way.

To be eligible for the 18-month pilot project, the patient must (1) occupy a bed at the North York General Hospital; (2) require immediate admission into a long-term-care home; (3) have been an alternate-level-of-care, or ALC, patient at North York General Hospital for at least 60 days, waiting for a long-term-care-home placement. We're very optimistic that this pilot project will improve the flow in our hospitals and help to end hallway health care. It's not going to be just one solution needed; it's going to be many solutions. But this is, as I said, something that we can learn from. We can potentially replicate it, iron out any issues within it, and it's also going to help us reduce that long-term-care wait-list. Potential residents are counting on that, as well as their families—and certainly, I understand as a family member, having gone through this with a couple of my family members. I know how hard it is when you reach a certain point.

With all of these types of solutions, I'm very hopeful that we will be able to make progress with that, and I look forward to good results from that. Overall, we need to improve quality of care here in Ontario. I appreciate everyone who is collaborating on that. Thank you.

Mr. Richard Steele: I think ADM Sheila Bristo has some additional comments.

Ms. Sheila Bristo: Thank you, Minister.

Good afternoon, Chair and committee members. My name is Sheila Bristo. I'm the assistant deputy minister of the long-term-care operations division.

The long-term-care operations division supports long-term-care-home placement in the province. The ministry's long-term-care placement process is based on the applicant or decision-maker's choice, need and consent. The ministry recognizes the importance of fairness and consistency in long-term-care access for those who need it. The ministry is working to build a system that focuses on residents in providing a place our province's most vulnerable can call home. We are investing in several long-term-care initiatives to move people off wait-lists and into homes faster.

Patients designated as alternate-level-of-care in hospitals are a key contributor to hospital capacity pressures in Ontario. These patients no longer require the intensity of services provided in a hospital. They remain in hospital beds while waiting for a space to open in a more appropriate care setting, such as home and community supports and long-term-care homes.

Across the province, we know that about half of hospital patients designated as requiring an alternate level of care are waiting for long-term-care home placement. For example, long-term care accounted for 45% of Ontario's alternate-level-of-care patients and 59% of the cumulative alternate-level-of-care days in August 2020. These hospital patients are part of over 38,000 applicants

waiting for admission to one of our 626 long-term-care homes that collectively have 78,000 beds. The median time to placement for all long-term-care-home applicants is 132 days. This high number of alternate-level-of-care patients contributes to hospitals being overcrowded. This results in longer wait times for Ontarians to receive hospital care and patients receiving care in places that do not support rest, healing or recovery.

In order to address these capacity issues across the long-term-care-home sector, the ministry is implementing several initiatives. For example, we are adding new beds and redeveloping existing older beds to modern design standards. The ministry is also investing in specialized services, such as behavioural support units.

The ministry is also aware that hospitals in Ontario are experiencing capacity pressures due to COVID-19 that are sometimes intensified by alternate-level-of-care patients in hospitals who are awaiting placement into long-term-care homes.

In response to COVID-19, the government modified and streamlined requirements for long-term-care-home admissions, readmissions and discharge to make this challenging time as simple as possible for families.

Long-term-care-home admission requirements have been modified to expedite placement for hospital patients. These pandemic provisions in the regulation provide rules in the special circumstances of processing the admission to long-term-care homes from a hospital during a [*inaudible*].

The Chair (Mr. Peter Tabuns): You're muted. We can't hear you.

Ms. Sheila Bristo: Hello?

The Chair (Mr. Peter Tabuns): We can hear you now. You were off there for a while.

Ms. Sheila Bristo: Yes, sorry, I don't know what happened there.

The Chair (Mr. Peter Tabuns): Gremlins.

Ms. Sheila Bristo: Gremlins. I'll continue.

The Chair (Mr. Peter Tabuns): Yes, please.

Ms. Sheila Bristo: One important targeted initiative I want to focus on today is a pilot project aimed at alleviating alternate-level-of-care pressures from patients who wait long periods for long-term-care-home placement. The pilot project is for direct access beds in long-term-care homes for eligible hospital patients.

The pilot project leverages a submission received by North York General Hospital. It is aimed at facilitating faster access to a long-term-care home, allowing hospital beds to become available more quickly for patients in need of hospital care. The pilot project will last for 18 months, in which alternate-level-of-care patients at North York General Hospital who are awaiting discharge to the Seniors' Health Centre long-term-care home for at least 60 days would have priority access to some existing beds at the long-term-care home. These beds are called direct access beds.

The rules for placement into long-term-care homes are set out in the Long-Term Care Homes Act, 2007 and O. Reg. 79/10, and, as of July 10, 2020, include requirements specific to these beds. The regulation allows the Minister of Long-Term Care to designate a specified number of beds as direct access beds and set out terms and conditions for these beds. The long-term-care-home licensing must comply with the terms and conditions in the designation. The regulation also sets out the eligibility criteria applicants would have to meet to be placed into the direct access beds and establishes operational requirements to facilitate the implementation of direct access beds.

Applicants would be eligible for a direct access bed if they:

—require immediate admission into a long-term-care home;

—are determined to be eligible for long-term-care-home admission as a long-stay resident under section 155 of the regulation;

—occupy a bed in a public hospital specified in the designation; and

—have been an alternate-level-of-care patient at that hospital for at least 60 days, waiting for long-term-care-home placement.

The appropriate placement coordinator is required to keep a separate waiting list for direct access beds and will place eligible applicants on the waiting list. Applicants who are placed on the waiting list for a direct access bed are not allowed to be placed on any other waiting list at the long-term-care home where the direct access beds are located.

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The placement coordinator must only place an applicant on the waiting list for a direct access bed if the applicant or their substitute decision-maker consents to their being removed from every other waiting list for the home.

Of note, the decision to put someone on the direct access bed waiting list for Seniors' Health Centre has no impact on the applicant's position on waiting lists for any other long-term-care home.

As with all admissions, if the applicant has a substitute decision-maker, they must also be provided with the relevant information, and consent must be sought from the substitute decision-maker.

Applicants on the direct access bed waiting list must be ranked for admission based upon the time at which the hospital they are occupying the bed in determines they require an alternate level of care leading to discharge to a long-term-care home.

If there are no eligible applicants on the direct access bed waiting list when a direct access bed once designated becomes available for occupancy, the bed may be made available to regular, long-stay applicants.

To maintain system flow and priority access for direct access bed applicants, residents who are admitted to a direct access bed from the regular waiting list must be transferred to another bed in the home in the class of accommodation chosen by the resident as soon as such a bed becomes available. The licensee must notify the placement coordinator of every transfer out of a direct access bed and into a regular bed in the same long-term-care home within 24 hours. This will allow the placement

coordinator to know that a direct access bed is available for a new admission.

Different transfer rules apply to residents who were admitted to a direct access bed from the direct access bed waiting list. Residents admitted to a direct access bed from the direct access bed waiting list can request to transfer to another class of accommodation in the long-term-care home. This kind of transfer must be done in accordance with the existing transfer rules set out in the regulation. If the resident transfers to another class of accommodation, they are deemed to continue to occupy a direct access bed. The bed the resident is transferred into is deemed a direct access bed, and the vacated bed is deemed a regular long-stay bed.

Since July, the ministry has been working with the participating hospital, long-term-care home and placement coordinator, which is the Central LHIN, to address implementation considerations and to prepare for the pilot. The ministry anticipates that a designation letter will be sent to the licensee shortly to officially designate direct access beds and specify the terms and conditions for the designation.

It is intended that existing long-stay beds at Seniors' Health Centre will be converted into direct access beds. The direct access beds will not be additional new beds.

Applicants on the current Seniors' Health Centre long-term-care wait-list who are not at North York General Hospital will still have access to the home. Every second long-stay bed that becomes available for admission will be designated as a direct access bed, provided there is someone on the direct access bed waiting list who either matches the class of accommodation—or the placement coordinator offers admission to someone on the direct access bed waiting list. The rotation between direct access beds and long-stay beds will continue until a maximum of 18 beds are designated. This represents 10% of the long-stay beds at Seniors' Health Centre.

The purpose of this pilot project is to assess whether this approach to long-term-care placement should be implemented at other long-term-care homes and hospitals. It is proposed that the designation letter require North York General Hospital to submit to the ministry progress reports at the six- and 12-month marks, with a complete evaluation at the end of the pilot project. The reports would include key performance indicators to track impacts on North York General Hospital's alternate-level-of-care rates, North York General Hospital emergency department impacts, long-term-care-list impacts, and occupancy rates of direct access beds. The ministry will use this information to assess the success of the pilot.

The ministry is aware that the current COVID-19 pandemic may have an impact on the pilot project and will keep that in mind in its analysis of the outcome of direct access beds. The—

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're now out of time.

We will go to the official opposition. MPP French.

Ms. Jennifer K. French: Just to refer back to some of the earlier conversation around fines or penalties: It's my understanding, Minister—you said that this came out of the envelope funding, and you expressed that fines would perhaps reduce the funds available for care. Does that mean that somebody who should have a fine just gets to operate unpunished or without consequence?

Hon. Merrilee Fullerton: Let me start, and then I'll hand it to the deputy.

I think if we look at the compassion that workers bring, the important role that—

Ms. Jennifer K. French: I'm referring to the operators in this case, not the workers. I'm thinking of Orchard Villa—and it's personal for my community.

Hon. Merrilee Fullerton: I understand that, and my heart goes out to everyone who has been affected by this.

COVID-19 is a worldwide challenge. It is a virus that attacks the most vulnerable, and it has been a real challenge for homes of all different types.

When we look at the importance of being able to support the staff—and that's why I talk about fines—

Ms. Jennifer K. French: No, my question, Minister, with all due respect, is—because you said it would reduce levels of care, by fining an operator. Therefore, can the operators continue without penalty?

Hon. Merrilee Fullerton: I don't recollect if I used the words "level of care." If I did, then so be it. I don't remember using that. I do remember saying that because the envelopes are quite defined and homes actually have to return dollars if they do not use the full amount in those envelopes—so if those don't get spent, they get sent back to the government.

