

Legislative  
Assembly  
of Ontario



Assemblée  
législative  
de l'Ontario

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**Official Report  
of Debates  
(Hansard)**

M-6

**Journal  
des débats  
(Hansard)**

M-6

**Standing Committee on  
the Legislative Assembly**

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

2<sup>nd</sup> Session  
42<sup>nd</sup> Parliament

Thursday 25 November 2021

**Comité permanent de  
l'Assemblée législative**

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

2<sup>e</sup> session  
42<sup>e</sup> législature

Jeudi 25 novembre 2021

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Chair: Laurie Scott  
Clerk: Valerie Quioc Lim

Présidente : Laurie Scott  
Greffière : Valerie Quioc Lim

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON  
THE LEGISLATIVE ASSEMBLY**

**COMITÉ PERMANENT DE  
L'ASSEMBLÉE LÉGISLATIVE**

Thursday 25 November 2021

Jeudi 25 novembre 2021

*The committee met at 0900 in committee room 1 and by video conference.*

**PROVIDING MORE CARE,  
PROTECTING SENIORS,  
AND BUILDING MORE BEDS ACT, 2021**

**LOI DE 2021 VISANT  
À OFFRIR DAVANTAGE DE SOINS,  
À PROTÉGER LES PERSONNES ÂGÉES  
ET À OUVRIR PLUS DE LITS**

Consideration of the following bill:

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

**The Chair (Ms. Laurie Scott):** Good morning, everyone. I call this meeting to order. We are meeting today for public accounts on Bill 37, An Act to enact the Fixing Long-Term Care Act, 2021, and amend or repeal various Acts. Are there any questions before we begin?

I'll go over some of the timelines here to help us. Our presenters have been grouped in threes for each one-hour time slot. Each presenter will have seven minutes for their presentation. After we have heard from all three presenters, we will have 39 minutes of questioning, divided into two rounds of seven and a half minutes and one round of four and a half minutes for the government members, as well as two rounds of seven and a half minutes and one round of four and a half minutes for the official opposition members. When you begin speaking, please state your name for Hansard. I will let you know when you have one minute left.

**MS. CATHY PARKES  
ONTARIO LONG TERM CARE  
ASSOCIATION**

**ONTARIO LONG TERM CARE CLINICIANS**

**The Chair (Ms. Laurie Scott):** The first group of three this morning is Cathy Parkes, followed by the Ontario Long Term Care Association and the Ontario Long Term Care Clinicians.

I would now ask for Cathy Parkes to begin her presentation, except for—one second. I just want to let MPP French state her name and confirm where she is, please.

**Ms. Jennifer K. French:** I'm MPP French, and I am here at Queen's Park in Toronto.

**The Chair (Ms. Laurie Scott):** Thank you very much. And when we go to questions, we are going to start with the government side first.

Please, Ms. Parkes, if you would start.

**Ms. Cathy Parkes:** Good morning. Thank you for having me here. My name is Cathy Parkes. My father was Paul Parkes, a resident of Orchard Villa long-term care home, which is a home owned by the for-profit chain called Southbridge Care Homes. Southbridge is an investment company that, until recently, contracted the management of Orchard Villa out to Extendicare, another company with a horrible record of care behind it during this pandemic.

My father was one of 78 residents who died in Orchard Villa during wave one of this pandemic. The experience I had with my father in long-term care was like running through an obstacle course at breakneck speed, with the one goal of keeping him safe and healthy—a goal that I now realize was never within my grasp because of how his home was run.

My father lost his life gasping for air, needing water and medication, denied the right to go to the hospital and kept from his family in the last weeks and days of his life. Sadly, he is one of over 4,000 residents who have died since last year, and many with similar circumstances. In the two years since my father first entered Orchard Villa, I had been forced to pay extra attention to all things long-term-care-related, as his death taught me a lesson on how to care for other elderly members of my family who may also need long-term care in the future, as well as all Ontarians who simply deserve better.

When I first reviewed this new act, I was struck not by how much it changed but by how much had stayed the same. In light of the long-term-care disaster of the past two years and even decades, Bill 37 had the potential to create real change for our long-term care homes, but instead, it falls well short of what is necessary to fix long-term care in Ontario.

Similar to other speakers you have heard, I am very concerned about the preamble wording which includes the term "mission-driven." As every long-term care home in Ontario could claim to be mission-driven, this term indicates to me that this government intends to issue licences to for-profit homes even if, like Orchard Villa, they have a track record of abysmal failures.

I've been seeking accountability for the atrocities that happened in Orchard Villa for 19 months. I have learned terms like "incident reports," "voluntary plans of care" and "written warnings," and I've read the current long-term care act section on enforcement, all of which could hold homes like Orchard Villa to account, but none of which have been used.

Since the announcement of this bill, I have heard statements lauding the sections on accountability and the new powers given to inspectors, but my experience is that all the words, sections and promises mean nothing. The accountability section of this bill may as well be the alphabet written on paper because that's how meaningless it is without enforcement.

Among family members, the term "surprise inspections" is sure to incite eye rolls. There are only three groups of people who understand how useless the word "surprise" is when it comes to inspections. Those groups are staff, residents and families: those of us who have spent days, weeks and years consistently inside a long-term care home, those of us with the experience of living it or working in it. Staff and family have been saying for years that there is no such thing as a surprise inspection, but I consistently hear members of this government claim the opposite. To me, this is one more attempt to silence families as we seek to share the truth.

My biggest concern, aside from mission-driven homes, is changes that have been made to the licensing portions of this act. The current act states that the director may issue a licence only if eligibility has been met. Bill 37 has the same criteria, indeed, but has removed the word "only," which then means that this limits the ability for the public to question or challenge new licences being given to homes by Orchard Villa, and it opens the door for the director to make broader decisions and potentially issue new licences to homes with horrible track records.

In July, I participated in a public hearing for Southbridge's licence request for an extra 87 beds and a 30-year licence. Although other licences have been granted within a short time after their public hearings, we are now four months on the hearing for Orchard Villa and no decision has been announced. My fear is that this government is waiting to pass this act that's allowing homes with horrible records like Orchard Villa to obtain 30-year licences, when previously they would have been denied.

The answers to these licence requests should be very clear: They do not meet eligibility, and it should be an absolute no. I have heard Minister Phillips state that his focus is on building vast numbers of beds as quickly as possible, but the quantity of beds will only dig this province into a deeper hole if the quality of care does not also accompany them. When a home's primary goal is profits, care will always fall behind. We need more beds, but we need them to be non-profit in well-run homes.

Finally, Minister Phillips has publicly stated that this new bill, with all of its words of accountability and enforcement, will not be retroactive to ensure accountability for the mass deaths over the past 20 months. Residents who have suffered and lost their battle against

insurmountable odds, staff who have worked themselves weary, families like myself who are left broken have no recourse, no assurances and no accountability. To me, Bill 37 is nothing more than the statement, "Trust me. We really mean it this time." The words seem empty and the promises ring hollow. In the name of 4,022 residents, plus my father, we demand better.

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

We will now move to the Ontario Long Term Care Association. Please unmute, and we'll try to help you on this end too. Just introduce your names when you come on.

**Ms. Donna Duncan:** Good morning. My name is Donna Duncan. I'm CEO of the Ontario Long Term Care Association. We represent 70% of Ontario's long-term care homes, including non-profit, private, municipal, northern, rural and culturally specific, including First Nations, homes across Ontario. I'm joined today by Brent Gingerich, chair of the board of OLTC, and chief executive officer of PeopleCare Group, which operates and manages long-term care homes in southwestern Ontario.

We are joined by Ruth McFarlane, vice-chair of the OLTC board, chair of the OLTC emergency health human resources emergency task force and chair of our recovery and modernization advisory group. Ruth is also chief executive officer of Durham Christian Homes, which operates several non-profit homes in Durham region, including a newly opened home. We thank you for this opportunity to comment on Bill 37, An Act to enact the Fixing Long-Term Care Act, 2021 and amend or repeal various Acts.

The tragedy of the COVID-19 pandemic highlighted the long-standing systemic and structural issues in Ontario's long-term care system:

- old buildings with three or four people living in a room;
- a critical human resources shortage;
- long-term care homes isolated from the rest of the health, home and community care sectors and models of care; and
- staffing and funding that had not evolved over decades to support the increasingly more complex needs of our residents.

The proposed new legislation and its associated regulations, should the legislation pass, must serve as a purposeful foundation for the transformation of our long-term care services, to build a system of care and supports that truly places resident needs and wishes at the centre and balances quality of living with quality of care.

Through expansive consultations with our board, committees, broader membership, sector partners and others, we have developed a comprehensive platform for change and transformation to support our aging population today and for the future. Our platform is anchored in rebuilding accountability and meeting resident needs.

The existing legislative and policy framework is highly prescriptive and focuses on assessing compliance with legislative processes for every element of activities in our homes. The current framework creates a rigid cookie-cutter approach to care that fails to recognize our residents

and their needs and has prevented homes, in adapting their models of care and living supports, from aligning with the diverse needs and wishes of our residents and their families.

It is in this context that our recommendations include adapting the language with regard to residents' rights and palliative philosophy to affirm and maximize the self-determination and quality of life of residents or such language as is supported by the Ontario Association of Residents' Councils. Their voice must anchor the legislative and regulatory framework, enshrining and defining the role of the essential caregiver in legislation, including:

- providing for dispute resolution processes to be set out in regulation;

**0910**

- supporting the introduction of a provincial chief long-term care medical officer for Ontario to provide provincial leadership, support and oversight for long-term care medical directors and physicians in the province;

- allowing for new models of care, including emotion-focused care, as well as more specialized classifications of care models, homes or programs, such as those tailored for younger residents, residents requiring more specialized treatment for mental health and addictions, and other evidence-based models that may arise;

- given the health human resources crisis and its impact on long-term care, amend the bill to provide for the precedence of the Regulated Health Professions Act over the Fixing Long-Term Care Act and associated regulations to allow all regulated health officials to work to their full scope of practice in long-term care;

- ensure that all inspectors are current with any changes in scope of practice;

- in addition, provide homes with an ongoing adaptability to allow for entry-level support roles, such as resident support aides, and to expand the roles of allied health professionals, including recreation therapists;

- providing for more culturally specific homes and care models, including allowing for transitions in care on campuses of care that may include retirement, assisted living, day programming, spiritual care and long-term care—this includes staffing, dietary, capital and other considerations;

- focusing on quality improvement and outcome measures for quality of living and quality of care, including a solutions-based inspection model that provides compliance support to homes.

We support full accountability and transparency for all parties in long-term care. There is zero tolerance for abuse or neglect, and the government must have the tools at its disposal to address those situations.

We support the introduction of a provincial standardized resident and family experience survey, administered by a third party, the results of which would be reported publicly annually.

This has been an extremely challenging time for everyone who lives in long-term care and for those who care for them and work with them, not just in Ontario but across Canada and around the world. It has been a dark time, but the prioritization of our residents and staff for vaccines, and the measures our government has

introduced, give us hope. But to realize that hope for the future, it will take all of us working together with urgency. Let's focus on those areas where we agree. We have to find bold solutions if we are to meet the needs of our aging population of today and tomorrow.

Thank you for your consideration. We welcome your questions.

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

We'll now move on to the Ontario Long Term Care Clinicians. I remind you to please state your name before you begin.

**Dr. Fred Mather:** Thank you. I am Dr. Fred Mather. I'm talking to you from Sunnyside Home, which is the municipal home for the region of Waterloo, where I've been medical director for over 20 years. I've worked inside long-term care for the last 40 years, and I also provide care in a couple of Revera Living homes as well.

Thank you for the invitation this morning. I'm past president of the Ontario Long Term Care Clinicians and representing our president, Dr. Ben Robert. With me this morning is Dr. Rhonda Collins, who will be presenting as well.

The last 21 months have been a very challenging time for our organization, which is a volunteer organization. We represent physicians, medical directors, nurse practitioners and pharmacists who work in long-term care. We offer educational opportunities, which include our medical director course and also courses on fundamentals in long-term care, LEAP palliative care and the IDEAS quality assurance course. We also provide the largest conference for long-term care physicians in Canada. That has just concluded. It was offered virtually again this year over four half-days in October.

During the pandemic, our physicians were really challenged because there was a lack of recognition of the needs of the long-term care sector. It's worth repeating that in March and April last year, we were gearing up for a surge that would impact our emergency departments and hospitals. Meanwhile, we were seeing fatal outbreaks in long-term care, and some homes were particularly vulnerable.

As then-president of our organization, I provided responses to questions our members had, and they included things like proper use of PPE, outbreak management, visiting more than one facility and the role of virtual care.

The vision of Ontario Long Term Care Clinicians is that we believe in a dedicated, collaborative, interprofessional team with physician leadership that provides the highest-quality comprehensive, evidence-based medical care for long-term care residents.

In terms of specific recommendations with respect to Bill 37, I'll just briefly mention culture and education. Since 2012, we've offered the medical director course. It's been offered virtually twice this year. We feel that that course should be mandatory for all medical directors in long-term care. I feel it's an issue of equity, that some homes perform very well and other homes are lacking strong leadership. Assuring the education and continuing

professional development of our medical directors, physicians and nurse practitioners will assure greater equity over the sector. We feel that there should be ongoing support for education for physicians, nurses and other health care professionals.

We also support the palliative approach to care, keeping in mind that palliative care is not end-of-life care but recognizes that many of our frail elderly are in the last stages of life, with medical interventions that are often fruitless and doing more harm than good, and recognizes that symptoms of dying can be managed in good palliative care.

Before I pass it over to Dr. Collins, I just want to end on what the palliative philosophy of care is here and share with you the definition of the World Health Organization: that the palliative approach to care improves the quality of life of patients and their families facing problems associated with a life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. In long-term care, we not only address pain and physical symptoms, but also the psychosocial and spiritual aspects of care.

I will have Dr. Collins now address our recommendations on leadership and accountability.

**Dr. Rhonda Collins:** Hi. Thanks so much, Fred. Rhonda Collins, vice-president of OLTCC. I'm speaking to you today from Fonthill.

Fred has spoken to a couple of the recommendations. Definitely, the medical director's course we think should be mandatory, because this course provides necessary knowledge and training to be an effective leader in long-term care and delivers support and a culture of quality of care, which we feel is so important.

This course is turnkey. It's low-cost or no cost to the government. Most physicians pay for it themselves or their organizations pay for it. It allows the sector to immediately leverage existing resources and expertise for better resident care. It's nationally accredited. It's updated regularly to stay current with Ontario legislation, regulation and the realities of long-term care. It comes with a living manual, as Fred already pointed out.