My concern with a fine would be a situation where a home is struggling to provide staffing in a crisis, and instead of helping them get the staff that they need to provide the resident care, we somehow—I do not see how fining them would help them in that situation. Ultimately, if the staff aren't showing up for work, if the staff are sick, if the staff are not supported, then they can't get the residents the care they need.

Ms. Jennifer K. French: I am very clear in wanting the staff to have the support that they need, as is, I'm sure, everyone across communities. It is that the owners and operators, if they are problematic and have a history and a track record of problematic management, that there's no way—the profit, then, is guaranteed—for them to feel punishment or pain or any kind of consequence. That's my concern.

Hon. Merrilee Fullerton: Certainly, anything that's negligent or unlawful needs to be addressed through the proper channels.

During the context of the COVID-19 outbreaks—particularly the one in your area, which I completely understand would be quite close to your heart—what we have to understand is how to support those homes in a crisis.

1610

A fine, in the context of COVID-19, will not get more staff into that home. The urgency is to shore up the staffing and to shore up the care for the residents—

Ms. Jennifer K. French: Sorry, we're circling through the same—I hear the minister. You very clearly made that point, and I value the input. However, I'm going to move on, because what I'm not hearing is that there is a financial disincentive for the owners and operators at this time.

Hon. Merrilee Fullerton: Perhaps the deputy has something to add, if you wish.

Mr. Richard Steele: Thank you, Minister.

To your earlier question around the number of homes that have been fined: I believe the answer is, there aren't any, because under the current regulations, when you look at the range of compliance tools that are available—at this point, fines are not one of the tools that are currently available under the act. That's the answer to that question.

In terms, though, of financial implications for an operator who is non-compliant, I think it is important to recognize that if, for example, the ministry imposes a mandatory management order, the licensee has to pay the costs of the manager. That, typically, is not a cheap proposition. Generally, that in and of itself would be a financial disincentive, regardless of costs of the reputational impact of having a mandatory management order on a licensee, which is significant.

Ms. Jennifer K. French: Unfortunately, as I'm hearing from families, the reputational harm is the only disincentive. That is a frustration, I think, for folks in communities. However, I'm moving on.

I found it interesting to hear about the direct access care beds. I have a question not related to that, but not unconnected. In terms of pilots with the transitional care beds, I do have a follow-up question that is a bit more involved.

Specifically, as we're seeing more transitional care spaces pop up, which ministry is the regulatory authority for these spaces?

Mr. Richard Steele: For transitional care beds?

Ms. Jennifer K. French: Yes.

Mr. Richard Steele: It would be the Ministry of Health.

Ms. Jennifer K. French: Thank you.

I understand that, not just during COVID-19 but pre-COVID-19, there is a need for a creative stopgap because successive governments didn't address the need for long-term care. We are all very familiar with the pressures of ALC, alternate-level-of-care, beds in communities.

Matt Anderson, when he was the CEO of Lakeridge Health, remembers my sitting in his office and reading quite upset emails from some community members. To his credit, he and I were on the same page to try to remedy those concerns from community members regarding the transitional care beds—that there were some pilot projects and problems with the transition.

Since that time, my office is hearing from families who, because of COVID-19, were very challenged too. They were unable to visit their loved ones initially. That has been remedied. But again, what we were learning was that these transitional care units were not regulated the same way, that they did not have the directives from this ministry. It seemed to be that they are in a grey area and figuring it out as they go.

As we have moved further in the pandemic, my concerns are: Who is directing the transitional care units and ensuring that they're following the policy of the private retirement home that they might be based in, that they're getting consistent information—that the families are getting what they need that would be consistent with the care and directives provided were they indeed long-term-care residents or patients?

Hon. Merrilee Fullerton: I'm going to pass that to the deputy because the retirement homes are under the Ministry for Seniors and Accessibility.

Ms. Jennifer K. French: Yes, you're right, and this is where the challenge comes in. You have the hospitals or the Ministry of Health paying room and board to private retirement homes for the physical space, and then they're paying public dollars to the private care providers—Bayshore, for example—for their care. They don't fall under anyone's actual jurisdiction; they're a weird grey area. When we've had an alleged COVID-19-positive case in a transitional-care unit in my area, on a floor of a retirement home, they couldn't move the hospital beds because the doors aren't wide enough. So it's a challenge for now—the actual policies and procedures in the face of a pandemic. I want to know who's going to take responsibility and be liable, because the families are begging to know.

Mr. Richard Steele: It's not perhaps a particularly helpful answer, but in the transitional bed context that you're referring to there, essentially the hospital would be contracting with the retirement home for space. So it would be the hospital—and because of that, it would be the Ministry of Health. It would be a question you'd have to pose to the Ministry of Health. It certainly is not being regulated under the Long-Term Care Homes Act.

Ms. Jennifer K. French: Thank you very much. That was a clear answer, and that was what I thought was the case.

Does that also mean, though, that their numbers are not going to be reflected in the—where are those numbers reflected of those patients if they are COVID-19-positive?

Mr. Richard Steele: They would certainly not be reflected in the long-term-care-home numbers.

Ms. Jennifer K. French: So the hospital, right now, as I'm hearing from families, is not responsible for the care; they are directing them to Bayshore. But Bayshore, for example, is not receiving directives from long-term care, and yet they are providing that care.

I'm drafting a fairly comprehensive letter laying out all of the questions that I have. I can maybe save some of them for that, but I would be very glad to connect, because this is a very strange grey area that is problematic, potentially, and that I would say needs to be addressed as we have these temporary stopgaps and we continue moving forward with them.

France?

The Chair (Mr. Peter Tabuns): Madame Gélinas.

M^me^ France Gélinas: If you can share anything about this—everywhere there are transitional-care beds, there are those issues. We also have them in Sudbury. The

hospital partnered with the long-term-care home to put people in a hotel, who now get staff from an agency, and it's really hard to know what protocol they are supposed to follow, what they fall under. I fully understand why we are doing this. It's just not clear for any family members who run into an issue which door they knock on—Bayshore, the long-term care, the hospital that started this—so they come to their MPP. But I'll move on.

I want to come back to testing. I know we talked a little bit about this yesterday, and I want to make sure that I get it right. Long-term-care residents will get tested if there's an outbreak in the home. Staff get tested every two weeks. Visitors get tested before they can show up for a visit. Essential caregivers have to get tested every two weeks. Did I get that right?

Mr. Richard Steele: Yes, except visitors would essentially also need to be tested every two weeks if they're coming regularly.

M^me^ France Gélinas: But if you're a one-off, as long as you can show you've been tested, you're good.

Mr. Richard Steele: Yes.

M^me^ France Gélinas: So long-term-care residents, as soon as there's an outbreak—and we all know what the definition of an outbreak in long-term care is. If one staff tests positive, every long-term-care resident gets tested?

Mr. Richard Steele: I think the extent to which—is it every resident, is it residents on a particular unit? That would be very much at the direction of the local public health unit. They would provide direction to the home—again, is it everyone, is it some of the residents—based on their assessment of the outbreak.

M^me^ France Gélinas: And who would decide if those tests get a priority turnaround time? If we have an outbreak in a home and we have to test a section of a home or a whole home, then they automatically get priority testing? How does that work?

Mr. Richard Steele: It should be the case that if there is an outbreak at a long-term-care home, those tests should be getting priority treatment by the public health labs. It's a process like any other process, and sometimes the process breaks down. But that is the objective, and it's something we continue to work with all of our partners on, to ensure that that is in fact what's happening.

M^me^ France Gélinas: Does the priority testing come with a deadline, as in, "Once the swabbing is done, we want the test result within 24 hours" or "We want the test result within 48 hours"? Are there deadlines to meet?

Mr. Richard Steele: Typically, the target for the testing would be 48 hours. There certainly have been circumstances where that target has not been met, just because of the general testing situation. But that is the target, yes. And clearly, the sooner the better.

1620

M^me^ France Gélinas: I agree. Is the 48 hours including the swabbing, or from the time that it hits the lab?

Mr. Richard Steele: This is in terms of the specific definition of the 48 hours. My preference would be to get back to you so I'm completely accurate, but I believe it's from when the swab is taken to when the result is posted and available online. But I would prefer to confirm that and make sure that's completely accurate.

M^me^ France Gélinas: Chair, can I have a note so that I can remember to ask again to get the answer to that question? Sometimes I forget.

The Chair (Mr. Peter Tabuns): It will be noted by the Clerk.

M^me^ France Gélinas: Thank you.

I am moving on. Are you able to tell us how many WSIB claims happened because of the pandemic or during the pandemic in long-term care? Are the number of claims up, down, the same?

Mr. Richard Steele: I don't have that information.

M^me^ France Gélinas: It's not something that you keep track of ever?

Mr. Richard Steele: We certainly haven't been tracking WSIB claims as a general practice.

M^me^ France Gélinas: Okay. Let's say there is a whistle-blower in a home, so a PSW who finds out—there is mandatory reporting for regulated health professionals. I think there's mandatory reporting for all care providers in a long-term-care home.

Interjection.

M^me^ France Gélinas: You're saying yes, I'm still on the right track?

Mr. Richard Steele: For resident abuse.

M^me^ France Gélinas: For resident abuse. This goes to the director of care of the home. Where do those reportings of resident abuse go to?

Mr. Richard Steele: Essentially, it could come in to us in a number of different ways. If it's coming formally through the home, it would come in to the ministry as a critical incident report. If it's not coming through the home, if it's just a staff member, as you say, exercising their right to whistle-blow—and they may just call the ministry directly—that would come in as a complaint.

M^me^ France Gélinas: And that would go to the complaint line for long-term care?

Mr. Richard Steele: That's right.

M^me^ France Gélinas: Can you tell if those complaints are going up, down or the same?

Mr. Richard Steele: I'm going to ask if ADM Sheila Bristo can comment on the numbers of complaints for this year versus last year. I might have that information here.

Ms. Sheila Bristo: I will have to get back to you on that.

M^me^ France Gélinas: Thank you. Do you know what percentage of workers in long-term care have access to sick days, and did that change during the pandemic?

Mr. Richard Steele: The staffing study that was completed and released in July—certainly, yes, as part of that exercise, there was data gathered in terms of both full-time and part-time, and also casual staff who would not have benefits. So we do have some information on the percentage of staff who do and don't have sick leave benefits. Again, we can certainly get that for you from the staffing study.

I don't know if ADM Janet Hope—

The Chair (Mr. Peter Tabuns): You have three minutes left.

Ms. Janet Hope: I'm Janet Hope. I'm the assistant deputy minister for the policy division with the Ministry of Long-Term Care.

We can check the details that are available in the staffing survey, but at the top of my memory, I don't know that we have specific data on the number of staff who are in receipt of sick days and those who are not. But we will double-check whether, in fact, I'm correct in that and get back.

M^me^ France Gélinas: Sounds good.

Mr. Richard Steele: If I could just make a supplementary comment—one thing we certainly do know is that with putting in place the single-site order in wave 1, that did lead to a significantly increased number of staff working full-time versus part-time, and there would have been benefits associated with that.

M^me^ France Gélinas: The follow-up question will be from Wayne.

The Chair (Mr. Peter Tabuns): Mr. Gates.

Mr. Wayne Gates: I know my colleague asked about this, but I don't think she followed it up as strongly as maybe we should. I think it's extremely important. How many WSIB claims have been made by long-term-care workers since the start of the pandemic?

Mr. Richard Steele: As I noted, I don't have that information right now.

Mr. Wayne Gates: Are you aware that it's quite high?

Mr. Richard Steele: It wouldn't be surprising to me that there have been significant WSIB claims, but I don't have that information.

Mr. Wayne Gates: The WSIB claims are extensive in long-term-care facilities. I would appreciate, either through the Chair—that you make sure that we get that information to us. I think we're only going to have an hour or an hour and a half left when we come back next week. Can you get that information for us? I think it's very, very important to show, because the problem that we're having in a lot of long-term-care facilities is that they're being denied claims. That's where presumptive language—the bill I put in place—would protect workers who did get it and are being denied by WSIB. So can you try to have that for us the next time we meet? It gives you a full five or six days.

Hon. Merrilee Fullerton: The Ministry of Labour is involved in making sure that the occupational health and safety legislation is being followed. I think what we've found in this sector is that there has not been a lot of data and—

The Chair (Mr. Peter Tabuns): I'm sorry to say you're out of time.

We're going to the government. MPP Hogarth, the floor is yours.

Ms. Christine Hogarth: I'm new to estimates. It is a pleasure to join this committee, especially in talking about the important topic of long-term care, so I do appreciate the opportunity to ask a question today. This is something that I talk about with my riding; we talk a lot about our health care workers. Everyone here in this room has talked in the Legislature about our true heroes on the front line, from our pandemic so far. All of us are grateful for the contribution and sacrifices that they've made throughout this pandemic.

In long-term care, our PSWs often develop relationships with residents—and not just the residents; the families of those residents. Sometimes those residents don't even have families, so they do become that close family. When my grandmother was in a long-term-care facility, she had a personal support worker who really did become one of the family. We really can't thank them enough for helping to make long-term care a better place to live and helping to make it a place that's a home for these people. We need to support them, we need to invest in them, and we need to protect them. We need to protect our staff so they can continue to do the critical work.

I believe it's really important for all of us to recognize what has been done to date. Can you talk about what you are doing to help these critical front-line health care workers throughout the pandemic?

Hon. Merrilee Fullerton: Thank you for all the good work that you're doing and for caring so much about our residents and staff in long-term care.

I think what we see with COVID-19 really laying things bare in terms of the shortcomings—and our staff in long-term care really are the backbone; they really are the heart of our homes—and to make sure that they are supported. We knew that the personal support worker shortage existed, and that's why we were addressing this in some ways with the Justice Gillese recommendations for registered staff. We included personal support workers in that staffing assessment that we had the expert panel do and report on, which will inform a comprehensive staffing strategy by December 2020—and to understand that there are issues with the personal support worker pipeline and retention; so not only attraction to the field, but retention.

We have really understood that economically, financially—our government has put dollars behind making sure that they are supported. But ultimately, we have to make sure that the working environment that they're in, the culture of work that they are in, values them and supports them. So there was a pandemic pay that went out earlier, a number of months ago, to our front-line personal support workers. This was a mechanism through which they would be supported during that time, with a financial improvement for their work during such a challenging time. They were asked to do things that they never would have done otherwise. So I just think it was such an important time to address that and, as we look forward, to address how we support them going forward.

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At the beginning of the pandemic, we implemented an aggressive COVID-19 action plan for protecting long-term-care homes. We issued four emergency orders, introduced three packages of amended regulations and announced $243 million in emergency funding to support the needs of the homes. This was in an effort to make staffing more flexible, understanding what the homes

would be facing with COVID-19, and also to understand that we really needed to retain these workers and to demonstrate their value. That $243 million went towards supporting personal support workers, as well as a number of other areas.

During the first wave, it was a way to demonstrate their dedication and the value of their dedication—supporting them with the financial improvement. It was a combination that led to a $4-an-hour increase for them, and that was for about 100,000 full-time, part-time, casual, clinical and support staff. I know that it was one way to demonstrate our appreciation for what they have done. Those who worked over 100 hours a month also received an extra $250 per month on their paycheques. This is monetary appreciation.

But ultimately, we do need to make our homes stabilized during COVID-19, so that we provide them with supports, integrated with hospitals, with IPAC specialists and, in some instances, Red Cross or community paramedics—people who will help—to come into the homes and make sure that the staff know that they are supported. So above and beyond the dollars, those other measures are also being taken.

Recognizing that a motivated workforce is critical to a sustainable long-term-care system, our government is providing an additional $461 million to temporarily enhance wages for PSWs. This investment will help the province attract and retain, as I mentioned before. It is an ongoing challenge for us to understand what we can do to create the interest in this sector and really destigmatize it, because it has been stigmatized for too long. I think that when we really look to the path forward, it has to be about creating an environment where people want to work, where they are valued for the work they do, not only in the dollars, but in the environment and the support that they receive, and integrating it into the rest of the health care system. It cannot be a separate entity. We understand how important it is for ending hallway health care, but also so that people can get the care they need. I've said many times that the complexity of our residents is high. Pandemic pay is one part of it, but there are many, many pieces to this—to make sure that our workers in long-term care are supported. We're developing this comprehensive long-term-care staffing strategy—that's the long-term vision dealing with the urgency of the staffing crisis that was pre-existing—and also taking measures to evaluate homes during COVID-19 outbreaks to make sure that they're receiving the support they need for their staff. I know that there sometimes is confusion about how we're approaching staffing—but there has to be not only an understanding of the emergency requirements for these homes in outbreak, but also, going forward, modernizing the long-term-care homes and the way we support the staff there.

I just think that the pandemic pay is one piece, but we need that integration. We need to understand how we modernize health care and bring it up to the 21st century for long-term care. The complexity of people in these homes really speaks to the need not only to address the dollars for the workers there, to train them, to provide an experience for them that is meaningful—even more meaningful than what they do, because it already is—but also to retain them and demonstrate appreciation and support for them.

I believe we have an ADM who is ready to speak to this, as well.

Mr. Richard Steele: Yes, I believe ADM Janet Hope had some additional comments.

Ms. Janet Hope: Thank you.

I'm pleased to expand on Minister Fullerton's remarks and give you a bit more information about the pandemic pay program in our long-term-care homes.

As has been acknowledged, some of our homes have experienced unprecedented challenges in keeping fully staffed as workers became ill, were unable to work due to concerns, perhaps, with pre-existing conditions that might put them at greater risk or, in some cases, refused to work out of fear of exposure.

The health and well-being of long-term-care residents, their families and staff have been and continue to be the government's top priority. As the minister mentioned, in recognition of the dedication and long hours of our front-line staff, the government announced in April temporary pandemic pay. This additional pandemic pay was aimed at helping front-line staff who experienced severe challenges in the workplace and were at heightened risk during the COVID-19 outbreak in the spring. It was available to support the critical work of over 375,000 eligible front-line employees working for over 2,000 employers across multiple sectors in Ontario, including long-term care—but also hospitals, retirement homes, home and community care and other congregate care settings.

From April 24, 2020 to August 13, 2020, temporary pandemic pay consisted of two elements: hourly pay, which was an additional $4 per hour on top of the existing hourly wages for all hours worked; and in addition, lump sum payments of $250 for those who worked 100 hours or more during a designated four-week period, for a total of up to $1,000 over 16 weeks in lump sum payments. This meant that eligible staff who worked full-time hours might have received up to $3,400 in pandemic pay over the 16-week period.

The implementation of pandemic pay in the long-term-care sector followed some key principles:

(1) Recognizing that long-term-care staff face an increased risk of exposure to COVID-19, it provided an incentive to encourage employees to come to work and to attract prospective employees to work in long-term-care homes.

(2) It was temporary and had no impact on pension benefits or base salaries.

(3) Eligibility was not dependent on whether there was a COVID-19 outbreak in the home or not. All staff in a home faced a real and perceived risk of COVID-19 exposure, and the goal was to incentivize all types of staff to continue working so that homes could safely operate.

(4) Eligibility was not dependent on working directly with residents. For example, cooks, security guards and

cleaners were eligible, as were nurses and personal support workers.

Following on these principles, all workers in long-term care working on-site in a long-term-care home, with the exception of management staff, were eligible for pandemic pay. This included full-time, part-time as well as casual staff, whether they were clinical or support staff. In addition, third-party agency staff or other contracted staff who were hired by or otherwise working on-site in a long-term-care home but who were not a direct employee of the home were also eligible for pandemic pay.

Tens of thousands of workers in long-term care have received pandemic pay over this 16-week period, and the Ministry of Long-Term Care has spent $321 million for pandemic pay in this sector. This investment has been enabled by funding support from the federal government, which has covered approximately three quarters of the total pandemic pay cost, with the provincial government covering the remaining amount.

The ministry has worked closely with our partners across other participating ministries and the Treasury Board Secretariat to support a consistent approach across government on many factors related to pandemic pay, payroll and implementation. This included ensuring consistent approaches to statutory entitlements and benefits.

The ministry covered the long-term-care homes' share of statutory entitlements and contributions so that there was no out-of-pocket cost to the homes to provide pandemic pay. This included covering the cost of statutory entitlements such as vacation pay, public holiday pay and overtime, as well as employer contributions, such as the Canada Pension Plan, employment insurance and the employer health tax, as well as any increases in an employer's WSIB insurable earnings due to temporary pandemic pay.