There are two tiers of learning: a full course for medical directors and a second course for attending physicians, nurse practitioners or those who are considering a career in long-term care. There are many high-yield topics in this course that include regulations and legislation, compliance and inspections, residents' rights—

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

**Dr. Rhonda Collins:** Thank you—and IPAC, among others.

Fred already spoke to the palliative philosophy of care, so I'd like to speak about a chief medical officer for long-term care role, which we suggested. This position would be able to develop and establish standards of care, inform long-term care building design and infrastructure, advise with regard to government inspections and assist the sector in a crisis of any kind, not just a pandemic. It would draw on best practices from around the world. It would also

include a regional role, something similar within each of the five Ontario health regions, to make sure that we are informing, collaborating and coordinating with other health care system sectors and partners, such as hospitals and public health.

I thank you for the opportunity to present and look forward to your questions.

**The Chair (Ms. Laurie Scott):** Thank you very much to all the presenters.

We will start with seven and a half minutes and the government side. MPP Triantafilopoulos will start.

**0920**

**Ms. Effie J. Triantafilopoulos:** Good morning, all. Thank you very much to all the presenters for being here this morning. We very much value your advice and input.

My first questions are, in fact, to the Ontario Long Term Care Clinicians. I want to thank all of you for joining us today. I know that your members—physicians, nurse practitioners, pharmacists and other professional health care providers—have worked hard to provide care to residents during the COVID-19 crisis during a very, very trying time. I've met with your leadership several times, as has the minister, and we both value the advice and counsel you've offered us. You have a unique perspective on the increasingly complex needs of seniors in long-term care.

I wonder if you could tell us more about the importance of medical directors in long-term care and about your proposal for them to take a mandatory medical director course. Dr. Mather, perhaps you'd like to start.

**Dr. Fred Mather:** Thank you. The legislation, the Long-Term Care Homes Act, requires all homes to have a medical director who is a physician, and then that medical director is responsible for the medical programs of the home.

I should say that the role of medical director really varies. It's a part-time job. Often, our medical directors are also in office practice or may be working in the hospitals and in clinics as well. The medical director looks for guidance as to what he or she should do in the role. It is a role that's not really recognized for the time that's required to give proper medical direction.

I can speak to the compensation to make that point. If you're a medical director in a 100-bed facility, you get compensated \$10,000 a year, which means leading the professional advisory committee and sitting on other mandatory committees, such as infection prevention and control.

I am heartened, actually, by the interest we have in people entering medical practice in long-term care. Unlike myself, who worked in family practice and went into long-term care because that's where I needed to look after many of my patients, we now have physicians who are wanting to do this work because they've been exposed to it in their training. But they also want the proper training and guidance beforehand.

Rhonda?

**Dr. Rhonda Collins:** Hi. Thank you. Yes, I agree with Fred. The physicians coming into long-term care have changed over the years. The medical director role has a lot



of responsibility associated with it and, unfortunately, not a lot of the authority associated with it. When we think about allocation of resources in long-term care and decision-making, medical directors don't have any role in decision-making or allocation of resources, so that makes the role a bit challenging.

In the medical director course, we absolutely recommend and advocate for the triad of medical director, director of care and administrator or executive director to work collaboratively to ensure best outcomes for residents. When we speak about the course, we teach that to our participants, and the feedback we've gotten from directors of care and executive directors, for medical directors who have taken the course, is that they understand the role more, they understand the legislation more and they're much more engaged in the home. That's why we think it's really important, because it's not meant to be a side practice where you come in for an hour a week to see residents. There's an administrative role for the medical director. That's what the course helps medical directors to understand and to become more proficient at their jobs.

**Ms. Effie J. Triantafilopoulos:** Thank you. I'm very interested in this concept that you've also touched on, the chief long-term care medical director. Could you expand further on that as well?

**Dr. Rhonda Collins:** Certainly. I'll speak from a personal perspective because I am a chief medical officer for a long-term care organization, so I can speak to the things I've been able to accomplish within my organization. I think we would be well served for the population at large if we had a similar role at the provincial level and at the regional level who is able to communicate and collaborate and share information.

Fred spoke about some of the challenges in the beginning of the pandemic. One of the biggest challenges for physicians was that there was no direction from physicians working in long-term care. Direction came from the College of Family Physicians as to providing virtual care. The recommendation was that all care should be provided virtually, to prevent physicians from going into their offices. That was speaking to family physicians who were working in an office setting. It didn't speak to family physicians who were working in long-term care, and about 94% of physicians in long-term care are family physicians. They were not getting guidance around what they should be doing in their long-term care practices. It led to an awful lot of confusion.

If there was somebody sitting in a role who could disseminate information, who could help interpret directives, and who could communicate and provide guidance, direction, assessment and evaluation of long-term care physicians, I think it would be a better-coordinated approach.

**Ms. Effie J. Triantafilopoulos:** Thank you. I'd like to turn for a moment to the concept of palliative care. As you know, Bill 37 is introducing the concept of a palliative care philosophy to long-term care legislation, and this is for the first time. I know you have suggested bringing more of a palliative approach to care education for all staff involved

in the long-term care sector. We know that this could make a difference for residents and family members. Do you support the references to palliative care that are part of Bill 37, and how do you see a palliative care philosophy working in long-term care?

**The Chair (Ms. Laurie Scott):** You have 45 seconds to answer—I'm sorry.

**Dr. Fred Mather:** Okay. I'll quickly answer that one.

We do support the term: "palliative" approach to care. My observation over the last year is that if you don't say that's what your approach is, where you're looking at the entire individual, providing physical, psychosocial and spiritual care, people don't realize that that's the care that we give. It includes advanced care planning, establishing goals of care, the appropriate use of tests and investigations, and assuring that our residents get the care they deserve in their home, which is long-term care.

**Ms. Effie J. Triantafilopoulos:** Thank you.

**The Chair (Ms. Laurie Scott):** Thank you very much. We will now go to the opposition for seven and a half minutes. MPP French, please go ahead.

**Ms. Jennifer K. French:** I'd like to welcome and say good morning to and thank all of the presenters. I just have a question for Cathy Parkes. Cathy, it's nice to see you this morning. Thank you for your words. Of course, they are words that have become very familiar in the Legislature. You have been an excellent advocate on behalf of your father, Paul, and other families, especially in the Orchard Villa community.

My question is: Certainly, we have been, as the families and as the community have been, pushing back against the licence extension, first calling for a revocation of the licence for Orchard Villa and now digging our heels in and trying to stop this 30-year extension of the licence. So I really appreciate your comments about licensing, but it's your comments on inspection that I'd like to delve into. It isn't sufficient to have just the surprise, even if it were a surprise. What could inspections look like that families would want to see? What criteria should be included? And would it be okay for a long-term care home operator to be involved in designing these inspections, or do you have thoughts on that?

**Ms. Cathy Parkes:** I do not think that a long-term care operator should be involved in planning any of the inspections. It would be nice if inspections were genuinely a surprise, and I don't know how you get around that when there are tip-offs. That's what I was talking about. For families who are in the home constantly, we see the change. We see the sudden extra staff on the floor. We see that everything is all of a sudden very clean, where it's not normally up to that standard. As far as inspections go, I'm not sure how you could have it genuinely be a surprise. I think that there need to be inspectors who are specific to one home, and that they go more than once a year, become familiar with the home and do a genuine drop-in.

But when I see in this bill that there are statements about what the inspectors can do and the enforcement that they can make right on the spot, my question is, then, "But will they?" Will they be told, "Don't do it unless you absolutely have to"? To me, that's concerning, and a lot of

it has to do with how it hasn't been done. You can enact what's currently in place, you can use it, and it has just not been done. So it seems like a lot of empty promises to me.  
**0930**

**Ms. Jennifer K. French:** Cathy, how important would it be for what is learned in the inspections to be accessible to the public and easily findable, rather than having to search and dig for the public reports?

**Ms. Cathy Parkes:** Extremely. I would like to see it even posted on the home's website, where you can just access it directly from there.

I do have to say, when we're talking about incident reports, it's really frustrating as a family member to see consistent IPAC failures and the only answer right now, currently, is a voluntary plan of care—so we will write and say, "We'll do better"—or a warning. And then the next incident report, there's another IPAC failure. It doesn't seem to be working. The legislation is there, just not put in use, and I don't understand why.

**Ms. Jennifer K. French:** Thank you, Chair. I'll defer to my colleagues.

**The Chair (Ms. Laurie Scott):** MPP Singh, please go ahead.

**Ms. Sara Singh:** Good morning, everyone, and thank you for your presentations.

Cathy, thank you so much for continuously advocating for families. I know that we've had a chance to connect in the past and I thank you so much for turning a tragedy into the advocacy that you've engaged in in our communities.

Maybe I'll start with a question for you. I know MPP French was asking about some of the accountability measures that families want to see moving forward. As you indicate, and many presenters have shared already, much of the enforcement and fines and inspections are already in legislation, but they aren't being acted upon. Can you perhaps share a little bit more of that perspective in terms of what families actually want to see happening with the inspections and how we can hold homes accountable more effectively?

**Ms. Cathy Parkes:** Sure. The most prevalent things in my experience in long-term care are falls and UTIs, which often go left untreated for so long that our family members end up in hospital. My own father was in renal failure because of that. He was left for far too long.

There's a process right now where we have to go to a director of care to issue a complaint, and it's supposed to go up the chain and then issue an inspection. I can say from my experience that that happened and an inspection was never followed through on. There's a break in the link there. I think we'd like to know that when we're speaking and advocating for our loved ones, it's being taken seriously and it's going up the proper chain.

Then we want a quick turnaround and follow-up, especially when it's something really serious that's putting our loved ones' lives in danger—something that's more severe and acted upon, rather than a voluntary plan of care. After maybe the second voluntary plan of care, we need to step up to another level and say, "This has now become critical and it needs to be dealt with." That's something

that's obviously going to have more of an effect on the home and push them to do the proper procedures.

**Ms. Sara Singh:** Thank you so much for that, Cathy. We hear of this time and time again from residents and family members who are part of councils as well, who are making complaints but nothing is actually being done about the complaints they are making, or the inspections are not being acted upon. I really appreciate you sharing that perspective as a family member as well.

My next question is for Donna. I know that much of what has been proposed in this new bill is actually creating a culture of fear in the sector around the enforcement and compliance, and that there's very little being done here by the government to actually help support the capacity-building that's needed in long-term care.

Donna, can you help shed some light on how members in the sector are feeling about this new legislation, and what else can be done by the government to truly build capacity in the sector?

**The Chair (Ms. Laurie Scott):** You have one minute left.

**Ms. Donna Duncan:** Thank you very much. I'm actually going to ask Ruth McFarlane to respond. She chairs our HR task force.

Ruth?

**Ms. Ruth McFarlane:** Hi. Good morning. Thank you for the question. Health human resources was identified years ago by our membership as the number one concern we had. The COVID-19 pandemic just amplified that.

The changes within this bill are worrisome for our leadership and for our front line and for our management. We really need to prop and hold our staff up. We need to support them to be able to take care of our residents, to meet their individualized care needs, and we need to do that by enabling them and not actually opening them up to criminal charges.

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

We will proceed to the next round of questioning. I'll go to the government. MPP Wai, please.

**Mrs. Daisy Wai:** I want to say thank you to everyone who came in to share your insights with us.

First of all, I would like to express my condolences to Cathy. It is a sad thing for us to see how people suffer, and also have a loss, during the COVID-19 pandemic. I want to say, on behalf of everyone here, all our caucus members and our government—I just want to express my condolences to you. Thank you for sharing your insights, and continue to advocate where you are, just so that we understand more. We're working on this through this bill.

I would also like to ask a question to Dr. Collins. Thank you very much for coming in and sharing your ideas. I know the experience that you have and all the work that you've been doing.

You also have a regular podcast, *Coming of Age*, that provides an in-depth glimpse into the long-term care sector from a variety of perspectives. Based on your own experience and those of your guests on the podcast, how do you see this proposed legislation enhancing the work

conditions for staff in this sector and improving the quality of life for residents?

**Dr. Rhonda Collins:** Thank you very much. It's a great question, but I'm going to turn it to Donna Duncan because I've been a guest on Donna's podcast, *Coming of Age*, but it's her podcast. So I would like to turn it to Donna to answer that.

**Ms. Donna Duncan:** Thank you very much, and thank you very much for your question, MPP Wai.

I think the key for us as we reflect on our guests—we've had guests from around the world, from Australia, the United Kingdom and the United States—and looking at the parallel experiences that we've all lived through over the last 20 months, but also the structural issues that every country is struggling with—Ontario and Canada are not alone, tragically and sadly. We have to make sure that what we're doing puts the residents and the families at the centre.

I think Cathy provides a really important voice for us and a reminder of who we're here collectively to serve. That is the thing that really has resonated through our discussions with our guests on *Coming of Age*.

We have to look for new solutions where we feel supported by the new legislation and the legislative framework that it is enabling. The real work will come through the regulatory process and building out the regulations, ensuring that we're all working together, whether it's residents, families, clinicians and our leaders in our homes, to come together to problem-solve. I would argue that that's the real foundational piece for us in our podcast.

It's about people with a common ground, a common vision and about reimagining seniors' care: building out campuses of care and providing more culturally responsive care, including for our First Nations communities; ensuring that we can support transitions in care; and recognizing, with 40,000 people on a wait-list, how do we support better home care or day programming or other assisted living models and shared care models and build on some of the work that has been done in a very constructive way, and a helpful way, over the last months.

So, we are very optimistic. We believe that this legislation does give us hope. The tone, approach and the culture will be really important, but also urgency. All of us have baby boomers who are aging and we do need to make sure that we build on the awareness that has been built over the last 20 months, tragically, through devastating loss of life. And how do we make sure that those losses of lives are not in vain and that we use this for the good? So, we're optimistic. This will give us a foundational enabling tool, but the real work is ahead of us over the coming months.

0940

**Mrs. Daisy Wai:** Thank you very much, Donna. Yes, we're working very hard on that, and we understand the urgency. Thank you for sharing.

I'd like to pass the time to MPP McDonell.

**Mr. Jim McDonell:** I wanted to thank everybody for coming in today. First of all, there was a comment that came up on the voluntary plans of correction being used for enforcement. I just wanted to point out that this

legislation is removing voluntary plans of correction from the practices we've seen in the past.

Just a question for the clinicians: In the recent fall economic statement, the government announced \$58 million in funding to hire 225 new nurse practitioners. The government's priority to increase the number of nurse practitioners in the sector was informed by consultations with the organization, as well as nursing organizations such as the RNAO, who presented at this committee yesterday.

Minister Phillips presented at the RNAO nurse practitioners knowledge symposium this week and further highlighted the importance of this professional discipline in the care of long-term care residents. The training and the role that nurse practitioners play in long-term care and our health care system more broadly is not well understood by the public. Can you please describe that role nurse practitioners will play in long-term care and the impact this investment in nurse practitioners will have for long-term care residents across Ontario?