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Salary-related benefits, such as life insurance coverage and long-term income protections, were not impacted by pandemic pay. In addition, pandemic pay did not impact pensions, with the exception of Canada Pension Plan benefits or base salaries. Pandemic pay was not provided for the time employees were not in the workplace for any reason, whether that was vacation, authorized paid leave, including sick leave and time and benefits awarded under the Workplace Safety and Insurance Act, 1997.

The ministry team also worked closely with our partners—the long-term-care associations and the 613 eligible long-term-care homes—to ensure that the rollout was as smooth as possible. Upon launching the program, we held a webinar with the Ontario Long Term Care Association, AdvantAge Ontario and long-term-care operators to provide guidance on the implementation of the pandemic-pay policy. We provided detailed information on eligibility, the funding approach, reporting and payroll considerations.

We also walked operators through different redeployment scenarios so that they would be clear on how payment would flow to employees redeployed from other sectors. This ensured that an employee from another sector in receipt of pandemic pay, such as a hospital that was redeployed into long-term care, did not receive duplicate pandemic pay. If, however, an employee was redeployed from a sector that was not eligible for pandemic pay, such as a school board, that employee would receive pandemic pay by virtue of their redeployment to a long-term-care home.

Ministry staff have remained available over the past months to answer questions from the associations and from homes to help ensure that they've had the information they needed to implement pandemic pay successfully. It was decided that for the long-term-care sector, the fastest way to ensure that the funding was received by the eligible employees was to leverage our existing funding mechanisms that we have in place with long-term-care homes. In this regard, we amended our existing transfer payment agreements with the long-term-care homes to provide them with the funding necessary for them to provide pandemic pay to their staff.

To determine how much funding each home was allocated, the ministry made an estimate based on the size of the home and provincial staffing averages. This methodology was chosen because the ministry could not have, in advance, an accurate count of the number of staff who work in a long-term-care home during the eligible period or a complete understanding of the hours these employees would be working.

The estimated amount provided to long-term-care homes will be reconciled with the actual amount spent over the pandemic-pay period. This means if the funding the home received was too little to meet the actual cost of pandemic pay, the ministry will be providing additional funds. And similarly, if the funding the long-term-care home received was too much, the long-term-care home will return the additional money to the ministry.

Based on the estimation process I have just described, each long-term-care home received an allocation of $996.29 per bed for each four-week period to support pandemic pay for eligible staff. Payments provided to homes were intended to cover the hourly pandemic top-up, the lump sum payments, as well as the applicable employer statutory entitlements and deductions associated with pandemic-pay payments, as I previously described.

For smaller long-term-care homes, and these are defined as homes with 96 or fewer beds, they were given additional funding in recognition that the bed count methodology might underestimate the number of staff in smaller homes. These smaller homes received an additional allocation of up to $10,000 for each 10-week period over the 16-week period. This was intended to recognize the different economies of scale these homes face and the likelihood of a more challenging cash flow situation in a smaller home.

Payments to long-term-care homes were provided in two instalments. In June 2020—

The Chair (Mr. Peter Tabuns): Two minutes left.

Ms. Janet Hope: —each home received the first instalment, equaling 75% of the home's total 16-week allocation, or the estimated total cost; and then in July

2020, homes received the second instalment, equalling the remaining balance of 25%. Each home was responsible for allocating pandemic pay according to the conditions of the funding agreement and the pandemic-pay policy. As previously mentioned, in the long-term-care sector, payment was provided to non-management employees, workers and agencies providing on-site services.

To ensure that long-term-care homes only paid those employees who were eligible for pandemic pay and that funding for pandemic pay was used only for those purposes and not for other purposes, a number of accountability mechanisms were built into the program:

—Each long-term-care home must provide the ministry with an attestation that the information they report back to the ministry on how the funding was allocated is correct;

—All long-term-care homes are required to submit a report by an external auditor as part of a long-term-care-home annual report submitted by each home; and

—Long-term-care homes are required to maintain payroll records of the amounts paid and must make these records available upon the ministry's request.

All of our long-term-care homes received their funding for pandemic pay over the summer. While we expected employers to provide pandemic pay to eligible workers as quickly as possible, we also recognized that variations in pay periods and payroll systems exist across long-term-care homes.

As part of the reporting requirements, long-term-care homes were required to submit a mid-term report by July 17, 2020, with information on the first eight weeks of the program—

The Chair (Mr. Peter Tabuns): I'm sorry to say you're now out of time.

We're going to the official opposition. We'll start with Madame Gélinas.

M^me^ France Gélinas: I'm just curious to see on the long list of numbers you gave us—$996 per bed. How did you come up with that number? Why not $995, $999? How did you get $996?

Ms. Janet Hope: As I described, there was an estimation of the number of employees or staff in a home and numbers of beds, so it was arithmetic.

M^me^ France Gélinas: Do you remember what formula you used? What was your estimate of the number of staff per bed, to come to $996?

Ms. Janet Hope: I don't have that in my memory. We were working with the estimate of approximately 100,000 staff who would be eligible. We were estimating hours of work. We knew the number of beds in the system. As I said, we were also trying to take into account that smaller homes wouldn't have the same economies of scale, so we had the adjustment for them.

M^me^ France Gélinas: I wouldn't mind if you could go back and show me how you did the math to get to this. I would appreciate if you could share that with the committee.

I have always used about 100,000 to 120,000 staff, but now when we talk about the number of people working in long-term care—yesterday, Minister, you used 50,000 or 52,000. I forgot; I'm going by memory. Are those PSWs and 100,000 is everybody including cleaners and—who is included in those two numbers?

Mr. Richard Steele: I believe 50,000 would be the number of PSWs. Again, ADM Janet Hope might be able to provide the definitive answer to how many—the area where we have to be clear on what we're talking about is that we're talking about the number of people or the number of full-time equivalents. Obviously, the two are different.

ADM Janet Hope, maybe you could clarify our current understanding of the numbers of people and FTEs.

Ms. Janet Hope: Our estimate for pandemic pay was approximately 100,000 individuals. That would not be the total employees of all long-term-care homes, because management employees were not eligible. So that would be a slightly higher number. Again, I'm sorry I don't have that number in my head, but it's not a significant percentage.

M^me^ France Gélinas: Talking of staffing, I know that your ministry sent a memo—I'm assuming it's your ministry. Long-term-care homes, anyway, received a memo last week to provide data about staffing and other issues in the different homes on a weekly basis. I'm guessing that it goes to somebody within your ministry—Deputy Minister, you're saying, yes, I'm on the right track.

1650

Would you know, right now, of the 626 homes, how many of them have staffing concerns?

Mr. Richard Steele: I don't have that information in front of me.

If I could just describe what we've been trying to do—since the start of the pandemic, our inspection team has been reaching out regularly to our homes to check in and identify if they are in fact experiencing a range of issues, including critical staffing shortages. That's obviously something that's very important for us to understand. That's been happening on a very, very regular basis since March, and the homes have been reporting to us. What we're looking to do is to reduce some of the reporting burden on homes and switch from the inspectors gathering that information manually and calling the homes to actually having the homes self-report through an electronic system and identify for us directly if they have staffing concerns.

Basically, that is a number that's going to change daily, in terms of the homes that are reporting. I will say, at a general level, the number of homes that are reporting staffing concerns as we've been going through wave 2 has been significantly less than we saw in wave 1. Even as homes are getting into outbreak, we are seeing a different pattern play out than we saw in wave 1. That isn't to say there are no homes with concerns over staffing. We certainly do see some, but it is a substantially smaller number.

What we're seeing this time around as homes go into outbreak—we're not seeing the kind of collapse in staffing that happened in some homes in wave 1, unfortunately, as staff became infected and staff were concerned about their

safety. What we are tending to see now is that staff are more confident in the availability of PPE, in the steps that have been taken around health and safety and IPAC. Even where staff are positive with COVID-19, once they're cleared, they're coming back to work quickly. So we are seeing a different pattern in the staffing situation—again, in terms of the specific COVID-19 response that we saw in wave 1. We all understand the broader reality of staffing in long-term care—

M^me^ France Gélinas: So—

Hon. Merrilee Fullerton: May I just respond to that?

M^me^ France Gélinas: Sure.

Hon. Merrilee Fullerton: There are two issues with the staffing. One is the pre-existing staffing crisis, when there was no COVID-19. I think that has to be understood, that there are really two separate issues we're dealing with. The first is, how do we create a sector-wide improvement in staffing, in attraction to the field, in retention of the staff during normal circumstances? Then there's the piece with COVID-19. What we saw in the first wave, we all know; I won't reiterate. Now what we're seeing is a very different scenario, where the majority of our homes that we're tracking that are considered in outbreak—again, an outbreak can be no residents in the home who have COVID-19 and simply a staff member, one or more, self-isolating at home. The definition of "outbreak" needs to be understood. In the majority of our homes right now, there are no resident cases—

M^me^ France Gélinas: Coming back to my question—I agree with what you're trying to do, but what I'm interested in is the base level. Of the 626 homes, before COVID-19, how many of them had staffing issues—so that we know where we're starting from?

Hon. Merrilee Fullerton: Yes, and that's a very important point. But what we see when they're in outbreak is, they don't receive admissions. So you can see when the home starts to have a more steady state of conditions and no people coming in, then they manage better.

In terms of the number of homes that are actually reported right now, that are considered in outbreak even though they may have no resident cases, there is a very, very small number that are reporting any kind of staffing problem or PPE problem. It speaks to the steady state that these homes get into, once we can have a better controlled environment—they're not having to take admissions, or if there are other issues that would preclude those admissions from happening. What I'm saying is that it needs to be understood as two separate issues.

M^me^ France Gélinas: Yes, I get it.

This new directive, the memo that the long-term-care homes have received—will they be reporting on the number of RNs, the number of RPNs, the number of PSWs, the number of health care aides? What would those reports look like?

Mr. Richard Steele: I'm not quite sure what memo you're referring to, which isn't to say that it didn't get sent, but we do send a fair bit of communication to the sector requesting—I'm sure they will tell you—a lot of information from them.