**The Chair (Ms. Laurie Scott):** Just a minute and 10 seconds for a response.

**Dr. Fred Mather:** I can respond to that, because I think nurse practitioners have different roles. Where I work, we have a nurse-led outreach team nurse practitioner who is in the home two days a week. Her main mandate, when she started about six years ago, was to reduce the avoidable transfers to the emergency department, but she's been a great link in programs during the pandemic.

We also have attending nurse practitioners who usually work with a physician in a collaborative model of care, as Donna Duncan referred to in her presentation. Medical resources, clinical resources are going to be a real need going forward as we strengthen and build on long-term care. I think nurse practitioners, physicians, nurses and all health care professionals—the real emphasis needs to be on recruitment and retaining our colleagues from all disciplines.

**The Chair (Ms. Laurie Scott):** Thank you very much. We will now move to the opposition for their round. MPP Singh, please go ahead.

**Ms. Sara Singh:** I'm going to just pick up where I left off with my question to Donna and Ruth. Ruth, I know you were in the process of explaining some of the staffing capacity that's needed, health human resources. Would you like to continue that thought and expand on what's needed here in the sector?

**Ms. Ruth McFarlane:** Yes, I would. Thank you very much. Health human resources—there's a huge need, especially with the redevelopment of new homes. We need to find the people to take care of our residents. Our residents have very individualized care needs. They are much more complex than they were years ago, and we have to make sure that we have the adaptability within our homes to meet those individualized care needs to provide quality outcomes and to balance that with their quality of life.

We're challenged with not only registered staff but also personal support workers, dietary staff. This is not only for long-term care. This is across the health care sector. Really, we need to make some investments and make some changes to be able to move forward with recruiting

more people into the sector. That is why our recommendation is to take a look at the scope of practice and to be able to expand that so that our staff can perform the care that they are qualified to do within long-term care, as in other areas of the health care system.

**Ms. Sara Singh:** Thank you so much, Ruth. Just expanding on that, I know that this legislation lays out an average target of four hours of hands-on care. Do you think that with the current staffing plan the government has in place, those targets are achievable?

**Ms. Ruth McFarlane:** I know that we all welcome the average four hours of care, but it must be provided to ensure that each resident has their individual care needs met, and I think the clinicians were speaking to that, about the holistic care model where it's balancing quality of life with care needs—spiritual, emotional and physical.

Residents differ in every aspect, and resident populations are very different. They differ greatly. A one-size-fits-all approach is not going to support the diversity that will enable us to have quality outcomes and be able to meet the needs. While we support the increased investment in our staffing, it will still be a challenge. We need real solutions now, to be able to bring more people into the sector to provide that care for our residents.

**Ms. Sara Singh:** Thank you so much, Ruth. I think what we've heard from a number of presenters are serious concerns about being able to provide the level of care that is being enshrined in legislation without a real staffing strategy in place. Regardless of what sector you're operating in, there just don't seem to be the staffing supports there to meet these targets, so I appreciate you shedding some light on that.

I'm also curious with respect to emergency preparedness and planning. I know that Fred and Rhonda spoke about the need for having a medical director who is available to help provide support to homes. I know that through the pandemic, many staff felt that they were on their own trying to navigate the crisis in those homes, so I'm curious about the director's role. How often are they supposed to be on-site, for example, and what type of support are they supposed to be providing these homes, especially during a pandemic?

**Dr. Rhonda Collins:** It's an excellent question. One of the challenges throughout the pandemic was the lack of clear guidance. Even prior to the pandemic, there have never been legislated requirements for the frequency with which a medical director or even an attending physician is in the home or the duration that they are there, so it's variable across the sector. In some homes, the medical director is there regularly doing administrative tasks. In some homes, the medical director is there doing clinical tasks and not dedicating much time to the administrative tasks.

We really feel that there needs to be a dedicated amount of time. Some of my colleagues and I published a paper last year about the need for a standardized frequency and duration of visits based on the number of residents for which a clinician, be that a nurse practitioner or a physician, provides care. I think it's necessary for them to be on the ground and have eyes on the residents on a regular

basis, because of the complex health needs of the residents.

We know our population is changing. We know that there are more and more health care needs for our residents, and we need to balance their health care needs with their goals of care, so that we're not intervening when we don't need to, but we're there to identify when there's a change in condition and able to provide the level of care that's required to address that change in condition.

**Ms. Sara Singh:** Thank you so much, Rhonda, for that clarification. So enshrining this into legislation and setting a minimum requirement for medical directors to be on-site is something that you feel needs to be put in place here as well, to help ensure that families, residents and staff in these homes feel that their medical director is available if needed?

**Dr. Rhonda Collins:** Yes, we do, keeping in mind—and Fred spoke to this already—that it has historically been family physicians who go into long-term care, whatever the regularity is with which they attend, and it's part of other clinical practices or academic practices they have. They may have a family practice, they may have an academic practice, they may work in a hospital or they may work in a clinic, and so it's part of a larger practice.

What we're seeing now is that many physicians in long-term care are actually practising as long-term care clinicians exclusively. They're not working in family practice, they're not working in other environments, so they can dedicate their time to long-term care, and I completely support that.

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

**Ms. Sara Singh:** Thank you so much, Chair.

I think that in my final moments, I would like to just give the floor to Cathy to share a little bit of your perspective in terms of how we can better empower families to have their voices heard through, perhaps, the family councils. Do you have some thoughts on that, Cathy?

**Ms. Cathy Parkes:** Yes, I do. First, I just wanted to briefly say that in terms of doctors in the home, I can say from my experience, it was always having to leave notes and chase the doctor down to try to have a conversation. I ended up actually bringing my father's physician in to deal with him.

**0950**

As far as family council, I can speak from my experience with Orchard Villa. With my father entering the home, I didn't even know there was such a thing as family council. We were never invited to be a part of it. I actually didn't learn about it until after he had passed away. I think that family council really has the power to do good, but I also know from experience that there are some instances where family councils are somewhat co-opted by the owners. When you're having a family council meeting and you're trying to discuss things that are very important to the home and staff is there, it's not good.

**The Chair (Ms. Laurie Scott):** I'm sorry, we're out of time, but we will move to the next round of questioning with the government side for four and a half minutes this round. MPP Sandhu.

**Mr. Amarjot Sandhu:** First of all, I would like to thank all three presenters for their presentations. The committee very much appreciates you taking time out to present before the committee.

My first question is to the Ontario Long Term Care Association. The proposed legislation, if passed, contains provisions that would increase the amount of information and data publicly shared about long-term care homes. For example, indicators such as hours of care delivery would be reported and made publicly accessible. Could you please shed some light on how improving access to data would be useful for families and other stakeholders, and what successful implementation of data publication might look like?

**Ms. Donna Duncan:** Thank you very much for your question. Data and transparency are profoundly important, and as we've seen over the last 20 months, being able to report to the public, to our residents and to families is profoundly important for us in ensuring that we are all held accountable and that we are meeting standards.

It will be important that we collect the right data and report it in the right way so that it can be processed by real, regular people, and that we are reporting on the outcome measures that really speak to quality, that speak to the resident and family experience more broadly. We do support an experience survey to be done annually by a third party, and to have that reported on so that everybody will understand what is happening across the province and homes will be able to measure home against home.

I don't know, Brent Gingerich, if you'd like to comment on the work that you're doing in your home around reporting and accountability.

**Mr. Brent Gingerich:** Yes, thank you so much for that question. Data is very important. That is how homes know whether they're doing a good job, how we compare against best practices in other jurisdictions. I think that's where we need to get to, so homes are able to compare apples to apples.

Just throwing up a bunch of clinical indicators that maybe don't mean a whole lot is not very helpful. What we need to make sure we're reporting, and reporting publicly on, are things that are really important—really important to our families. To me, those are the most important data metrics: Have we met or exceeded our families' and residents' expectations in the home? These are the types of things and data metrics that are universally applicable and can be compared, because at the end of day, it's what we're all working towards.

**Mr. Amarjot Sandhu:** Thank you so much for your response.

I want to utilize some time asking questions to the Ontario Long Term Care Clinicians. As clinicians working in long-term care, you have a unique perspective on the needs of our seniors and their complex needs. Can you please let the members of this committee know how the legislation improves the quality of care and the services medical directors will deliver to residents in long-term care?

**The Chair (Ms. Laurie Scott):** I'll just say there's a minute and 20 seconds to respond, please. Yes, go ahead.

**Dr. Fred Mather:** I'll pick up from what Brent just said, which is that Bill 37 calls for more regular reporting, and that regular reporting will include benchmarks. It also specifies infection prevention and control, which we've talked about, that homes should have a dedicated infection control coordinator. From my front-line experience of observing outbreaks, those homes that were best prepared were the homes where they had a full-time infection coordinator who was familiar with best practices and prepared with proper PPE.

**Mr. Amarjot Sandhu:** Thank you so much, Chair.

**The Chair (Ms. Laurie Scott):** Thank you very much. We will now move to the opposition for the final four and a half minutes of questions. MPP Singh, please go ahead.

**Ms. Sara Singh:** I think I'll just start with Cathy, really quickly. Cathy, you were just finishing up your thoughts around the family councils and how family members can be better empowered. Do you mind just finishing that thought?

**Ms. Cathy Parkes:** I was just basically saying that there are frequently times when family council meetings have the owners present throughout the entire meeting. That, of course, causes a conflict when you're trying to discuss private issues between other members that need to be dealt with. And I hear that happens quite a lot. I don't know; I'm just familiar with what I'm involved in.

**Ms. Sara Singh:** Thank you so much for sharing that perspective.

My final question will be to Donna and Ruth. I know that you had touched upon the importance of addressing the staffing crisis that's in long-term care. I know that there has been a demand and a push to help internationally trained professionals have their credentials recognized and expedited.

Donna, can you share a little bit of that perspective in terms of how this is something that the government isn't maybe adequately doing and is an important part of addressing the staffing crisis here in long-term care?

**Ms. Donna Duncan:** Thank you for your question. OLTCA has been working closely and supporting the work of World Education Services and other newcomer organizations in problem-solving to expedite the process to credential internationally educated health professionals. We have a critical shortage of front-line staff in our long-term care homes, especially regulated staff. We have parts of the province where there are no nurses. We are hearing of the exodus of nurses from our hospitals and also from our home care sector as well.

We have 20,000 internationally educated health professionals in Ontario today who are not working in the health care system. We have to find a way to have them credentialed as quickly as possible. Two nurses from the same community, from the same program, having worked in front-line nursing in South Asia—one can go to Brooklyn and be credentialed in New York state within 90 days. In Ontario, her colleague who came to Toronto has to go through a four-year nursing program to be requalified as a nurse again. That is unacceptable. We have these extraordinary resources here today. We need to find a way to credential them as quickly as possible.

We have to have a very integrated health sector workforce plan that we are very committed to working on. We don't know what the gap is today. We've lost so many staff over the last 20 months. We have to make up for them as well as add the additional staff for the four hours of care. It's going to be a real challenge, and it really is going to take a lot of creativity and some boldness to cut out the process and streamline the process. We shouldn't have to hire navigators to help internationally educated health professionals get credentialed. That means the process is too complicated. We should make it as simple as possible and support them onboarding into our world as quickly as possible.

**Ms. Sara Singh:** Thank you so much. I think we're out of time.

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

**Ms. Sara Singh:** Okay, wonderful.

In the final minute, just picking up on the theme of training for folks in the sector, can you maybe speak to the importance of specialized training, for example, in dementia care, in working with people with intellectual disabilities and the need for this and the gaps that currently exist?

**Ms. Donna Duncan:** I'm going to ask Ruth McFarlane to speak to that and that front-line experience.

**Ms. Ruth McFarlane:** Great. Thank you. As I had said earlier, every resident population is different, and it goes to specialized dementia programming. There are also factors in cultural sensitivity. As people age, as you know, they revert back to their first-learned language, and then that becomes even more complex with cognitive impairment. There is a real need to specialize to be able to meet the needs of our residents. They are very complex. We need to look at individualized care. There is no one approach that is going to take care of everybody—

**The Chair (Ms. Laurie Scott):** Thank you very much. I appreciate that.

Thank you to the presenters and the questioners this morning. We will now recess, to begin again at 1 p.m. Thank you so much, everyone, this morning.

*The committee recessed from 1000 to 1300.*

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

ONTARIO PUBLIC SERVICE EMPLOYEES  
UNION

DR. VIVIAN STAMATOPOULOS  
GOLDBLATT PARTNERS LLP

**The Chair (Ms. Laurie Scott):** Our presenters are grouped into threes for each one-hour time slot. Presenters will have seven minutes for their presentation, and today's next group includes the Ontario Public Service Employees Union, Vivian Stamatopoulos and Goldblatt Partners.

We will begin with the Ontario Public Service Employees Union. If you would unmute, and we will unmute from our end. You can proceed when you're ready.

**Mr. Smokey Thomas:** Good afternoon, everyone. I'd like to start by thanking the Clerk and members of the standing committee for holding this hearing on Bill 37 and inviting me to say a few words on behalf of my union's members.

OPSEU/SEFPO proudly represents 180,000 public sector workers in Ontario, and that includes some 4,200 care workers in long-term care, retirement homes and related facilities who work in a variety of classifications, and also 200 inspectors working under the Ministry of Long-Term Care. Our members are highly skilled and dedicated workers who are passionate about providing the highest quality of resident care possible in Ontario's long-term care system. They are experts in this field and they are on the ground with long-term care residents every day, providing care, making sure homes are operating safely and keeping the entire system running. They have worked tirelessly during this crisis to help keep residents safe.

The submission before you is guided by their many years of knowledge and experience in our long-term care system, and we are pleased to see that Bill 37 addresses some of the key issues our members have been speaking about for many years. It calls for proactive long-term care inspections, increased fines for long-term care home offences and it grants inspectors more powers of enforcement to make sure our facilities are safe. It addresses the need for increasing the hours of direct hands-on care and it also shows the Ministry of Long-Term Care's willingness to be accountable and to take action to improve the quality of care.

These are all positive steps forward that will go a long way in strengthening our long-term care system, but in order to fully repair the system to meet the growing demand for care, to support workers and to protect residents from this pandemic and any future pandemics, we believe that there are additional steps to be taken and some additional changes needed to Bill 37.

As we all know, Ontario's long-term care homes experienced extremely high rates of infection and transmission of the COVID-19 virus. The introduction of an infection prevention and control program, outlined in Bill 37, is an important step in keeping our long-term care facilities safe. However, it should not be left up to individual facilities to map out their own programs. Leaving this up to individual facilities is a disservice to workers and residents alike. There must be a comprehensive province-wide infection control plan that all facilities abide by. That way, we can be guaranteed that each home is held to the same high standard of health and safety, and our long-term care inspectors can assess and report on it.

While we're on the topic of infection prevention and control, one of the key ways to prevent the spread of the infection is to provide better job opportunities for the sector. All long-term care workers deserve full-time jobs that provide them with decent wages and benefits.