I don't know if ADM Sheila Bristo can comment on any specific ask that we might have recently made on staffing.

Ms. Sheila Bristo: As Deputy Minister Steele mentioned, we send a number of memos out to the field to keep communications going, particularly during COVID-19. I am not specifically recalling a memo that I have sent with regard to staffing. There was the initiative, as the deputy mentioned, about data collection, which is a range of data sets that we're asking the homes to update themselves electronically so that they can do it at their convenience and not be called multiple times and have to deal with it over the phone. It's certainly more efficient for them.

We did send out a memo asking for the homes to report in on their finances from the first quarter so that we can have a better understanding of their spend—particularly related to COVID-19 and how much they are spending. There may have been a reference to staffing in that one, but I'm sorry, I'm not recalling a specific memo with regard to staffing.

M^me^ France Gélinas: All good.

If you look at the $3 that is going to the PSWs—in many of the homes, the difference in pay between the RPN and the PSW is not that wide. Is there a reason why PSWs are getting the $3? The health care aides, who have the same level of risk, do the same kind of jobs, but don't have the label "PSW," don't get it—and the RPNs either or the RNs.

Hon. Merrilee Fullerton: If we go back to the expert panel for the staffing study that was done, one of their recommendations was to make sure to look at long-term-care staff, PSWs, in conjunction and in association with and coordination with PSWs in other sectors, because if you do one thing over here, it has an impact.

The biggest issue is the shortage of personal support workers—and you've heard the numbers. Looking at how we not only create more PSWs faster—whether it's fast-tracking, return of service, keeping the ones who are in the workforce who might be considering leaving to another industry, keeping them in with the pandemic pay and increasing their wages. But ultimately, the RPNs, the registered practical nurses, appear to be in sufficient numbers; there are shortages more on the RN side and on the PSW side. In order to bring the PSWs up a little bit, as well as the home care PSWs, as well as the hospital PSWs—these were done at the same time so that we weren't losing them to another PSW sector, to try to create that pool of a stable workforce for our long-term-care homes.

Obviously, in Justice Gillese's report, she touched on the importance of understanding the supply of registered staff, including the RNs and the RPNs, but there does appear to be a reasonable supply of RPNs—not much for the RNs. I just want to give that context.

M^me^ France Gélinas: And that comes from your staffing study?

Hon. Merrilee Fullerton: Yes.

M^me^ France Gélinas: What are you going to do with this study and when can we expect action on it?

Hon. Merrilee Fullerton: That's been ongoing. We heard, as soon as we became a ministry, from multiple sources and all the consultations that we did with the sector—we heard from everyone that there was a shortage of PSWs and that we needed to act quickly on that. That's why. At the same time as we were becoming a ministry, Justice Gillese was putting out her recommendations, and I want to thank her for her good work on that. The recommendations were specifically for registered staff, but we included PSWs. So that began very, very early. That's the piece that we were building—also understanding the capacity, that as we build more long-term-care spaces, we are going to need more staff. You can't build more capacity without the staff.

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That was ongoing, but when COVID-19 hit, there was special attention on stabilizing the sector—and that's why the pandemic pay. That's why the Ministry of Health is actually the entity overseeing and leading the health human resource aspect of the strategy for PSWs—because it is in their purview. But we did have input into that. Things like return of service, as I mentioned, the rapid training, the increase in pay—all of this has an impact.

Also, how we put out the dollars and support the homes to provide the training—in the recent $540 million that we just put out maybe three weeks ago, there were dollars there for training for infection prevention and control for staff, the $405 million.

All of this has been ongoing, but particularly with COVID-19 we've had to be more intense with the support to get those staff to be interested in working.

M^me^ France Gélinas: One of the recommendations of your staffing study is the four hours of paid hands-on care. Are you committed to this? Did you cost this out? Do we know how far from this we are? Are we going to report on where the homes are at?

Hon. Merrilee Fullerton: I can tell you that this is something that we heard very strongly in all of our consultations—the complexity of the residents; the increasing need for this integrated process with the medical expertise that our hospitals can provide; the infection prevention and control expertise that was there and that we can amplify in the homes with more training, more support and more dollars; and understanding, ultimately, how we bring different entities into the homes to support the residents, whether it's simply PSWs or whether it's other measures of support that can be brought in. But it's the complexity that is really driving the need for this—again, understanding that we're already running from behind because of years of neglect. The staffing crisis was pre-existing. We're the ones who are dealing with this and actively taking measures to address it. As we try to ramp up and build capacity, we really have to understand how that four hours of care will be done if we are already in a shortage of staff.

All of these have to be integrated. Understand, you can't just do one thing without causing an impact somewhere else. This has to be thoroughly understood in a coordinated way so that we can have all these things move at the same time. The concept that we do one thing without having an impact—it just isn't the case.

If the deputy would like to add to any of that—

M^me^ France Gélinas: Deputy, with the 78,600 beds that we have, the 626 homes that we have, if we were to implement four hours of hands-on care right now—did you ever do the math?

Mr. Richard Steele: In the context of the staffing study and the government's commitment to bring forward a staffing strategy, certainly we are doing the analysis and will be providing advice and our recommendations for consideration by the government around all of the recommendations in the staffing study, including the four hours of direct care.

M^me^ France Gélinas: Does that mean that you know where we are at right now in the different homes or on average in the homes?

Mr. Richard Steele: We do have information—I believe it was in the staffing study—on what the current hours of care are. It obviously does depend a little bit on how you count, like everything.

I'm wondering if ADM Janet Hope could just provide us with our understanding of what the current picture is.

Ms. Janet Hope: Certainly. Our source of information on this is an annual staffing survey that is undertaken each year. I would say that the most recent year we have completed the survey is with respect to the 2018 year. Normally, at this time of year, we would have data on 2019, but because the reports would have been done in the spring, when homes were dealing with COVID-19, we suspended the completion of the staffing survey.

As of 2018—and this information is in the staffing study report—homes report an average of 3.73 direct hours of care per resident per day, based on paid hours. There is also a breakdown of how much of that time is provided by different categories of care. So there is an average of two hours and 18 minutes provided by personal support workers—

The Chair (Mr. Peter Tabuns): Two minutes left.

Ms. Janet Hope: —one hour and two minutes from registered nurses and registered practical nurses, and 24 minutes from allied health professionals and other programming supports. The study also provides some data on how those numbers have changed over time.

M^me^ France Gélinas: But those are paid hours, not worked hours.

Ms. Janet Hope: Correct.

M^me^ France Gélinas: If we talk about the four hours in the report, the four hours is four hours worked, hours of care; not hours paid. Did I read that wrong?

Ms. Janet Hope: The data I've read to you is—

M^me^ France Gélinas: I recognize that the data you just read to me is paid hours. But the recommendation from the staffing study that was done was to be four hours of care provided, not four hours of care paid.

Ms. Janet Hope: I believe that was the advice of the advisory group, yes.

Mme France Gélinas: That's what was shared with me.

This data used to be available. I used to FOI it every three months and get my list of 626 homes and where they were at by different staffing categories. Is there any desire by this government to make that kind of information available again?

Hon. Merrilee Fullerton: I think if we understand what we're trying to do in long-term care, which is to shore it up after many, many years of neglect, understanding the staffing and the capacity—I look at what we're attempting to do and the levers that we have to do it. It will take time to address all the shortcomings—

The Chair (Mr. Peter Tabuns): Minister, I'm very sorry, but your time is up.

We're going to the government. MPP Cuzzetto, the floor is yours.

Mr. Rudy Cuzzetto: I want to thank the minister and your PA for all the work you've done with long-term care.

I know that getting long-term care built in this province has been challenging for many governments to achieve in the past decade, which I find concerning because we know that Ontario has an aging population that will one day put further demand on a system that is already at 99% capacity. It leads me to believe there must have been something fundamentally wrong with how we were getting beds built in this province.

In last year's budget, you announced a series of red tape reduction measures for long-term care. My question is, how have these measures been impacted in the long-term-care sector, and how have these measures helped to get these beds to be built in this province?

Hon. Merrilee Fullerton: MPP Cuzzetto, thank you for all your good work. I'm particularly very grateful to you for the work you've done with some of the long-term-care homes in your area. I really appreciate it.

First of all, when we became a ministry, we set about to understand what had happened—why homes didn't get built, why spaces didn't get created—and also to understand the complexity of the residents, the staffing issues and the myriad of other shortcomings that had been neglected over many, many years. What we heard loud and clear was the frustration from the sector. Whatever kind of long-term-care home it was, it was similar—the frustrations with the very confounded process. They would sometimes put an application in and not hear back. Just listening to their stories of frustration, you could feel their discomfort with the amount of time that was going by.

So we set about to allow the process for applications to be more streamlined, to reduce the layers and the hoops that the applicants had to go through, to streamline the process so that we could get the shovels in the ground faster. Ultimately, it is about the residents, to get them into the places of care that they need, and also the families, who are struggling in many cases to support their loved ones. So this whole concept of streamlining and reducing red tape was a critical factor in getting to the levels of projects that we have on the go now, that are in the pipeline, and some of them being constructed as we speak.

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To be very specific, our government has made amendments to the Long-Term Care Homes Act, 2007, under Bill 66, Restoring Ontario's Competitiveness Act, 2019, including modernizing the public consultation process, providing the ministry with the flexibility to determine when in-person public consultations are required, and streamlining the processes related to temporary emergency licences and short-term authorizations by considering these into a single license transaction and removing written notice requirements.

Our government has taken this absolutely seriously. The commitment we had with the $1.75 billion to create 15,000 new spaces in five years and 30,000 new beds in 10 years—we've taken this absolutely to heart and have been working on this since we started in 2019. We have made good progress in reducing the red tape, and we've heard positive responses from the homes that have applied. We've used the creation of a risk-based approach for licensing approvals based on the project and the licensing risk, to understand if there is a potential for a home not really to be able to get through the process, and which ones are more likely to be able to get through it.

Standardizing the financial report form provides proof of lender information to the ministry. What you find as you delve into these, as we did back in the fall of last year, is that it's a very complicated process. And so it's not only looking at the required application process, but supporting our applicants to basically give us the information once, so that we didn't send them back with one little thing missing==so that we could get through it in a timely way and they could get on with what they needed to do.