Ontario has an aging population, and it's a fact that we've long been aware of. The demand for long-term care in Ontario is high, and that demand will only keep growing. Our long-term care workforce must grow to meet this demand too. The government has shown that they

understand this by investing in PSW training and temporary PSW wage increases, but we must pay all long-term care workers in all job classifications more fairly and increase the number of full-time positions available. Long-term care workers shouldn't be forced to work three jobs to make ends meet, and reducing the movement of staff between homes will also help reduce the spread of viruses like COVID-19 and will improve the continuity and quality of resident care. How can we attract the skilled workforce needed if the work is part-time, precarious and dangerous? More quality job opportunities mean higher retention, and I believe it's that simple.

Improved staffing levels also are crucial in making sure our long-term care system is able to meet the rise in patient acuity and the growing complexity of care. This is why OPSEU/SEFPO is also recommending that the ministry mandate staff-to-patient ratios. Having staff-to-patient ratios in place would improve both the quality of resident care and worker safety. If the government is committed to meeting the direct care target of four hours per resident per day as indicated, then they must invest in hiring the appropriate number of staff to make sure of it.

Bill 37 outlines that the ministry will report on this direct care target annually to ensure it is being achieved. That's a positive and promising step, but it doesn't go far enough, because averaging the four-hour target across all long-term care homes is problematic. It may paint a broader picture, but it doesn't ensure that this target is being met within each home or that each resident is getting the hands-on care they've been promised. Based on how it's currently phrased in the legislation, an individual home could fail to deliver the required four hours of care for residents and still not be in violation of the act.

Our vulnerable citizens in long-term care deserve much better than that. That's why OPSEU/SEFPO is recommending that the direct care target be evaluated per home, to hold each long-term care facility accountable and maintain the highest standard of care. The pandemic has shone a light on many of the issues in the long-term care system, and there are many lessons that we must not take for granted while reforming long-term care.

For decades, we have fought hard against the privatization of our health care system. We have long said that people must always come before profits. There is no better example of the pitfalls of privatization than our very own long-term care system, which some have called the Wild West of Canadian health care. During the COVID-19 crisis, this was more obvious than ever, because the private, for-profit homes, which are infamous for cutting corners to cut costs, had the highest rates of infections and fatalities. Public versus private health care can mean the difference between life and death, and this lesson must serve as a wake-up call for governments of all stripes.

The for-profit long-term care business model is broken. It's time to focus on making long-term care fully public, and Bill 37 should include strong language to make sure that this is implemented.

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

**Mr. Smokey Thomas:** We're recommending a freeze on issuances of licences for private, for-profit organizations in the long-term care sector.

If I can conclude by saying this: There has been a lot of blame cast around throughout all this crisis, but this crisis in long-term care is the collective shame of every political party, of every union, of every citizen in this province. We have all let our seniors down. I would hope that while we push hard to take profit out and to improve care and reform the system, I would really implore all political parties, all unions, everyone to take the politics out of it as well. Let's come together in a non-partisan manner to fix this system once and for all. Let's listen to each other, let's listen to the good ideas and let's do what's right for our seniors, who built this province.

**The Chair (Ms. Laurie Scott):** Thank you very much. Vivian Stamatopoulos, please. If you could just state your name before you begin. Thank you.

**Dr. Vivian Stamatopoulos:** It's Dr. Vivian Stamatopoulos. I do want to point out that it is "Dr."; I worked very hard to get those three advanced degrees, and it was curiously absent on the public agenda, so let's be clear on that.

Second, I also want to start with pointing out the rushed process of these proceedings. Giving people a day to apply for standing and only providing two days of public hearings is frankly unacceptable and wildly undemocratic.

That aside, I'm going to jump into my three points that I want to focus on. To start: the morally repugnant removal of the commitment to non-profit delivery in the preamble and its replacement with the curiously undefined "mission-driven" terminology. To me, in my opinion, this appears to be a blatant tool to allow for more Harris-style damage by further entrenching the for-profit sector in this Ontario long-term care sector.

Minister Phillips recently revealed that this government is allocating 64% of the recently approved LTC contracts to the private sector. For contextualization, what got us into this for-profit mess in Ontario—and keep in mind that Ontario has the largest share of for-profit long-term care across Canada—is because of the Harris days, when he allocated 68% of all of the contracts to the private sector. What we are seeing this government do is to replicate, essentially, the bad strategy that we saw the Harris government first put in place, and that's wildly problematic.

I want to know what is being done to reduce the stronghold of for-profit in long-term care, and I want to remind everyone that the contracts that are being given out now are generational. These are 25- to 30-year contracts, so the decisions being made today have consequences for the entire next generation of our seniors and persons with disabilities in these facilities. So it's not for nothing; it's really important that we get it right now.

Just in case people missed the statistics, I want to remind everyone how badly the for-profit sector failed during COVID. We have long-standing international and domestic evidence of the failure well before COVID, but during COVID in Ontario, the most recently available data from the Toronto Star revealed that 7.3 deaths occurred in

the for-profit sector for every 100 registered beds. That goes down to 3.8 for the not-for-profit sector, the lowest being the municipal sector with 1.5. Frankly, in my opinion, given the clear evidence—particularly in this case, during COVID, but also well before—the municipal model is the only model we should be expanding going forward.

**1310**

I want to remind everyone that this pattern held despite factoring in community transmission and facility design, while also removing the 10 homes with the worst mass casualty events, being Tendercare, Roberta Place, Orchard Villa, Camilla Care, Hawthorne Place, Village at St. Clair—all of these homes that I've just mentioned are for-profit. I think it's so vitally important that we not only remove the "mission-driven" language from this preamble, but that we strengthen it and reiterate the commitment to non-profit delivery, which is something our long-term care commissioners made very clear in their final report.

When we look to the Ontario landscape, I'll remind everyone the breakdown of ownership of the three types of homes, being private for-profit, private not-for-profit and municipal. The private for-profit industry holds 58% of all of our long-term care share, so to speak; the private not-for-profit homes, 24%; and the municipal sector holds 16%. How is it that the model with the most documented worst outcomes has the greatest share of our long-term care sector and the model with the best documented outcomes, being the municipal, has the lowest share? That makes zero sense to me and everyone else on the ground floor and all of the experts in long-term care. We want to know what you're doing to address this very glaring failure in terms of the for-profit model.

Next I want to move onto the four-hour care standard, section 8. There are several issues here. The timeline is blatantly unacceptable. Let's be real here: Our residents will be deceased by the time any of these improvements take effect; it's just unacceptable. Also, scrap the language that allows you to extend the target, in section 41(2)(f).

Smokey mentioned this: The fact that we are using an average across the sector is so wildly problematic. Let me tell you why. We all know that we need a minimum of four hours of care per day per resident and, most importantly, per home, because any statistician will tell you—I teach my students this every year—that of all the measures of central tendency you shouldn't use when you have a skewed distribution, it's the average, because we know, for example, it obfuscates the outliers and we know that non-profit, particularly in the municipal sector, provides much greater levels of care. So what adding this all together cumulatively does, by using the average as your measure, it will mean that it will obfuscate and it will hide the poorest of the poor performers, particularly for-profit performers, and make them appear better than they are, and that is simply unacceptable. We need per-home minimum care targets, care standards with clear penalties for non-compliance—not targets; we need requirements.

I also think we need to be very clear with transparency and public reporting. I'd like to see these staffing data

publicly reported in two places. I also want these data to be updated frequently, and I want it to be open to surprise audits because that's crucial. I want it somewhere—and this is done in US jurisdictions, so it's important that we model best practices, right?—posted physically inside the home, prominently for staff and families to see, and then, second, obviously post it electronically somewhere. My suggestion for that would be the long-term care inspection public reporting website where all the inspection reports are housed. I think it would be a great place, to put those data there.

Also, something that is glaringly missing is, where is the information on the workplace? This is your time right now to include regulations around the staffing, the precarious work arrangements in this sector. You could mandate a 70-30 full-time/part-time split. You could mandate that operators hire staff directly and stop abusing agency workers.

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

**Dr. Vivian Stamatopoulos:** You could provide paid sick leave, a minimum of 10 days, which would eradicate what we saw in the wildfire of the first two waves. Provide livable wages. The unequal staffing mix: Deal with that.

But to end, I want to deal with the most particularly egregious indignity that was suffered by these residents: the unlawful isolation and separation from their families. The ability of long-term care homes and this government in the emergency orders to trample over their rights—which did exist in the previous act, by the way—and to forcibly confine these residents for nine months was the most disgusting facet of this pandemic.

MPP Daisy Wai, I appreciate that you got to spend your final days with your mother at her bedside, but thousands of Ontarians didn't get that right, and I didn't see anyone from this government stand up and defend the rights of those families while they died alone without their loved ones around. That is a trauma that they will never get over. I want you to understand that, because I've heard the trauma, and it is unbearable how the pain lives with them to this day.

I want to see clear, non-negotiable language granting EFCs, essential family caregivers, non-interrupted and private—

**The Chair (Ms. Laurie Scott):** I'm sorry to interrupt, Doctor, but your time is up. Thank you very much for your presentation.

The next presenter is Goldblatt Partners.

**Mr. Steven Shrybman:** My name is Steven Shrybman, and I'm a partner in the law firm, Goldblatt Partners. Thank you very much for the opportunity to present to the committee today.

I practised public interest law for several decades, including various matters related to Canadian health care, including proceedings before the Supreme Court of Canada. I've worked extensively with trade unions and for health coalitions across the country and provided an opinion to the Ontario Health Coalition—a brief opinion—on two elements of Bill 37, which I believe they'll be providing to the committee.



I'm also the co-author of a report with several experts in the sphere of long-term care about the need to transition away from for-profit care in the province. As Dr. Stamatopoulos pointed out, unfortunately, the act all but negates the preference for non-profit long-term care rather than take a step in the opposite direction, which is one we desperately need to pursue.

I want to restrict my remarks today to one element of the current legislative framework around long-term care and Bill 37, because I believe that it, more than any other provision in the act, is probably the most important safeguard against the reoccurrence of the horrendous consequences that have befallen residents of long-term care over the last few years.

The recent and unnecessary loss of life and suffering of long-term care residents, if it is never to be repeated, whatever the precipitating cause, one provision of the act is arguably most important, and that provision is set out in the current act under section 98, which provides that, "A person is only eligible to be issued a licence for a long-term care home if, in the director's opinion ...

(1) "the past conduct relating to the operation of a ... home ... affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity ...

(2) "it has been demonstrated by the person" or corporation, including "its officers and directors," that it "is competent to operate a ... home ... and is in a position to furnish or provide the required services ...

(3) "the past conduct" of the prospective licensee "affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents."

These are the eligibility standards in section 98 of the current act, and they're actually carried forward in Bill 37 under section 101. But the current act provides critical reinforcement for the importance of these standards by making explicit reference to them in the provisions of the act empowering the director to issue licences. For example, under section 99 of the current act, "The director may issue a licence for a long-term care home ... subject to any restrictions by the minister ... and subject to section 98." That's the section that set out those eligibility criteria. I quoted three of them, but there are more. In other words, in empowering the director to issue a long-term care licence, the act reminds her that this can only be done if the recipient is eligible.

But while Bill 37 preserves the eligibility standard, it removes all subsequent references to it. For example, the power to issue a licence remains essentially unaltered in Bill 37—it's in section 102 now—except that the qualifying reference to the eligibility standard has been deleted. The same is true for every other reference to the standard that similarly has been removed from the provisions empowering the director to give an undertaking to issue a licence, to impose conditions on the transfer of a licence, to approve someone gaining a controlling interest in a home, or approving management contracts. In other words, under the act as it is now written, these director powers are explicitly to be exercised subject to the

eligibility requirements. This stipulation is inexplicably removed by Bill 37.

These omissions are particularly important because as we know, there are several long-term care licensees with terrible records of non-compliance with the act and the regulations, that have repeatedly failed to operate homes in a manner that wasn't prejudicial to the health, safety and welfare of its residents. These include homes in which literally dozens of residents perished during the COVID pandemic because of neglect and incompetent management. Such companies and individuals are clearly not eligible to be licensed under the act, and there is no reasonable basis upon which a ministry official could conclude otherwise. Nevertheless, several of these same companies are now applying for licences so they can continue and even expand their operations.

**1320**

Surely, it can't be the government's intention that licences be given to companies and individuals that have persistently failed to comply with the act and that have, through neglect or indifference, caused serious harm and death to residents in their care; or to shield such a decision by a ministry official to issue a licence to a company like that from judicial review. Yet this is precisely the signal ministry officials are likely to take from amendments that seem to have no other purpose.

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

**Mr. Steven Shrybman:** I've limited my remarks to this one issue because in a voluminous bill, it would be easy to overlook the simple deletion of references to a single statutory provision—that's now section 101 in the bill. But in my view, the assiduous application of the eligibility standard will have more to do with guarding against a failure of a catastrophic character that far too many long-term care residents had to suffer. Thank you.

**The Chair (Ms. Laurie Scott):** Thank you for your presentation. We'll now move to Goldblatt Partners, if you would like to begin, and state your name.

*Interjection.*

**The Chair (Ms. Laurie Scott):** Oh, I'm sorry. That was Goldblatt; I apologize. Now to questioning—

*Interjection.*

**The Chair (Ms. Laurie Scott):** Sorry about that. I believe MPP Lisa Gretzky has joined us. If she would please state her name and where she is.

**Mrs. Lisa Gretzky:** Yes, it's Lisa Gretzky, MPP for Windsor West, and I am in Toronto.

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

MPP French, was that just for the first round, or did you have a question? No? Okay.

The first round of questioning starts with the opposition. It's seven and a half minutes, and I will look to MPP French to begin.

**Ms. Jennifer K. French:** I welcome everyone to this afternoon. Thank you for your presentations.

I would actually like to first say to Mr. Shrybman, your specific remarks, if we could have a copy of those, I would love if you could share that with the committee, the specifics. It's the first that I've heard this at this committee. Thank you. It's an important point.

I would like to ask a question of Dr. Stamatopoulos. I think you got cut off there at the end. Was there anything that you wanted to continue in your remarks, before I ask a specific question?

**Dr. Vivian Stamatopoulos:** Thank you. What I wanted to say for clear action items that we need to maintain the rights of essential family caregivers in long-term care is not only clearer and very non-negotiable language of immediate and non-interrupted private access to residents at all times, we also need a formalized, ideally tribunal, system that we see in other sectors to address immediate violations as they occur, because we know that they will occur.

Frankly, there is a bill before this government, Bill 19, the More Than a Visitor Act, tabled by NDP MPP Lisa Gretzky here, that would legislate legal rights for essential family caregivers across all congregate care, which is so desperately needed. So you don't even have to do the work; you just have to pass that bill, and we will have legal rights for all families to never be forcibly separated from their loved ones again.

**Ms. Jennifer K. French:** Thank you. We're hearing a lot from this government and others focused on the PSW hiring. We haven't seen the government willing to make a permanent wage increase or make it a career with benefits etc. Do you have thoughts on how we can address the staffing needs, separate and apart from that, in your work with folks? Do you have a recommendation on that?

**Dr. Vivian Stamatopoulos:** Yes, I do. Frankly, what I've been seeing from this government is just putting Band-Aids on the bullet hole that is long-term care in terms of staffing.

What we're seeing is an overreliance on PSW programs, getting as many recent graduates accelerated through programs into this workforce, while not dealing with retention. Furthermore, we have thousands of workers who left long-term care during the pandemic. Why aren't we focusing on attracting them back? Is it because it's cheaper, and new students are more docile and more amenable to exploitation? Why don't we talk about that? We could get thousands of well-skilled, highly trained workers back in long-term care. They'll come back, and they've told their unions they'll come back, if you provide them with safe living and working conditions, a livable wage and proper care standards now.

**Ms. Jennifer K. French:** Thank you very much. I'm actually going to hand it over to my colleague Sara Singh.

**Ms. Sara Singh:** Thank you so much, MPP French.

Good afternoon, everyone. Thank you so much for your presentations. I'm just going to carry on with that line of questions to Dr. Stamatopoulos. I think that the concerns around section 8 and meeting these targets when there are already concerns around the average per home, but also the staffing resources that are actually needed to meet these targets—can you maybe share a little bit around the staffing crisis that we have in long-term care and how the government will even meet the targets that it has set out in this legislation?

**Dr. Vivian Stamatopoulos:** The government will not meet its targets; there's no question about that. We have

lower staffing levels now than we've ever had, and this is a real dangerous issue. We've lost so many workers during COVID because of dangerous working conditions. Who blames them for leaving for greener pastures? I mean, this was a terrible place to work during COVID, and they were completely unprotected by this government, and I've pointed that out all throughout the last 16 months. We also know that the current staffing targets are less than 20% of what we actually need to get to that target, and CUPE experts really pointedly mentioned that yesterday during the reviews.

I also want to point out that this is a very exploitative staffing strategy, focusing on PSWs, the only unregulated worker segment of this population—which, conveniently enough, when the for-profit sector took on their stronghold of this sector, you saw the staffing mix flip on its head. It used to be predominantly nurses working in nursing homes—hence the term “nursing homes”—and then it went to a vast majority of PSWs, an unregulated workforce comprised primarily of racialized women, many of whom are new to Canada, and refugees. This is the problem: They are exploited by agencies, and they are exploited by many of these homes and not provided proper working conditions and proper paid sick leave. Some of them earn as low as \$13 an hour. This is atrocious.

What about hiring more nurses? The 200 that I heard the other day—that's not going to do anything. What about the doctors? Do you know how many times I hear from families that doctors are missing in action? Where are they? It's a side gig for them. Why don't we have daily physician care in these facilities so we don't have stories like—we put one out yesterday in the news of a family that had to contact their own family doctor to get help for their loved one in long-term care because they couldn't get a hold of the physician. How about that?

**Ms. Sara Singh:** Thank you so much, Dr. Viv, for highlighting what is a crisis in long-term care and the fact that the government's announcements are not going to help adequately address the staffing ratios that are needed, but also that there isn't a mix in the staff that are going to be allocated in homes.

I think this also brings up a really important point, and you did a fantastic job of highlighting this through your presentation as well, in terms of the differences in outcomes with respect to for-profit homes versus municipal homes and the value for dollar, really, that you see when we compare the outcomes in those homes. We hear often from the government that it's simply not possible to transition the long-term care sector from one that is predominantly favouring for-profit homes to one that is not-for-profit. I know Dr. Shrybman also touched on this, as did Smokey Thomas—Warren—as well.

Viv, can you maybe share a little bit about how this transition is possible to more municipally operated not-for-profit homes and why the reliance on for-profit care is so detrimental to actually addressing the crisis that we have?

**Dr. Vivian Stamatopoulos:** Well, we have three cases right now. I'll give you a local, a provincial and a country-level specific example of how you can do this. We heard

last month that Sienna, one of their homes, Camilla Care, which was rocked badly during COVID, is now being sold to the non-profit organization Trillium Health Partners. It's happening right now, pending provincial approvals, so we know it can happen.

Provincially, we just saw Saskatchewan last month end all of its relationship with Extendicare, transitioning all their homes to the Saskatchewan Health Authority. We could do that.

And then a country-level case which is particularly important: Norway. The entire country, in 2015, after noted issues with the for-profit sector, many of which we—

**The Chair (Ms. Laurie Scott):** Sixty seconds remaining.

**Dr. Vivian Stamatopoulos:** They ended all existing contracts with the for-profit sector and prohibited new contracts going forward, and the municipalities took over. It clearly demonstrates that we can, with political will, reverse the dangerous dominance of corporate for-profit ownership in long-term care.

**Ms. Sara Singh:** Thank you. I think that's my time. We'll certainly continue this conversation in the next round.

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

The next round of questioning goes to the government side for seven and a half minutes. MPP Triantafilopoulos will please begin.

**Ms. Effie J. Triantafilopoulos:** I'd like to thank all of the presenters for taking time out today to join us, providing such thoughtful testimony.

I think that we can all agree that seniors' care and their needs have been ignored for far too long, as Mr. Smokey Thomas has said in his remarks. It's important for our government to note that we inherited a broken system. The Minister of Long-Term Care has had extensive stakeholder consultations, as I have in the last few years, and I know that many of these consultations were in fact with members who are on this panel today. We're also going to continue these consultations through the strategic long-term care table that is being chaired by the deputy minister of long-term care and myself as the parliamentary assistant.

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This legislation before us will, in fact, set the framework for care, so your feedback today and on an ongoing basis will be very helpful to us, as will be the feedback for many stakeholders. We're all in this together. Together, we're going to be able to move forward in order to truly change the culture that we need to change, going forward, in the care of our seniors.

My first question is going to be for Mr. Thomas. It's specifically tied to the inspections. As you know, we've spent, as a government, \$20 million to hire 193 more inspectors by the fall of 2022. That's more than doubling the number of inspectors. A year ago, Ontario had 156 inspectors, so our increase will mean we'll have about 350 in the field, on the ground, spending more time in homes and helping keep our loved ones safer in long-term care.

We are also increasing compliance and enforcement in this bill. We will increase fines and penalties for the major provincial offences: for individuals, \$200,000 for the first offence and \$400,000 for the second offence; and for corporations, \$500,000 for the first offence and \$1 million for the second offence. These fines will be equal or greater than those in any other province in our country. Any staff or volunteers convicted of provincial offences will not be allowed to work in the long-term care sector again.

This is on top of the inspections already in place. Some 1,478 inspections have been completed from January 1 to October 1 this year. Every home receives an inspection at least once a year and inspections are prioritized daily based on harm, or risk of harm, to a resident. So my question to Mr. Thomas is, do you believe that these new measures will increase the safety and security of long-term care home residents, and what additional advice do you have for us today?

**Mr. Smokey Thomas:** Thanks for the question. One thing I would say that the government is on the road to getting right is the inspections. Fifteen years of the Liberal government, and Harris before that, we saw inspections all but virtually eliminated. The inspectors—when you recruit, I'm hoping you will recruit people with some lived experience, and experience in health care and/or pharmaceuticals. Plus, I'm told you're going to hire some people who are actually investigators. That's really good. That is all really, really good news. The ability to drop in and not be denied access is key. I would say you're on the right track.

I do have some more input for the ministry. I'm having another call tomorrow with some of our long-term care inspectors for some more right-from-the-front-line experience and how it's working to date, how the recruitment is going and some comments on the proposed legislation. We did submit our presentation. So I will have more input for the government from the front line on that.

I think the key will be in the operational procedures that the inspectors can have. Senior managers, mid-managers can no longer be allowed to deep-six reports. They can no longer be allowed to alter them, can no longer be allowed to ignore them. I see that in some of the communication so far that that will be addressed. I have to say, on this one, the government is well on their way to getting it right. I and my members are grateful for that. I think that bodes very, very well for the residents of long-term care.

**Ms. Effie J. Triantafilopoulos:** Thank you very much. Just a further question on this whole issue of accountability: As you know, this is one of the pillars that is going to be embedded in our legislation. The Minister of Long-Term Care has indicated that this bill will hold the system accountable by measuring the quality of care and the quality of life of residents of long-term care. Ontario will track a number of different indicators for homes across the province, using home-by-home annual surveys of residents, families and caregivers. These results will be made public for residents, future residents, families and the general public to review.

What advice would you offer to help the government ensure that these results will give people the information

they need, whether it's for a resident to decide on a long-term care home, or a family to see that excellent care is being provided?

**Mr. Smokey Thomas:** I would say the comments made by the previous two speakers are very relevant and certainly bear very careful consideration. I would support what they've said.

I'll give you one way of increasing accountability: Every nursing home should have to take students. One of the problems in the education system is finding co-op placements for experience. I'm an RPN by trade, working most of my adult life in a psychiatric hospital, so I've done every kind of nursing care you can imagine, which includes what's done in nursing homes. If you have RPN, RN, physiotherapy, occupational therapy and PSW students, if all these homes have to take placements, people get experience.

**The Chair (Ms. Laurie Scott):** Sixty seconds.

**Mr. Smokey Thomas:** But the key is that it's another set of outside eyes and ears. Believe me, these students will go back to their instructors and say, "Do you know what I saw in that home today?" I've worked with a lot of students over my time.

If you want to do something really good to remove the stigma of working in there, but also to bring in those additional eyes and ears for real, true accountability, just have students. Each home must take students.

**Ms. Effie J. Triantafilopoulos:** Thank you very much for that suggestion. It's a great idea.

I think we're out of time, Chair?

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

The next round will be seven and a half minutes, and we will start with the official opposition. I'm just looking for a hand—

**Ms. Sara Singh:** That's me. Thank you, Chair. I'll be kicking us off, and I'll be sharing my time with MPP Lisa Gretzky as well in this round.

I want to pick up on the theme of inspections. I think it's important to highlight that inspections obviously are necessary, but what I think is even more important is acting on those inspections and holding folks accountable.

I'd like to ask this question to Dr. Vivian. If you could maybe shed some light, as we've heard a number of concerns around the inspections and the fact that they aren't comprehensive. They aren't a resident quality inspection, and so they're very limited in scope. But also, we've also heard a number of concerns around a culture of fear that is being created around inspections. Can you shed some light on this?

**Dr. Vivian Stamatopoulos:** Sure. We know that the RQIs, the resident quality inspections, have been all but decimated under the Ford government, and that needs to be reinstated. There's no question about it. One of the most glaring differences that we can really focus on is comparing us to Australia, which gives thousands of their version of RQIs every year. We should be doing a minimum of two RQIs every year, per home. We did, what, nine in 2019? Nine out of 626 homes—are you kidding me? In 2015, at least each home was getting one

per year, and that got decimated to nine of 626 homes. That's a clear problem.

We need to reinstate a minimum of one unannounced surprise inspection per year, and we need to make sure that these inspectors have no conflicts of interest with anyone working at the homes that they are inspecting, because we've heard that this can be a problem. So it's not for nothing, but we need to immediately reinstate those and make it very clear that there will be no conflicts of interest with the inspectors.

And hiring more inspectors is great, but again, what's the point of hiring them if they're not going to go out there and do their jobs, actually inspect and proactively catch problems before they occur? The result is the massively increasing critical incident inspections that have actually happened as a result of removing resident quality inspections, which will more proactively catch the errors before they happen.

So obviously there's that, and then there's accountability. If you just keep writing people up for negligence contributing to death—and, by the way, if you keep Bill 218 in place, which allows these homes, by this government, to operate negligently—how do you expect any of these homes to actually change their behaviour when they know they have a get-out-of-jail-free card? Let's be real about accountability and let's show that we mean what we say, that we're going to protect these residents and repeal Bill 218, and actually start levying the penalties that have long been in place against these bad actors—and we know who they are.

**Ms. Sara Singh:** Thank you so much. Just in the interest of time, I'll throw it over to MPP Gretzky for some questions.

**Mrs. Lisa Gretzky:** Thank you, Sara. I appreciate that.

My question is to Dr. Stamatopoulos as well. I was actually going to ask about Bill 218 and that legislation, and how what is in this current bill changes anything with Bill 218 in place.

I just want to add on to the fact that not only did this government—in the height of a pandemic, when 4,000 seniors died in long-term care from negligence—bring in legislation to protect the for-profit long-term care operators, that legislation also protects this current PC government from any liability for that as well. I think it's very clear what the priorities are of this government, and they certainly aren't the workers, the residents or the caregivers.

**1340**

Since Dr. Stamatopoulos already touched on Bill 218, I'm going to go back to the caregiver access piece. Dr. Stamatopoulos, as you had mentioned, I have retabled the More Than a Visitor Act. It is now Bill 19. I'm just wondering if you see anything in this legislation before us that would enforce or really change anything when it comes to a resident's ability to access their essential caregiver, and if you could also touch on the importance. I know I've heard stories, obviously, through the development of the bill, but you have heard from many, many families around the province, many more than me. What

have these residents gone through when their caregivers have been locked out?

**Dr. Vivian Stamatopoulos:** I cannot tell you how traumatic it was for these families. This is why I started my advocacy: I knew how terribly damaging it would be to lock out families because of the known issues in long-term care, the staffing gaps that existed well before COVID and knowing how much unpaid labour these caregivers provide and how they are really a crucial safeguard. Once you pulled that crutch, the system immediately collapsed. That's exactly what happened.

The trauma of these families to know and to see the accounts in the media—the military reports, the documented negligence and abuse and preventable death—knowing that they could help, but were locked out, was one of the most traumatic things that I have ever seen in my life. I cannot tell you how many times it keeps me up at night, hearing what these families went through. It is something that they will never forget, and they have never experienced a proper acknowledgement of or amends for the nine months of trauma of being locked out.

I conducted research with families across Canada, most of them being in Ontario, about this specific facet of being locked out and what it was like to be an essential family caregiver during this time, and it was tantamount to post-traumatic stress. What these families have been through will live with them forever, and I don't see anything in Bill 37 to reduce that damage and to make sure that we never, ever do this again to families across Canada, particularly in Ontario, where really the worst outcomes were had in the first two waves.

**Mrs. Lisa Gretzky:** If I can build on that, then: When we're talking about staffing, we know there have been staffing issues for many, many years under successive governments that have not been addressed. Do you feel that Bill 37, as it is written now, will truly address those issues, especially if there is nothing in the bill that ensures that residents have that right to access their essential caregivers, many of whom, as you pointed out, we know are not only there for moral support, but to actually provide physical support? They're there; they help feed. Do you find anything in this bill that will address that?