Streamlining the collection of information in the application process to enable a faster licensing review process—in October 2019, the ministry launched a new application that collects important documentation earlier in the process, to help reduce subsequent requests for information by the ministry at later stages of the process, so basically to do a lot of it upfront and provide an ongoing contact and communication with project managers at the ministry with the applicant, so that they have a one-step process to make it easier for them.

The elimination of duplicative financial information required from licensees that have been previously submitted to the ministry—a lot of times, what we were hearing in previous years is that, again, things would languish at the ministry, things would not get put back to the applicant and the applicant had no way of understanding what was missing from the application. So this is a much more efficient process.

Consolidating licensing documentations relating to correspondence requirements into a single streamlined correspondence process—as part of this process, the ministry sets out required timelines, public consultations and the financial review process, which provides greater transparency in the application review process so applicants could understand what had happened. Sometimes

what we were hearing is that they would apply, they'd hear something for a while, and then they wouldn't hear anything for a year. This is a much more timely and efficient way of dealing with it.

We're streamlining reporting requirements for long-term-care homes, reducing the number of line items the licensee must report for their annual expenditure reporting through a consolidation of funding policies and removing the requirement for the local health integration network endorsement for long-term-care homes meeting the criteria for occupancy protection funding if they fail to meet the ministry's occupancy targets for long-stay beds.

We're committed to improving the way our homes operate, so that they can spend more time caring for residents and less time doing paperwork. We need to provide as much resources as possible for resident care. I'll leave it there.

Interjections.

Hon. Merrilee Fullerton: Sheila, are you there?

Ms. Sheila Bristo: Hello.

Hon. Merrilee Fullerton: Oh, thank you.

Ms. Sheila Bristo: Thank you, Minister.

The Ontario government made a commitment to cut red tape and reduce regulatory burden, which are holding businesses back from helping to grow the economy and create good jobs. The government set goals to reduce regulatory requirements placed on businesses by 25% and achieve over $400 million in cost savings while maintaining the regulations that protect consumers, workers and the environment.

The 2019 burden-reduction report provided an update on Ontario's efforts and accomplishments to date to address red tape and build better business environments. Of note, on November 22, 2018, the Legislature passed the Making Ontario Open for Business Act, which repealed onerous regulatory burdens. On April 2, 2019, the Legislature passed the Restoring Ontario's Competitiveness Act, which is taking 31 actions to cut red tape in 12 sectors. On June 12, 2019, the spring regulatory modernization package was announced. This is eliminating regulatory burdens in the auto sector and other manufacturing sectors. The Better for People, Smarter for Business Act, 2019, was passed by the Legislature in December 2019 and supports various business sectors, including agriculture, trucking, construction, forestry and mining.

The Canadian Federation of Independent Business gave Ontario an A- in its 2019 red tape report card. That was Ontario's highest grade ever, and a big jump from the C+ the year before. The Canadian Federation of Independent Businesses gave Ontario an A- because of the province's commitment to tackle red tape—

M^me^ France Gélinas: Point of order.

The Chair (Mr. Peter Tabuns): Point of order. Deputy Minister, if you would hold.

Madame Gélinas.

M^me^ France Gélinas: The assistant deputy minister is talking about everything but long-term care. I like mining as much as the next person, but I would prefer if she talked about long-term care.

The Chair (Mr. Peter Tabuns): Thank you. I'm not sure that that is a point of order, but I would ask the deputy minister to focus on the ministry.

Ms. Sheila Bristo: Yes.

The government's red tape reduction strategy is guided by three key principles of reduce, revise and renew. The principle of "reduce" involves identifying unnecessary and duplicative policies, forms, data sets and other reporting requirements, and to eliminate these items entirely. The principle of "revise" applies to items deemed mandatory—for these items, consider if duplicative data fields can be streamlined, and also consider the frequency of reporting. The principle of "renew" focuses on modernizing requirements to improve user experience. Principles driving this phase include digitization, use of industry standards, plain language, a small business lens etc.

The strategy is being implemented in three phases. Phase 1 involves setting ministry-specific targets by establishing a baseline count of compliance requirements found in legislation, regulation, policies and forms. Phase 2 involves finding reductions and cost savings while maintaining protection of the public, health, safety and the environment. Phase 3 focuses on implementing and reporting progress in order to measure, track and publicly report the reductions of compliance requirements.

The Ministry of Long-Term Care committed to modernizing the long-term-care home sector to contribute to the government's commitment to reducing compliance requirements. The ministry's efforts to reduce compliance requirements affecting long-term-care operators will focus on unnecessarily duplicative policies, forms and reporting requirements, while ensuring that the health and safety of long-term-care home residents remains paramount and is maintained.

The ministry is streamlining, reducing and refining the application and approvals process for long-term-care applicants for long-term-care programs, identifying opportunities to streamline approvals, reduce applicant costs and eliminate red tape in the long-term-care development program; utilizing the principles of Lean Six Sigma to develop a series of proposed changes aimed at modernizing the long-term-care development program; as well as improving policies and processes.

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To support the Unleashing a Competitive Ontario by Cutting Overregulation strategy, all ministers are required to develop a two-tiered burden reduction plan. The Ministry of Long-Term Care's two-year plan focuses on modernizing the long-term-care-home sector to streamline compliance requirements affecting long-term-care operators, while prioritizing the health and safety of long-term-care-home residents as of the utmost importance.

The Ministry of Long-Term Care has identified areas for red tape reduction in the Long-Term Care Homes Act, 2007, Ontario regulation 79/10, policies and forms. This includes items from licensing, long-term-care development, operational policy, inspections, and the funding and programs area.

Reducing the administrative burden for long-term-care homes by streamlining and modernizing the licensing program in the long-term-care sector—we are streamlining approvals, reducing applicant costs and eliminating red tape in the long-term-care development program. We are reducing red tape for prospective long-term-care applicants and long-term-care homes by eliminating duplication in policies and forms by applying the "tell us once" principle.

We are implementing recommendations from the public inquiry and adopting a balanced and risk-based approach to inspections to allow for a more proactive focus on specific areas that have not been inspected, and consolidating and streamlining expenditure reporting requirements as well for long-term-care homes. All ministries are required to report quarterly on their progress with their two-year plan.

The COVID-19 pandemic has created unprecedented challenges in the health and long-term-care sectors. COVID-19 demands a culture of continuous learning. The more we learn, the better we can plan and prepare for future waves. We are committed to applying what we have learned during this outbreak to build and strengthen the long-term-care sector.

Modernizing the regulatory environment has taken on new urgency following the COVID-19 pandemic. In order to mitigate the impacts of the pandemic on business and to position Ontario for success coming out of COVID-19, immediate attention needs to be paid to regulatory barriers and irritants for businesses without compromising important health, safety and environmental protections. Regulatory modernization during the economic recovery period supports reducing unnecessary administrative burden and increasing flexibility for long-term-care operators to more effectively respond to the COVID-19 pandemic.

The Ministry of Long-Term Care has contributed to several red tape legislative and regulatory efforts since June 2018. Most notably, amendments made under Bill 66, the Restoring Ontario's Competitiveness Act, 2019, helped reduce administrative burden for long-term-care homes and the Ministry of Long-Term Care by streamlining the licensing process and increasing flexibility for responding to emergency situations. This makes it easier for businesses to operate. Under Bill 66, schedule 8—the amended subsections of the Long-Term Care Homes Act, 2007—we have removed the director from the list of persons who must be provided a written notice if a licensee withholds approval for admission; allowed the director to determine how public consultations will be conducted; and allowed the director to issue non-renewable temporary emergency licences for a term of not more than one year, to accommodate persons affected by a temporary emergency.

The majority of the Ministry of Long-Term Care's compliance requirements are found in policies and forms. We are also identifying ongoing work. To date, there has been a reduction of 717 regulatory compliance requirements out of our target of 6,598, which is 25% of the baseline count. This represents a 10.9% reduction in red tape across the long-term-care sector.

Efforts made now through transformation initiatives are laying ground for future reductions and savings. For instance—

The Chair (Mr. Peter Tabuns): Just to note, you have a minute and a half left. Thank you.

Ms. Sheila Bristo: —this includes ongoing work on long-term-care modernization. The Ministry of Long-Term Care has focused on streamlining and eliminating red tape in its policies and forms to maximize long-term-care capacity and enable appropriate placement for those who need long-term care. There are new opportunities to identify potential burden reduction that would yield benefit for stakeholders. This will enable the Ministry of Long-Term Care to support stakeholders through the following burden reduction principles: "Tell us once," plain language, a small business lens and "go digital."

By reducing red tape and streamlining our processes, these beds will be built more quickly in communities where need is greatest. We are working towards reducing red tape, streamlining policies and increasing funding flexibilities to leverage existing investment into small homes to improve supports.

The Ministry of Long-Term Care will continue working together with our long-term-care partners to find opportunities for reducing regulatory burden, while protecting the health and safety of residents and staff—

The Chair (Mr. Peter Tabuns): I'm afraid your time is up.

With that, we go to the official opposition. MPP Armstrong has the floor.

Ms. Teresa J. Armstrong: My question is to the minister or the ADM, whichever one would like to answer.

There has been a lot of confusion around the Red Cross. In the media, it's very confusing; my constituents have been very confused around the Red Cross. I have three parts to my inquiry. When did the Red Cross first offer to provide supports for Ontario long-term-care homes? Which homes have the Red Cross coming in to help? And then, specifically, some of the Ottawa homes didn't know they were going to receive Red Cross help or, in fact, didn't ask for the help—so I just wondered if the minister could clarify if these homes weren't aware of what was happening with the Red Cross.

Hon. Merrilee Fullerton: Certainly, resources that are available for our long-term-care homes to help shore up their staffing—because there is a general staffing shortage of PSWs, and RNs as well. The federal government had offered this supply. A lot of the work that the Red Cross does is also doing assessments in terms of IPAC, in terms of processes within the home.

An old list, a preliminary list had been put together that involved homes that were previously affected in wave 1. The majority of those homes do not have any resident cases right now. So we looked at the homes that could be using that support right now, and the Red Cross is going into Prescott-Russell—which is in Hawkesbury, so it's not

in Ottawa per se, but this was primarily meant for homes in the Ottawa area.