**The Chair (Ms. Laurie Scott):** One minute and 10 seconds, just before you start.

**Dr. Vivian Stamatopoulos:** No. I'll also point out that staff would tell me repeatedly that they missed having the family around, because they knew how much help they provided in these homes.

Until you do things like repeal Bill 218; until you do things like repeal Bill 124, which freezes nurses' wages; until you go out of your way to attract the people who left in this sector because of the improper care standard; until you create that care standard right now, which doesn't exist—the four-hour minimum per resident per day per home—then all you're doing is throwing Band-Aids at bullet holes. You're throwing money down the drain. If you focus on just recruiting new, recent graduates, we all know what's going to happen: They're going to get into the jobs; they're going to see what it's like working in this

very difficult occupation in these facilities, with no real rights, whistle-blower protections or proper regulations to protect their very difficult skilled work; and they're going to leave. That's what happens.

This government has done nothing to address the revolving door. All they're doing is throwing money down the drain by trying to get new students into the sector as fast as humanly possible to make it look like they're doing something, while knowing in the end that it will not do anything to address retention. And they will leave.

**Mrs. Lisa Gretzky:** I don't think there's [*inaudible*]. I thank you for your time.

**Dr. Vivian Stamatopoulos:** Thank you.

**The Chair (Ms. Laurie Scott):** Thank you very much. The next round of questions will go to the government. You have seven and a half minutes. I believe—MPP Ghamari, yes.

**Ms. Goldie Ghamari:** Thank you, everyone, for your presentations. I appreciate the time you took to be here with us today. It's been very informative.

Mr. Thomas, I just wanted to continue a little bit along the line of questioning that MPP Triantafilopoulos was asking you about. You made some comments about how you're pleased with the way our government has been working on this file and the changes that we have made with respect to protecting workers and supporting workers in the long-term care sector. I just wanted to ask a little bit about your experience with that. When you had the opportunity to meet with Minister Phillips and his team, could you please let me know how your advocacy has helped shape the increased inspections regime announced in this legislation?

**Mr. Smokey Thomas:** On the inspections, they listened, really did listen, and what they're proposing is a vast improvement over what has happened in the past. I would like to point out that under the Liberal government, which is really the government that decimated the inspection system, actually laid off inspectors and then cut the RQIs—this government made some mistakes early on, but they've listened, especially on the inspection piece, and my hope is they'll do it right.

And for some comments alluding to the fact that inspectors don't do their jobs and stuff, I'd take great umbrage with that. They're all professionals, they take great care at what they do, and they did the best job they could for the last 20 years with dwindling resources. I'm very proud of the work that they have done. During the pandemic, they weren't refusing to do their jobs. Actually, the government intervened—actually, the Premier intervened to make sure they got proper PPE and that they were cleared to go into the homes and the homes couldn't refuse. They got trashed when they shouldn't have been trashed.

Again, at the end of the day, I will rely on front-line workers and I will continue to advise the government, and I'll hope that the fine points, the procedures, how they roll out the manuals, all that kind of stuff—I hope that's all listened to. So far, from what I see, I've got to give them credit, because they're listening and doing.

**Ms. Goldie Ghamari:** Thank you for that. Could you provide maybe a few examples of what you just mentioned, so some of the examples you've seen of us listening?

**Mr. Smokey Thomas:** I can remember when the Liberals cut back on the RQIs. They promised to do X number in a year and didn't meet that target. What happened was, in the past, they'd been in a home for a week to two weeks, but everything would be inspected—plumbing, treatments, pharmacy, the electrical systems, the building systems, the layout of the facility—and they would get to speak to residents. The Liberals chipped away at all that in favour of less inspections. They changed to what they said would be a more efficient system, a complaint-driven system. That's all being flipped back on its head and being put back in place.

The key here is that the senior management level in the government, which those bureaucrats were inherited from the Liberals—they need to understand that when an inspector writes an order, just like it would be in the Ministry of Labour or transport enforcement, those orders must be adhered to. They do now have—if they show up at a home, they can enter. That is one of the key components, because it's great to say you're having an RQI once or twice a year—when I worked in a hospital, you used to have to get accredited. They spent a month getting us ready and the facility ready for accreditation. It's those drop-in inspections—I'm showing up at 6:30 in the morning or showing up at 7 o'clock at night—that are the key. That's what will keep people on their toes. They're back there now, and my folks, my members, are quite pleased with what is happening. Would they like it to happen a whole lot faster? Yes, but they understand that the wheels of government—all governments, in my view; it doesn't matter who has been in government—have two speeds, slow and stop, in all three parties I've dealt with.

I think on that part you're getting it right and I just hope they get it 100%.

**Ms. Goldie Ghamari:** Thank you very much for that, Mr. Thomas. I appreciate your input.

With respect to continuing to work with the government like you mentioned, could you maybe let the committee know how you are continuing to work with government to ensure that the target of increased enforcement is going to be achieved?

**Mr. Smokey Thomas:** Again, it's now in the recruitment and hiring phase, so the input that I've had is, "Can you please try and hire people with some lived experience?" Hire people who have been a registered nurse for a few years, or an RPN, who have experience.

They'll get extensive training. When you hire a Ministry of Labour inspector, they've got skill sets, but they get six weeks of very comprehensive training—it's really difficult to pass—on all the legislation that you're going to deal with.

1350

They're actually implementing it the same way with the long-term care inspectors, because I said to Minister Phillips, "Go look at the Ministry of Labour, get their guidance and they'll show you how they do the training."

They're actually doing that, and I think we're going to come out with a cohort of new hires that, while there will be certainly a steep learning curve, they will basically hit the ground running and have a very good handle on the work that they have to do. And it does take time to hire. Again, in the recruitment process, I think they're being quite selective, and frankly, I hope they are selective.

**Ms. Goldie Ghamari:** Thank you for that. So would you say that your experience with Minister Phillips and the government in working on reshaping and improving the inspections regime—would it be fair to say that it's been a positive experience—

**The Chair (Ms. Laurie Scott):** Final 60 seconds.

**Ms. Goldie Ghamari:** Thank you—and that, on behalf of your members, you feel that you've been listened to and that your input has been taken into account?

**Mr. Smokey Thomas:** Yes, I would say that's the very first statement, because they have listened. I just want them to listen to some of the stuff on some of the things about removing the stigma of actually working in long-term care. So, I want to work with the government and anybody interested in it. Let's start a campaign to remove the stigma on being a PSW or an RN or a doctor or somebody in long-term care, because the occupations have been vilified by many, many parties, sometimes rightly, sometimes wrongly.

But now we've got this huge recruitment problem, which the other two speakers spoke about. So now the work we need to do is, how do we improve the system so that we can demonstrate it's improved, and then entice and encourage people to actually apply and make a career of it? Good jobs, good wages, stability and that—but that is a monumental challenge, given everything that's happened.

**Ms. Goldie Ghamari:** Thank you very much, Mr. Thomas.

**The Chair (Ms. Laurie Scott):** Thank you very much. We'll now move to the final four and a half minutes of questions. We will begin with the opposition and MPP Singh. Please go ahead.

**Ms. Sara Singh:** My first question is to Mr. Shrybman. If you can just speak a little bit about the importance of using this as an opportunity at this critical juncture here in our province to transition our long-term care system to one that is not for profit—I know that the "investing in care" report outlines several recommendations on how we could do that, but could you succinctly share some of those ideas here with the committee?

**Mr. Steven Shrybman:** Well, I agree with Dr. Stamatopoulos that, really, you need to find ways in order to facilitate municipalities getting more and more long-term care licences and funding support to do that. One of the reasons those homes perform so much better than others is that municipalities top up the inadequate budget that's provided by the province for long-term care, so that's the first thing you can do to encourage more municipalities to take on this challenge.

In terms of not-for-profits, apparently the biggest problem they confront is having no access to capital. So even the provincial infrastructure bank—and this is true of

federal infrastructure funding, as well—is routinely not provided to not-for-profit providers, because they don't have capital reserves, and the reason they don't have capital reserves is that they spend all the money the province provides to them to provide care, on care—not profits, but care. And so they don't put away money in the bank, so that when they go for a mortgage, they don't have the capital reserves necessary to acquire one. If the province actually wants to support not-for-profit care, it has to make sure that not-for-profit providers have access to capital, so they can get in the game of getting new homes licensed. That's fundamental.

The third thing that needs to be done—and that's the thing I commented on most particularly—is that bad operators can't be relicensed, and many of them are now in the queue to get precisely that: a licence to continue to operate for the next 30 years. Regardless of how many inspectors the province hires, if the incentive of the care provider is to first and foremost make sure that there's a return on the investment of private investors in the facilities, they will find a way to finesse the requirements of the act so that less care is provided to residents within their care. So that seems to me to be fundamental.

**Ms. Sara Singh:** Thank you. I appreciate that, Mr. Shrybman. I think it really highlights how we can transition our system and what's needed here to support the not-for-profit sector.

Just with the last few remaining moments we have, I'll pass it over to my colleague MPP Mantha, who I believe has some questions for Dr. Stamatopoulos—I'm going to get it, one of these days.

**Dr. Vivian Stamatopoulos:** Okay.

**Mr. Michael Mantha:** Good afternoon, Dr. Stamatopoulos. What I want to come to you on is, I'm experiencing a very high level of frustration, and I'll tell you why—and I think you share that same level of frustration. Here we are. A couple of weeks ago, this bill was introduced and rushed through the House and discussion. Here we are now. We have two days of discussions and questions that we're going to have. On an issue of this importance—

**The Chair (Ms. Laurie Scott):** Final 50 seconds.

**Mr. Michael Mantha:** —on an issue that has been dwelling on us for the last years and years and years by preceding governments, I'm asking you: Was the seven minutes you were given today enough time to express and give you the ability to bring those suggestions forward?

**Dr. Vivian Stamatopoulos:** Seven minutes? Seven years wouldn't be enough to communicate the trauma that I have heard these families experience first-hand. From the hundreds I've spoken to in Ontario alone, seven years wouldn't be enough. So no, seven minutes is frankly a slap in the face to the 4,000 families who lost their loved ones in the most horribly preventable, negligent ways. I can't put enough emphasis on how upsetting that is, but if we can do whatever we can to try to put that to the public, to really let people know how horrible this was for these families and how it will traumatize them the rest of their lives, that's all I can do.

**Mr. Michael Mantha:** By minutes, just to let you know—

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

**Mr. Michael Mantha:** —we're about to get rushed into making amendments on—

**The Chair (Ms. Laurie Scott):** I'm sorry, MPP Mantha.

The next four and a half minutes of questions will go to the government. MPP Wai will begin.

**Mrs. Daisy Wai:** I thank all the presenters who came in—can you hear me? Okay.

There has been a fair bit of bandying about regarding “mission-driven organizations” in the preamble. I just want to make sure that we know, that this is in the record, in the bill's preamble:

“The people of Ontario and their government ... are committed to the promotion of the delivery of long-term care home services by not-for-profit and mission-driven organizations; and

“are committed to all long-term care homes operating” as a staffed home. I just want to make sure that is clear for everyone, and also for the record.

The other thing, too, is that I want to say that the mission-driven organizations will have “resident-directed, safe, quality care as the primary goal.” It is in the bill of rights, points 20 and 21. It says:

“20. Every resident has a right to ongoing and safe support from their caregivers to support their physical, mental, social and emotional well-being and their quality of life and to assistance in contacting a caregiver or other person to support their needs.

“21. Every resident has the right to have any friend, family member, caregiver or other person of importance to the resident attend any meeting with the licensee or the staff of the home.” So everything is very clear: Yes, a resident has that right to express. I just want to make that clear.

I want to go back to Dr. Thomas again. I thank you for letting us realize how important it is for the inspectors, what we have been doing. I can understand that, yes, allowing surprise inspectors coming in—as you just mentioned, they can come in any time, whether it's 6 o'clock in the morning or 7 in the evening, so the long-term-care or retirement homes will be on their toes, to make sure everything is in place. How does that help your members, as well as help those who are inspecting the homes?

*Interjection.*

**Mrs. Daisy Wai:** Dr. Thomas, you're muted.

**The Chair (Ms. Laurie Scott):** Smokey Thomas?

1400

**Mr. Smokey Thomas:** Oh, there we go. I can't unmute. Somebody there somewhere—

**The Chair (Ms. Laurie Scott):** We apologize for that—a 60-second warning, also. Sorry.

**Mr. Smokey Thomas:** Yes, okay. No worries.

I think it's key, because those surprise inspections are to keep people on their toes, especially when a few of them happen. It's a very small community in some ways,

because owners all talk and that, so I think it really will keep them on their toes.

If I could just conclude by saying, though: I am a big fan of municipally run homes. I think they're the most efficient, the best run. And I will say that some private, for-profit homes did a good job, so they're not all horrible, they're not all bad, but some of them are really horrible and some of them are really bad.

I once again would like to say thank you for the opportunity to make some comments.

**Mrs. Daisy Wai:** Thank you very much for your comments. I have no further questions.

**The Chair (Ms. Laurie Scott):** Thank you very much. Our time has come for these three presenters, so again thank you from the whole committee.

COALITION DE LA SANTÉ  
PALLIUM CANADA  
SEIU HEALTHCARE

**The Chair (Ms. Laurie Scott):** I would then like to introduce the next three presenters, who will have seven minutes each: Coalition de la santé, Pallium Canada and SEIU Healthcare. You're going to be up and each have seven minutes for a presentation, and then we'll follow up with questions afterwards.

If the coalition could please begin when you're ready, that would be great.

**M. Edward Cashman:** Je propose de parler en français. J'espère que vous avez réglé le problème de la traduction. Mon nom est Edward Cashman. Je suis de la Coalition de la santé d'Ottawa sur le projet de loi 37.

Madame la Présidente, mesdames et messieurs députés et membres du comité, merci de votre accueil et de cette opportunité de faire cette présentation. Je vous parle aujourd'hui des terres ancestrales de la Nation algonquine et anichinabée.

Qui sommes-nous? La Coalition de la santé d'Ottawa est un regroupement non partisan, à but non lucratif, au niveau communautaire, composé d'individus et de groupes. Nous oeuvrons pour la protection et l'expansion de notre système public et universel.

Durant cette pandémie et la crise liée en soins de longue durée, nous avons tous eu un père, une mère, un grand-parent ou un proche affecté. Prenons un moment de penser à eux et osons tous de faire mieux.

L'avantage de pouvoir faire une présentation le dernier jour des audiences publiques est d'éviter de répéter les mêmes choses et de se concentrer sur les points qui ont rapport avec notre région en particulier. Je vais donc me limiter à cinq points importants.

Je veux d'abord parler du préambule. Le préambule fait mention, dans la version française, « d'organismes investis d'une mission ». On comprend mal ce que ça veut dire. Un tueur à gages est investi d'une mission. Il faut ajouter une définition dans le projet de loi.

Nous sommes troublés que le gouvernement semble favoriser davantage des opérateurs privés au dépend des opérateurs à but non lucratif et publics, municipaux. Le

gouvernement semble vouloir récompenser, par exemple, les opérateurs du foyer Revera Carlingview à Ottawa, avec un des pires taux de décès dans toute la province durant la pandémie, avec un nouveau permis d'exploitation et des dizaines de millions pour faire construire un nouveau centre. On voit la même chose avec les opérateurs des centres Extencicare West End Villa, Extencicare Starwood, Sienna Madonna, Revera Montfort, tous à Ottawa et en banlieue.

Je veux parler de la dotation. La situation dans les centres de soins de longue durée à Ottawa et dans l'est de l'Ontario est difficile. Il y a un manque flagrant de personnel à tous les niveaux. Il nous manque des infirmières, des infirmiers, des préposés aux services de soutien personnel. On comprend mal comment les programmes de formation de la province vont aider à combler ces manques de personnel. Jusqu'à tout récemment, on se permettait d'aller piquer des infirmières et des préposés aux bénéfiques de l'autre côté de la rivière, au Québec. Maintenant que le Québec a haussé ses salaires, il est plus difficile de doter nos postes dans l'est de l'Ontario. La loi 124, qui limite les salaires des infirmières, n'aide pas non plus.

Les normes de services de soins minimums : à Ottawa, on compte quatre centres de soins de longue durée qui sont opérés par la municipalité. La ville d'Ottawa a préparé son budget financier pour l'année 2022 sur une base de donner un minimum de soin de trois heures par personne, par jour. Nous sommes reconnaissants que la province de l'Ontario aidera financièrement la ville d'Ottawa pour atteindre ce niveau de soins. On comprend mal, par contre, qu'avec un même niveau de financement, des centres de soins de secteur privé avoisinant n'arriveront même pas à atteindre deux heures de soins par jour—certains, seulement une heure de soins par jour. De plus, nous cherchons une norme de travail pour l'ensemble du marché de travail. On ne peut pas améliorer la situation sans un but d'ensemble. Le projet de loi utilise « cible »; il devrait plutôt indiquer « exigence ».

Dans la rubrique « Déclaration des droits des résidents » et résidentes, cette loi propose une nouvelle protection sans adresser un mécanisme pour le faire. Il faut un tribunal administratif pour régler les plaintes de non-respect des droits, afin d'éviter que ces plaintes se retrouvent en cour.

Pour terminer, l'application de la loi : ce projet de loi vise à doubler, voire même tripler, les amendes pour les infractions. Ce même gouvernement a fait passer la loi 218 qui cherchait à protéger les opérateurs de leurs responsabilités et en même temps a abandonné les inspections sans préavis. Nous exigeons des inspections—de vraies inspections avec de vraies conséquences.

Madame la Présidente, mesdames et messieurs députés et membres du comité, merci de votre attention.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you so much for your presentation.

Moving along to our next presenter, Pallium Canada: You have seven minutes for your presentation.

**Mr. Jeffrey Moat:** Good afternoon. Thank you for the opportunity to speak with you today. [*Inaudible*], which is



a national organization [*inaudible*] focused on building professional and community capacity to help improve the quality and accessibility of palliative care throughout the country.

I wish to acknowledge the land on which I am presenting from, the city of Ottawa, which is the traditional, unceded and unsundered territory of the Algonquin Anishinaabe people.

I'd like to begin by commending the government and this committee for its work on Bill 37 and for taking the bold step to include in legislation a commitment to expand the rights of residents, to guarantee that residents have the option to receive care with a palliative philosophy. This is an important first step, and we feel that this commitment is critical to developing a strategy that ensures that more Canadians receive better palliative care.

A palliative care philosophy, or what we refer to as the palliative care approach, improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual. The quality of life of caregivers improves as well.

In long-term care, as in many other care settings, front-line staff lack these necessary core palliative care competencies to provide even basic palliative care. Our medical and nursing graduates aren't necessarily entering into practice with these skills, either. Several studies now show that medical and nursing schools provide inconsistent and inadequate palliative care training.

According to a report released by the Chief Science Advisor of Canada, care provision in long-term care homes is primarily provided by a vulnerable group consisting of mostly older, racialized women who have little formal training and manage high workloads with frequent interruptions. Most care providers have limited formal education. Through the pandemic, we have seen first-hand too many patients with severe COVID and other diseases such as cancer and advanced heart, lung, neurological and renal diseases experiencing unnecessary suffering.

This lack of preparedness to provide palliative and end-of-life care is highlighted in Ontario's long-term care staffing study, which identified the ability to provide appropriate palliative care and work in end-of-life environments as a key challenge for long-term care staff that negatively impacts their mental health and well-being. This problem, however, isn't limited to pandemic circumstances; most long-term care residents enter these homes with advanced comorbidities affecting their quality of life, causing considerable suffering and leading to inappropriate use of health care resources, such as unnecessary transfers to emergency departments and hospitals, because of a lack of goals-of-care discussions and the inability of a long-term care home to provide in-house palliative care.

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For many years, the call to equip the workforce with these skills has been ignored or not supported. This has to change, and we believe this is the beginning of that change. We have the potential to improve quality of life for people with a serious or life-threatening illness while

also reducing health care costs, but it cannot be achieved if there is a lack of commitment towards palliative care by funders, policy-makers, managers and providers, and a lack of basic training and support for that training.

I'd now like to introduce Pallium scientific officer Dr. José Pereira.

**Dr. José Pereira:** Thank you. Committee members, an example of what a difference a little bit of training can make: Many years ago, while working as a family physician in a small community in rural Manitoba, I was approached by a patient who said to me, "I know I'm dying of cancer, but I can't live like this, with so much pain. I need a doctor to help control the pain." The problem was that I, like so many health professionals then, and unfortunately still now, had received no or minimal palliative care training. Embarrassingly, I told him and his wife that I was not able to do anything more for them. He and his wife left my office dejected and tearful.

Fortunately, soon thereafter, I was able to find some basic palliative care training, but I had to fly all the way to McMaster University to get it. Upon my return to the small community, I called him and asked him to give me a second chance, which he graciously did. I cared for him until his death three months later. We were able to control his pain and other sources of distress, simply because of some core training. He lived well and died comfortably in his last months of life. Many years later, his wife thanked me for having made such a difference to him and his family. This is what inspired the creation of Pallium Canada and its educational programs.

More recently, as a clinician researcher, I've been studying the impact of core palliative care training on professionals and patients in the health care system. Here are some quotes from one of the studies, specifically in long-term care homes. This is what a personal support worker in long-term care shared with us in our research, a few months after completing the LEAP training:

"In the last couple of months, we have had a numerous amount of deaths in the home, and due to this training on palliative care, I was able to deal with these situations around death easier, and I was able to look at the situation in a different, more positive perspective. Deaths are still never easy to deal with, but I feel as if I've gotten stronger and better able to handle these difficult situations."

Core palliative care training is not only good for patients' families and the health care system, it brings meaning and joy back to the care professionals at a time when many of us, particularly those in the long-term care sector, are demoralized and burnt out. This is what a nurse reported to us:

"After the training, I became more aware of the principles of palliative and end-of-life care. I responded to the individual resident's right to dignity and optimal comfort. I treated the individual as a whole person with physical, psychosocial and spiritual needs. I listen now to their concerns, and the resident and the family are entitled to support and respect at all times. I received an appreciation card from a resident's family after the resident passed away, peacefully and with dignity in my facility."

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Dr. José Pereira:** The good news is that evidence-based, trusted solutions, paid for by Canadian taxpayers, already exist to bridge this gap and quickly provide health care providers with the knowledge and skills. But leadership is needed in order to put this in place.

Pallium Canada has trained over 17,000 health care professionals in Ontario since 2014, many of them in long-term care. We must continue to invest in building more homes and adding more beds, but only if we are able to ensure also that the individuals working in these establishments have the skills and confidence to provide earlier, more effective and more compassionate palliative care.

Thank you. We look forward to your questions.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you so much for your presentation.

We'll go to our next presenter: SEIU Healthcare. Can you please introduce yourself for the record? You have seven minutes for your presentation.

**Ms. Sharleen Stewart:** Yes, thank you. My name is Sharleen Stewart. I'm president of SEIU Healthcare. I am joined today by Michael Spitale, our director of government relations, and Ricardo McKenzie, our director of long-term care.

Our union represents 60,000 front-line health care workers in the province of Ontario. Our members work in Ontario's hospitals, in home and community care and in long-term care, where we're proud to be the largest union in that sector.

SEIU Healthcare lost five workers in Ontario alone from COVID-19, because they went to work in service of their community. Christine Mandegarian, Arlene Reid, Sharon Roberts, Maureen Ambersley and Lorraine Gouveia: all women; all women of colour. We're here for them today, to impress upon you our collective obligation to people.

SEIU Healthcare stands with the thousands of families who lost loved ones in this pandemic, families who are now demanding that we finally put people first. I've said it before and I'll say it again: Ontario's elder care system is sexist, racist and ageist. Health care workers and families alike, together with researchers, academics and public health experts as well as non-profit nursing home operators, are all united in our shared goal of putting people first. I'm here today simply to impress upon you the opportunity we have to put the care for people before profit, before greed, before the financial interests of real estate developers masquerading as care corporations. Regrettably, Bill 37 fails by those standards.

Our goal should be to make a bad system better. Instead, Bill 37 will just make a bad system bigger. Premier Ford promised this legislation would be the Cadillac standard for care in Canada. I submit to you today that Bill 37 is just a lemon. If Bill 37 passes, the everyday experience of health care workers will not change in fundamental ways. That means care will not change in fundamental ways.

Bill 37 does not change the conditions of work. That was a choice. Bill 37 does not remove the profit motive for

care. That was a choice. Bill 37 does not guarantee direct care for individual residents. That was a choice. Bill 37 does not deliver dignity for seniors. That was a choice.

I've observed members of this committee using their time to give prepared statements, so perhaps someone can answer for me how Bill 37 will stop nursing home chains from denying seniors the dignity of a clean adult diaper. You can build all the new beds you want, but what does Bill 37 mean to seniors sitting in those soiled beds? Members of this committee, you have the power in your hands to ensure that seniors sitting in soiled clothes and soiled beds have their adult briefs changed when dirty. Instead, Bill 37 will continue to permit operators to ration diapers. Like I said, that's a choice. It is a choice to give new and renewed contracts to the worst-performing for-profit nursing home operators.

In 2014, the Obama justice department fined Extencare \$38 million after billing for services that were "materially substandard nursing services so deficient that they were effectively worthless." Extencare then sold their business operations in the United States for greener pastures in Canada, where fines are but a few hundred thousand dollars. That tells us that without the opportunity to put profits before people, they had no interest in the work of care.

As families suffered and died, as workers and SEIU Healthcare members suffered and died, Extencare, as well as Chartwell and Sienna, paid out hundreds of millions of dollars in cash dividends to shareholders. Corporate executives at Sienna were caught on tape calling families "bloodsuckers" for taking them to court. These mission-driven corporations paid investors over \$230 million in the last 12 months alone. Ontario families support phasing these companies out, but Bill 37 welcomes them back in.

More seniors died from COVID in Ontario's nursing homes than all airline fatalities across the world in the past decade combined, yet big nursing home chains like Extencare, Chartwell, Sienna and Revera want weaker regulations, reduced oversight and lesser-trained, lesser-paid staff. That the airline industry is prepared to ground an entire fleet of planes after a crash, while the for-profit nursing home industry is rewarded with bigger contracts, perhaps tells us more about who legislators are beholden to than anything.

Unsurprisingly, then, we have an exodus of health care workers. Revera told us during the pandemic that all infection prevention and control measures were in place, and they begged us to encourage workers to come back. Front-line staff confirmed to us that the IPAC measures were not in place, as did report after report. What was the penalty for them lying during the pandemic? Nothing. Instead, legislation was passed to shield them from lawsuits. We pretend this is complicated, but it is not. End the exploitation—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

1420

**Ms. Sharleen Stewart:** —and you'll end the exodus of staff. Mandate full-time jobs so employers can't deny

workers benefits. Ensure a good job at one home as a means for reducing the spread of airborne viruses—not just COVID-19 but also the annual flu. Raise the wages of the lowest-paid health care workers, like PSWs, to at least \$25 per hour and at least \$35 for RPNs. Canada has as few as half as many staff per resident in long-term care homes than any of the better-performing countries. That tells us staffing levels should be double.

Members of this committee, you're asked to vote on a bill where many of the details will be decided in regulation. You're all honourable people, and I sincerely ask you, why haven't we rolled up our sleeves on the details after such public failures, failures by all political parties? How will you know what you're voting for or against when the details of those regulations will be decided exclusively by the government, whomever the government may be from time today.

For the record, I think Minister Phillips is a good man, but he doesn't know what he doesn't know. And that's okay—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize. The time has come up. We'll start with questions now, and we'll start the first round of questions with the government.

MPP Pettapiece, can you please confirm your attendance and from where you are calling?

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

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. We'll start the first set of questions with MPP Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** It's not—

**The Acting Chair (Mr. Amarjot Sandhu):** Oh, he's going first?

*Interjection.*

**Ms. Effie J. Triantafilopoulos:** Okay. Sorry about the confusion.

Thank you so much. I'd like to commend, first of all, all of the presenters. Thank you so much for being with us today. I know that you all have deep knowledge in your sectors and so what you do is help inform us in an ongoing way on how we can, in fact, improve long-term care for seniors.

I want to start by focusing on some questions for Dr. Pereira and Mr. Moat, particularly on the palliative care philosophy. As you know, palliative care is being referred to for the very first time in the context of long-term care in this new legislation. We know that for most residents, a long-term care home is in fact their final home, so good, compassionate palliative care is critical by way of supporting not only the resident but also the family members.

Obviously, you have a deep knowledge of palliative care philosophy, so I wondered whether you would be able to share with us what your experience has been, and specifically how we would go about training and providing other supports in homes to be able to provide that palliative care philosophy.

**Dr. José Pereira:** Certainly. If I may start, it depends on the long-term care home, but we know that between

15% and 20% or 30% of residents die every year. Sometimes in homes that have not been trained or have not integrated the palliative care approach, they don't think about palliative care until the very last hours, and sometimes just the last days. The effect of that is unnecessary suffering for a long time. Every single resident, with some exceptions, requires a palliative care approach from the moment they step in there, because they often have chronic illnesses and other advancing illnesses.

A palliative care approach means identifying needs, addressing those needs, communicating with patients and families and doing advanced care planning among others, and that can be done alongside treatments to control the heart disease or the lung disease.

In our experience, and the studies that we've been doing, when the health care professionals have this little bit of training, they're able to initiate the palliative care approach. In other words, 100% of residents then have access to this approach. Training of all staff is required, but what's also needed is the support of specialist palliative care teams across the province that can be called upon when the situation is complex to prevent these residents from then being sent into the emergency rooms, which sometimes is appropriate but many times is not.