I think it's really important to note the good work that we've done working across levels of government, whether it's with the federal government or whether it's with the municipal government. It really has been a time of tremendous collaboration. What happened there was that a list of homes that were previously affected—but the only one that they're going into at the moment is Prescott-Russell, although we are tremendously appreciative to the federal government and the Red Cross for assisting where needed, and we will be closely monitoring homes that will potentially need more support. We always have to be prepared to do that, and we're grateful to all the various groups that have come out to help. I know in Prescott-Russell the community paramedics from Renfrew have also come out while the assessments are made by the Red Cross, until they can get the additional resources to that home. So we're very much aware of how our homes are managing and we're monitoring that very closely. We appreciate all the support that is being provided from numerous groups.

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To be clear, the Ottawa area—although there are outbreaks there, it is primarily staff who are self-isolating at home. The Ottawa-area homes are generally in very good shape, the vast majority of them with no resident cases. In the case of Prescott-Russell, it is not in Ottawa proper; it's in the Champlain LHIN. But it is in Hawkesbury, and the Hawkesbury general hospital is also willing to provide support there.

It really is heartwarming to see the collaboration amongst various groups, whether it's Ontario Health, the Red Cross or the federal government.

Things can happen quickly in long-term-care homes, as you know, so we are on our toes. I think this is just a situation where there was a preliminary list that didn't get the proper approval before it went out.

Maybe the deputy would like to comment on that.

Mr. Richard Steele: Just to add to the minister's comments that we continue to assess whether the Red Cross would be an appropriate source of resources for other homes—obviously, it's really important that before any public communication goes out on any individual home, that's something that's worked through with the individual home, and the home has an opportunity to communicate with the residents and families in advance of any pubic communication rather than—

Ms. Teresa J. Armstrong: I didn't quite catch if you mentioned when this preliminary offer was made to support long-term-care homes by the federal government—the timeline.

Mr. Richard Steele: I'm sorry; it's quite hard to hear.

Ms. Teresa J. Armstrong: At roughly what time did the federal government offer the Red Cross assistance to long-term-care homes?

Hon. Merrilee Fullerton: What I understand is that we did have a home, the West End Villa in Ottawa, which had a very rapid rise in cases. We were able to get the Ottawa Hospital to come in and support, and that was done through the medical officer of health in Ottawa. So that lever was used, and then we also issued one of the management orders. Is that the way you recall it?

Interjection.

Hon. Merrilee Fullerton: Yes, there are a few of these.

Public health was able to act through its Health Protection and Promotion Act and reach out to the Ottawa Hospital. I thank the Ottawa Hospital for assisting with that—also, the community paramedics were in at the Ottawa Hospital. That would have been during the outbreak of West End Villa. What really happened was, the Ottawa Hospital was already there and the Red Cross wasn't needed. The supplies of staff and everything were being supported through the Ottawa Hospital. We didn't have need of the Red Cross at that time for West End Villa or for the other homes because they had no resident cases and they were doing quite well. But Prescott-Russell, as I mentioned, started to spike after, so we see a role for the Red Cross there. As I said, this takes multiple partners sometimes, so I thank the community paramedics for being there, too. They've been in multiple other areas assisting as well, so I appreciate that. It would have been sometime in September that that would have happened with West End Villa.

Ms. Teresa J. Armstrong: So the only home that the Red Cross is in right now is Prescott-Russell?

Hon. Merrilee Fullerton: Yes.

Ms. Teresa J. Armstrong: Were they informed before the Red Cross went into assist? You had mentioned that they get notified—because some homes said that they weren't aware.

Hon. Merrilee Fullerton: Yes. We were shocked by that as well. I think that's a situation where a preliminary list was put together and it was not approved. It's very nice to see the eagerness with which people are willing to pull together and do things in a rapid way. You can see our need for speed is very much the case with COVID-19. But in this scenario, our homes in Ottawa are doing very well. Despite being declared in outbreak, many of them—the vast, vast majority—have not a single resident case.

So, yes, Prescott-Russell is the only home right now, but we're constantly monitoring to assess. Simply because a home has no resident cases is not always a reason to put off getting any other groups in, because we know that things can change very quickly. So we need to make sure that there are plans in progress.

The Red Cross, I believe, came into Prescott-Russell on October 19 to do an assessment, and that the plan is to have staff in by the end of the week. It's very important that we work in COVID-19 time.

Ms. Teresa J. Armstrong: And if a home wants the Red Cross, would they be able to just initiate that themselves, or is it the—

Hon. Merrilee Fullerton: Well, this is an ongoing monitoring of our homes and being in close contact with them to understand what their issues are—not only the ones that had a difficult time in the first wave, but also the homes that are having challenges right now in wave 2.

They're not necessarily the same homes. I think that's important to understand. The situation changes for them, as well.

This is something that we will coordinate with our regular contact with the homes, but it would be expected that it would be primarily the homes that are in outbreak, whether they have zero resident cases or resident cases. Those would be the homes that we would be staying in very close contact with to understand what their needs are, and working with the medical officer of health in the areas to understand if they are needed to pull their levers as well. So we stay in continuous contact and monitor closely.

Ms. Teresa J. Armstrong: Yesterday, Minister, you mentioned that residents living in a Toronto long-term-care home didn't have to be moved out of three- or four-bed wards because it's their home. Right? You can clarify it.

Hon. Merrilee Fullerton: Yes. Sure.

Ms. Teresa J. Armstrong: This, to me, again, was a little confusing of a statement when you had said it's their home and when—when I get sick, if I need to go to the hospital, I definitely go to the hospital.

Could you explain if you consulted directly on resident policies regarding the three- and four-bed wards and decanting to hospitals—if you don't mind going into that a little bit more.

Hon. Merrilee Fullerton: Looking at the first wave, there were some homes that decanted to local hospitals, and that was done in some instances without any intervention from the Ministry of Long-Term Care. It was an arrangement that existed as a relationship between the hospital and the long-term-care home, and so it transpired.

What we're seeing is, as we coordinate our lessons learned from the first wave, that we say, "Is there a relationship with the local hospital? Is it going to happen organically or do we need to intervene to make things happen?" The medical officers of health would be looking at that as well in different units.

We looked at decanting in the first wave to understand the issues surrounding that and what would be feasible. After discussions with the ethics table, it really became very clear that the long-term-care settings that our residents are in— it is their home and that provides them with very strong rights. We do need to recognize, and it absolutely is a consideration, the frailty of some of the people in their end stage of life in long-term care.

Although decanting seemed like an obvious solution initially, if you explore it and you understand resident rights, a resident's ability to refuse and their right to refuse medical care or acute care and rely on their advance care planning to receive palliative care or supportive care in the long-term-care home—that is their right. It would actually be illegal to provide them, against their will, medical care.

The other piece that would be illegal is also ageism. We cannot discriminate against people who want to go to hospital. If they want to go to hospital and it's medically indicated and it's necessary that they go to hospital, then it has always been the case that they would receive medical attention. In fact, right now, there are people receiving medical care in hospital who have been transferred from long-term care.

The decanting—or what we call decanting, the removing of residents from long-term care to hospital—is a complicated one, with moral and ethical deliberations that must be taken at the forefront, because it is about the resident and it is about their rights. When I mentioned it is their right to stay in the home and it is their right to refuse medical care—that is what I intended to say, and if I said otherwise, I'm sorry. I would not have said otherwise.

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Ms. Teresa J. Armstrong: I just needed you to clarify.

Hon. Merrilee Fullerton: Yes. And so I think this is a situation where there is some confusion about residents' rights.

I want to be absolutely clear that they ought to have advance care plans when they go into the long-term-care homes. It is part of proper coordination and planning when they arrive, and these are continually looked at and updated as need be, depending on the medical condition and the status of the resident—

Ms. Teresa J. Armstrong: I have to interrupt you, because I have two more questions. My time is running out. But you did answer thoroughly. Thank you.

Can the minister or deputy minister provide an update on the progress to make directive changes, as mentioned by Dr. Yaffe last week? And when will the new directives be issued?

The last question I had about the wards—did the ministry crunch the numbers on how much it would cost the Ontario government to ensure that all long-term-care homes would be moved out of three- and four-bed wards, for their safety?

Hon. Merrilee Fullerton: Does your question mean immediately or over time?

Ms. Teresa J. Armstrong: Immediately would be great. Over time—if you have that. You can answer both ways.

Hon. Merrilee Fullerton: What we've done is created flexibility for our homes and adaptability by providing funding that is flexible for them. Out of the $540 million, over half a billion dollars that we announced a few weeks ago—part of that is to improve the capacity to prevent spread of COVID-19 or other infections in the home, so that certainly could be used for that. There's $61.5 million for operations that would improve their ability there; $30 million that would go to infection prevention and control, training and staffing. So those measures with the ward rooms have to be taken in conjunction with the other measures that we're doing—because we know the capacity of long-term care was at 99%, and is the alternative a safer alternative? We weigh the pros and cons. Is the home in outbreak? Is the home not in outbreak? Is the outbreak a resident case in the home, or is it a staff case isolating in their own home and no cases in the home? All of these things have to be taken into consideration.

The dollars being spent to redevelop the homes are critical because we have to move away from the four-bed ward rooms. Dr. Yaffe has been very involved in this

process. We take our advice from the Chief Medical Officer of Health and the Associate Chief Medical Officer of Health.

Looking at the individual conditions of these homes—and a home that is a newer home with more space, generally speaking, up to modern design standards, would be different from an older home built in the 1970s.

We do have to take into consideration the rights of the residents and their willingness to be moved or their ability to survive a move. As you can well understand, these residents of ours in long-term care are at the end of their lives. The average time in long-term care is about a year and a half. So we have to be very respectful and compassionate of their dignity and respect their individual circumstances. We work with our experts to make these decisions.

Ms. Teresa J. Armstrong: Could I ask you if you have a timeline for when the new directive would be issued?

Hon. Merrilee Fullerton: It seemed as though it was coming—-and again, we work with the experts, the Chief Medical Officer of Health and the Associate Chief Medical Officer of Health.

I can ask the deputy if he has heard anything more.

Mr. Richard Steele: I don't have specific timing as to when Dr. Yaffe or Dr. Williams may be issuing a new directive relating to three- and four-bed rooms.

Our priority focus right now in support of decision-making around where to go next with direction on the three- or four-bed rooms is to get as granular a set of information as we can to inform that—

The Chair (Mr. Peter Tabuns): You have three minutes left.

Mr. Richard Steele: As I mentioned yesterday, we have a detailed survey in the field with all 626 homes to understand what the occupancy is. That's now up and running. The homes are all on board. They've been trained so that we can gather that information and understand precisely where we are at right now.

Ms. Teresa J. Armstrong: One of my colleagues really wanted to squeeze in a question before we—

Mr. Richard Steele: Sorry.

The Chair (Mr. Peter Tabuns): MPP Gates.

Mr. Wayne Gates: I have to congratulate you guys; you're very good at taking up all our time.

I want to start by talking about an article that was in the Toronto Star on May 16. It talked about three for-profit companies over a course of 10 years that took $1.5 billion of profit from long-term care, which was going to CEOs and shareholders, not the care of our loved ones—our moms, our dads, our grandparents.

Do you agree with me that the profit from these long-term-care facilities would be better used to provide care for our loved ones?

Hon. Merrilee Fullerton: Thank you for the question.

I think there are a few things there that are important for context. The first one is that some of the companies that do run long-term-care homes also run retirement homes, which don't fall under the purview of the Ministry of Long-Term Care. I can tell you that they do both. I'm not an expert in their daily functions, but I can tell you that their profits are often related to the retirement home piece. In long-term care, there are certain envelopes that the companies are given for the long-term-care residents, and if they don't use all those dollars, those dollars actually have to come back to us at the Ministry of Long-Term Care.

Mr. Wayne Gates: Minister, I'm going to jump in because you only left me three minutes. My question was clear: Do you believe that the profits from long-term-care facilities should be going to care instead of to CEOs and shareholders? That was my question. I know how the system works. I know the regulations around retirement homes. My question is simple: Yes or no, do you agree with me?

Hon. Merrilee Fullerton: Well, I would say that it is the resident who is at the centre of this, and if the resident is well served, then that would be the determining factor. If the resident's quality of life, their care, the ability to provide—

Mr. Wayne Gates: Again, I'm going to jump in, because you only left me three minutes. The reality is that during the pandemic we've had almost 2,000 people die in long-term care; 85% of them were in for-profit care facilities. My question was clear. Rather than put that profit money into CEOs and shareholders, it should be going to the care of our loved ones, and—let me finish—maybe we wouldn't have had that number of deaths in long-term-care facilities.

I've got one more question and that's about all the time I'll have, unfortunately—

The Chair (Mr. Peter Tabuns): No, Mr. Gates, I'm sorry to say—

Mr. Wayne Gates: I don't even have that much time.

The Chair (Mr. Peter Tabuns): No. You're out. My apologies.

Mr. Wayne Gates: I feel like Tom Henke coming in at the bottom of the ninth.

The Chair (Mr. Peter Tabuns): With that, we go to MPP Pettapiece. You have the floor.

Mr. Randy Pettapiece: Thank you, Minister. Contrary to what my friend in the opposition has said about your answers and the answers from your staff, you've been very open and transparent today. I do appreciate that, and I think all members of this committee should appreciate that and do.

As you are aware, I am attached to the Ministry of Agriculture, Food and Rural Affairs, so this question has a bit of an agricultural flavour to it.

Minister, you were here last year, and a lot of hay was being made of a claimed $27-million cut in reference to the structural compliance premium and the high wage transition fund. Looking at the estimates, I think it's clear that government funding is not leaving the sector.

My understanding is that the high wage transition fund is still in operation. Earlier this year, you announced a minor capital program to replace the high wage transition fund and provide operators with a reliable source of

funding for ongoing minor capital repairs to maintain and extend the life of their homes.

Can you explain why you decided to launch this program, and could you shed some light on how this program can be used by long-term-care homes?

Hon. Merrilee Fullerton: I know you are also a champion for long-term-care homes in your area. I know you have your heart in this, as well. So thank you for everything you're doing to advance and repair and rebuild long-term care.

In terms of the high wage transition fund and the structural compliance premium, those were both programs or streams that had started back in the 1990s. At that time, they were expected to be temporary, but over time they continued, and our homes were starting to get quite concerned about the temporary nature of those. When we became a ministry in the summer of 2019, we suddenly saw that there was a deadline coming up, so we quickly acted and made sure that both these streams were extended at the time. The structural compliance premium has since ended and been replaced, and the high wage transition fund, I believe, is going to December 31 of this year.

So those were the two streams that we were often accused of cutting. These were never cut; they were simply transitioned, and we did extend them initially, while we were fully understanding what we needed to do to support our long-term-care homes, both from a minor capital aspect and from a staffing aspect.

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Our concept is really to modernize long-term care while we deal with the emergencies right now, and we needed to fill the gaps in long-term-care staffing and funding. So the minor capital program has had an initial outlay, as well as more dollars that just came through—just over half a billion dollars that we announced a few weeks ago. The minor capital funding piece of that is about $61.5 million.

The high wage transition fund really outlived its intended purpose as a temporary fund after—how many years? That's 30 years being temporary. We wanted to provide our homes with more certainty so that they could move forward. In tandem, we also announced the staffing strategy. We held consultations on what a minor capital program would look like, and we announced that in the spring economic statement as well. And, like I said, we've just announced another $61.4 million most recently.

We needed to understand that our homes had requirements to maintain certain elements of their physical structure that weren't covered with other envelopes, and, while these homes waited redevelopment, it was becoming critical. Some of them had redevelopment applications in or new-build applications in, but it didn't help them for the present circumstances that they were in.

With that improved financial support for our long-term-care operators, our $1.75 billion that's being deployed as the applications rolled out to those 129 projects, the operators can build new beds and also use these supports to redevelop beds—but also to maintain, whether it's programs to renovate homes or shore our homes up because of infection-prevention needs that are somewhat enhanced considerably with COVID-19. Homes will have the flexibility to decide how they wish to use their annual allocation within a list of eligible minor capital projects. This is a roughly $23-million investment surrounding the minor capital program. Some examples of that will include:

—electrical system repair or replacement;

—wireless nurse call system repair, installation or replacement;

—siding and insulation replacement;

—heating or cooling system, including air conditioning unit purchase, repair, installation or placement;

—wall/door protection and guard installation, repair or replacement;

—flooring repair, installation or replacement;

—lighting upgrades, repair, installation or replacement;

—renovations to homes to accommodate program changes or enhanced patient safety.

And other eligible expenditures may be considered at ministry discretion.

So we've attempted to be as flexible as we can for the partners, and we've listened very carefully and acknowledged and heard them loud and clear. Our government is really bent on creating a 21st-century support. That is part of our plan to repair long-term care, rebuild long-term care and advance long-term care. These temporary programs back from the 1990s have simply been transitioned into other funding mechanisms. I'm really proud to say that we've listened to the sector and we've heard them loud and clear.

I believe that we may have an ADM interested in responding, as well.

Mr. Richard Steele: I think the responsible ADM, ADM Sheila Bristo, has some additional comments on the minor capital program.

Ms. Sheila Bristo: I am happy to be here today to talk about the investments made in the facilities of our long-term-care homes. These investments will help to enhance the safety of residents, their families and staff, as well as extend the life of the long-term-care homes themselves.

Dedicated minor capital funding for long-term-care homes had been identified as a need that would have an immediate positive impact on helping homes to maintain their facilities and keep them in an optimal state of repair. In a span of only a few months, the ministry has been able to meet this need and help to equip the homes with the funding and guidance to not only help address their minor capital needs but also enhance the safety of their homes amidst the COVID-19 pandemic.

Last week, or maybe two weeks ago now, the ministry announced new funding of $61.4 million in 2020-21 to support long-term-care homes in completing urgent minor capital upgrades and improvements directly linked to improved infection prevention and control practices for the safety of their residents, staff and families. A number of reports arising from the sector's experience with wave 1 of COVID-19 identified a need for small-scale capital state-of-repair improvements linked to infection prevention and control and better sector preparedness for fall 2020.

The ministry reviewed relevant evidence and considered related stakeholder recommendations and developed the guidelines for an infection prevention and control minor capital initiative. This funding is part of the ministry's response to provide timely and effective support to the long-term-care sector to help stabilize the homes amidst the evolving challenges of the COVID-19 pandemic. All homes will receive an allocation, with funding being weighted towards homes with older facilities where IPAC minor capital needs are likely to be higher than those homes built to newer standards.

Allocations consist of a base allocation of $50,000 plus a per-bed allocation. The per-bed allotment will provide older homes with a higher amount of support to address the minor capital of older facilities, such as older homes that have bed classifications of "B," "C" or "D/Upgraded," and will receive $600 per bed. Newer homes with classifications of "New" or "A" will receive $254 per bed. For example, a home with 50 beds with a "B," "C" or "D/Upgraded" bed classification will receive $80,000. Conversely, a home with 50 beds with a "New" or "A" bed classification would receive $62,700. The base allocation will provide all eligible licensees with a substantial minimum allocation to ensure smaller homes with fewer beds are supported, and the per-bed portion will help support larger homes.

As part of the IPAC minor capital funding, the ministry developed a list of small-scale improvements deemed to be eligible expenditures, each linked to IPAC practices and needs. Eligible expenses include renovations that will help homes safely separate and/or cohort residents, as well as other improvements that will promote cleanliness and infection prevention and control.

Homes will have the flexibility to choose how they use their allocation to address a number of eligible IPAC minor capital expenditures. Examples of eligible measures include minor adjustments to support distancing—this will include renovations to support improved distancing of residents; for example, adding partitions or doors—ventilation and air conditioning systems, which will include assessments, repairs, upgrades and filters for LTC homes; and HVAC systems to improve air quality, remove and prevent—

The Chair (Mr. Peter Tabuns): I'm sorry to say that we're out of time for the day.

The committee is now adjourned until October 27 at 9 a.m.

The committee adjourned at 1800.

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