I've spent 21 years developing education programs with colleagues across Ontario and across the country to do exactly this. So we've got the means, we've got the tools; we just have to support those tools. It takes people to run these tools. It takes people to develop them and to bring health professionals to put them together, to present them, but there isn't the funding. And we've been to the ministry many times. We went to the ministry two years ago. We were there again last year, saying, "We've got the tools. Please support us and give us the funding so we can do the tools," because otherwise we can't. We've got to pay the people to do this work, and the nursing homes have to support that as well.

**Mr. Jeffrey Moat:** The second point to your question is around the approach: How do you go about tackling this, given that there are 600-plus long-term care facilities in the province? Obviously, you know, a staged approach to implementation, both by facility and by health professional, is key. In some of the proposals we put forward to government, initial capacity-building efforts can focus on a prioritized cohort of care facilities, with potential to grow and expand, in stages, to additional cohorts with facilities across the province. That includes training for health care professionals, leveraging as, Dr. Pereira said, courseware that has already been paid for by Canadian taxpayers. It already exists. They're evidence-based; they're proven to improve knowledge, attitudes and comfort levels, to rapidly certify physicians, nurses, PSWs in each of these facilities. So we've done this many, many times before, and it's poised to be spread and scaled, essentially.

So the solutions are there, the approach is there. There just has to be a willingness to get behind this and truly spread and scale this work.

**Ms. Effie J. Triantafilopoulos:** Speaking from my own experience, I've met with the palliative association of

Ontario, I visited some of the hospices in my own community and I've seen first-hand the kind of care that is provided for residents at end of life. You're quite right. One of the concerns that I do have, and that I've heard often, is the front-line staff, because they lack knowledge around palliative care and palliative philosophy, the first instinct would be to send someone to the emergency department. And that may or may not be the correct solution. So how would one go about being able to instill the kind of level of knowledge and training to be able to also make those judgment calls in those situations?

**Dr. José Pereira:** Yes, so, the training introduces exactly that. Why do some of the residents get sent into the emergency rooms? That's been looked at and in my experience, there are a number of reasons. As I said, sometimes that is appropriate, so we don't want to say they're all inappropriate, but there are many that are not appropriate.

What happens is there's a lack of planning, a lack of advanced care planning and a lack of goals of care discussions. There are no discussions about, "You're losing a lot of weight because of your disease and let's think about what happens in the future." What happens when your mother, your loved one, with very, very advanced dementia, is no longer able to eat or drink?

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Dr. José Pereira:** Without those discussions, what happens is they get sent to the emergency room for the insertion of feeding tubes that are not appropriate. So the training does make a difference and it allows the resident to be cared for competently and compassionately in their home, which is the long-term care home.

**Ms. Effie J. Triantafilopoulos:** Today, one of the presenters said that they did not want to see a palliative philosophy included in long-term care because she did not want long-term care to be considered a place where residents go to die. How would you react to that comment?

**Dr. José Pereira:** You know, I've been doing palliative care now for almost 30 years and a lot of part of my career has been to try and debunk the myth that palliative care is only about the last days or hours of life. That statement speaks exactly to the problem, that people still associate palliative care with the last days or weeks of life. The World Health Organization in 2002 defined it as care for people with serious illness. They took away the word "terminal."

And so part of this education is to—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize to cut you off. That's all the time we have for the government in the first round. We'll come back to you in the second round.

We'll go to the opposition now for their first round. Who would like to go first? MPP Singh.

**Ms. Sara Singh:** Thank you so much, Chair, and thank you to all the presenters. My first question—je vais essayer de parler en français pour Edward. J'avais une question. Vous avez, dans votre présentation, parlé des soins de longue durée qui sont privés. Dans ces maisons et

des espaces comme ça, on voit que les résidents ne reçoivent pas le même niveau de « care » dans des soins de longue durée privés qu'on voit dans les maisons qui sont opérées par des municipalités. Est-ce que tu peux parler plus sur le « value » qu'on voit dans les soins de longue durée qui sont opérés par les municipalités versus les soins de longue durée qui sont privés?

**1430**

Après ça, je vais passer la torche à mon collègue qui parle français très bien, M. Mantha.

**M. Edward Cashman:** Merci, madame la députée. On voit en Ontario, le système de financement est le même de la part du gouvernement de la province de l'Ontario. C'est-à-dire, que ça soit un foyer privé, public ou à but non lucratif, le financement est le même. Mais si vous regardez des statistiques, drôlement, on constate que le niveau de soins—en fait, si on regarde le nombre d'heures consacrées à chaque personne, chaque résident ou résidente—est meilleur dans le système à but non lucratif et surtout au niveau des municipalités. Donc, les municipalités, on reconnaît qu'ils reçoivent souvent de l'argent séparément de leur municipalité, mais c'est scandaleux de voir l'argent du gouvernement qui n'est pas versé à 100 % en soins de santé vers les résidents dans les foyers privés parce que le privé doit prendre une partie de cet argent-là pour payer des bénéficiaires à leurs propriétaires.

**M. Michael Mantha:** Je vais y aller le prochain. Bonjour, Edward.

**M. Edward Cashman:** Bonjour.

**M. Michael Mantha:** Et puis Sara, tu as fait une fameuse de belle job avec ton français. Tu es quasiment francophile et puis je t'encourage de continuer à parler en français.

Je veux revenir à toi, monsieur Cashman, sur la question de formation spécialisée, surtout pour les gens qui ont besoin, on va dire, de sensibilisation culturelle ou des langages, ou les gens qui sont dans les moyens ou dans les besoins et puis quand ils ont autres choses. Cette formation-là vient avec beaucoup de difficultés, mais comment est-ce qu'on peut prendre avantage de ça dans les soins de santé, surtout dans un environnement francophone?

**M. Edward Cashman:** Merci, monsieur le député. Le problème se pose à Ottawa. La philosophie des bureaucrates n'a pas évolué parce qu'on pense toujours que les francophones sont toujours dans le centre ou l'est de la ville, et, la réalité, on trouve les francophones aujourd'hui partout dans la ville d'Ottawa et partout dans l'est de l'Ontario. Et donc, les résidents sont obligés d'aller chercher une aide en français dans les anciens quartiers et ce n'est pas toujours le cas et ce n'est pas toujours à proximité de leurs proches.

Alors, pour la formation des employés, je vais d'abord parler du programme actuel du gouvernement qui veut qu'on va créer une nouvelle catégorie de travailleurs ou de travailleuses et pour les aides aux bénéficiaires, les préposés aux bénéficiaires. On crée une nouvelle catégorie de gens qui sont moins formés que les autres, et on voit l'argent qui est versé dans les collèges privés pour former ces gens-là. On

pense à ajouter les nombres d'employés au lieu de regarder la qualité de la formation que chaque employé recevra.

**M. Michael Mantha:** Je veux vous décrire un défi qu'on voit dans plusieurs des maisons de longue durée. C'est qu'on regarde encore les défis culturels pour les communautés où les gens sont indigènes, ou même les francophones, parce que dans le nord de l'Ontario, il y a plusieurs fois où la famille sent un gros défi parce que maman, papa, mère, père ne peuvent pas communiquer avec la personne qui est en train de lui offrir le soin. Ce qui fait que la plupart du temps, ce qu'ils font c'est qu'ils ne disent rien. Ce qui fait qu'on va dire qu'ils ont un blocage où ils ne peuvent pas venir à bout de relier leur message—où qu'ils sont, leurs malaises—et puis ça cause un plus gros problème avec la personne individuelle.

Je veux retourner sur l'importance de la formation spécialisée, non seulement sur la langue et non seulement sur le niveau culturel, mais le besoin d'avoir une bonne formation pour qu'il y ait une bonne ligne de communication.

**M. Edward Cashman:** Merci, monsieur le député. On a vu ça hier par certains témoignages. Le problème est toujours que la formation du personnel, il n'est pas toujours sensible aux besoins des résidents, que ça soit au niveau culturel ou de langue.

**M. Michael Mantha:** OK. Je retourne à ma collègue Sara. Merci beaucoup.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Singh.

**Ms. Sara Singh:** Merci beaucoup. It's actually going to be MPP Berns-McGown who will be next.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Berns-McGown.

**Ms. Rima Berns-McGown:** Thanks so very much for these important presentations.

Dr. Pereira, I'd like to pick up with you the question you were starting to delve into earlier, which is—and I have to begin by saying I'm a big fan of palliative care. I think it's hugely important. But we're facing two issues here: One is that—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Rima Berns-McGown:** —as you've noted, it's not—and perhaps if we don't finish this round, we can continue in the next.

It's not well understood by the general public and it's not well understood or the education isn't there for practitioners. So, I think, to be fair, what we were hearing yesterday was not so much, "Oh, my goodness, we don't want this," as, "We don't know that it's always appropriate, and we don't want people to feel"—this is one of the presenters, saying, "We don't want people to feel it's being pushed on them when it's not appropriate. And we also don't want practitioners who don't really understand it to view it as the total care equivalent of a do-not-resuscitate order."

So how do you navigate all of those issues in terms of making sure that as this is put forward in legislation, it calms those concerns and meets the goals you want?

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. Sorry to cut you off. We'll come back to that in the second round.

We have to move to the government side again for their second round. MPP Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** Thank you very much, and merci. I'd like to address my questions, as well, to the Coalition de la santé. I listened very carefully to your presentation and obviously the needs that are required in our francophone population in Ontario.

Currently, as you know, there are 928 beds for the francophone community in Ontario. Our government recently announced an additional 502 in the development pipeline. Training francophone staff is also a critical piece as we move forward. Obviously, we know that there has been a sad need of recruitment and retention of staff right across the board, whether it's personal support workers, whether it's registered nurses, whether it's RPNs. So that is the investment that our government has committed to make as we move forward to be able to make sure the needs of our community and our francophone community are being met.

In March 2020, our government announced seven projects that will serve the francophone population with an additional 502 beds. This is right across Ontario but also in Ottawa as well. There are also two publicly funded francophone colleges in Ontario. One is Collège Boréal; the other, La Cité collégiale in Ottawa. They are part of our Ontario PSW accelerated training program. It's a province-wide investment of \$115 million to be able to provide an additional 8,200 new PSWs as soon as possible.

Just giving you that background, I'd like to ask you what more we can do particularly to serve the francophone community. How will these publicly funded francophone colleges be able to meet the need that we have for our francophone long-term care homes?

**M. Edward Cashman:** Merci, madame la députée. C'est un excellent début, mais ce n'est pas assez. Vous avez parlé de créer 8 200 postes éventuels par entremise des collèges dans l'ensemble, mais les francophones ne sont pas seulement des préposés aux bénéfiques. Les francophones sont des médecins, des infirmières, des infirmiers, des experts en différentes matières, donc où est le niveau de financement en français pour ces gens-là?

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**Ms. Effie J. Triantafilopoulos:** Please can you continue and further elaborate?

**M. Edward Cashman:** Bravo pour les 502 lits sur ce projet, mais comme j'ai dit tout à l'heure, vous visez des quartiers ou des endroits dans la province traditionnellement francophones. Mais je peux vous dire, madame—vous êtes d'Oakville—on trouve les francophones dans votre circonscription également. On trouve des francophones au cœur de Toronto. Alors, est-ce que [inaudible] recevront les services en français? Ce n'est pas forcément le cas. Si on construit à Kapuskasing, ça n'aide pas forcément les gens de Toronto, ni d'Oakville.

**Ms. Effie J. Triantafilopoulos:** Let me, for example, elaborate. The Centre d'Accueil Roger-Séguin will have a

new 128-bed home in Prescott-Russell, which will be designated francophone. There's a new 224-bed home going into Orléans also designated francophone; a 256-bed home in Toronto, a first full-service francophone home in Toronto that is being designated; and there are additional beds for francophones in Georgetown, Barrie, Hearst and, as we know, in Ottawa.

So I believe that our government is committed to ensuring that the francophone population is able to receive care as close to their communities as possible. As you say, it may not be enough, but it's a very good start considering the legacy that we inherited from the past government where between 2011 to 2018 there were only 611 net new beds created in all of Ontario.

As you know, with our Minister of Long-Term Care we have already got over 20,000 net new beds in the pipeline and over 15,000 redeveloped beds—well on our goal to be able to meet our commitment of 30,000 new long-term-care beds.

**M. Edward Cashman:** Vous avez raison, madame, mais c'est trop facile de se fier ou de blâmer quelqu'un pour le passé. Il faut construire pour le futur, un futur meilleur pour nos aînés. Sans parler de votre âge ou du mien, un jour on aura besoin de ces mêmes services, nous-mêmes. Alors, c'est notre futur qu'il faut bâtir aussi.

**Ms. Effie J. Triantafilopoulos:** I think we're all headed in that direction because we're all an aging population. You're quite right.

I'd also like to share my time with MPP Ghamari.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Ghamari.

**Ms. Goldie Ghamari:** Thank you, MPP Triantafilopoulos, and merci beaucoup. Merci, monsieur Cashman, pour—for being here today. I am an MPP in the Ottawa area, and je suis allée à l'école immersion, parce que mes parents ont reconnu l'importance de parler français.

I just wanted share some information with you. I'm not sure if you're aware, but I'm also the parliamentary assistant to the Minister of Colleges and Universities, and we made an announcement recently, just a few weeks ago, where we're investing over \$400,000 dans des programmes novateurs de formation et d'apprentissage—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**M<sup>me</sup> Goldie Ghamari:** —pour les étudiantes et étudiants en sciences infirmières de langue française à Ottawa, afin qu'ils puissent continuer à recevoir une éducation de classe mondiale pendant la pandémie de COVID-19.

I know that my time is running out, so I look forward to continuing this discussion in the final round, but we were at collège La Cité, à l'Hôpital Montfort, and they're going to be offering à environ 350 étudiantes et étudiants en sciences infirmières les outils et l'expérience clinique dont ils ont besoin pour renforcer les secteurs des soins de santé et des soins de longue durée de l'Ontario.

With my time being up, I'll leave my question for the next round so that we don't break it up. Thank you very much.

**M. Edward Cashman:** Merci.

**The Acting Chair (Mr. Amarjot Sandhu):** We'll go back to the opposition for their second round. MPP Berns-McGown.

**Ms. Rima Berns-McGown:** Thank you so much, Chair.

Dr. Pereira, I wonder if you could answer the question I put to you the last time. Thank you.

**Dr. José Pereira:** Certainly. So equating palliative care with only very end-of-life, DNR and stopping resuscitation, and not doing anything active, is extremely disappointing and upsetting. It's upsetting me because, if you look at the research on residents arriving in long-term care homes, the majority of them are experiencing significant symptoms already: pain, shortness of breath, nausea, depression, vomiting, etc. That is what the skill set of palliative care does: It helps people live in the time that they have left.

I have lots of patients who are still on full resuscitation, I've got lots of patients who are getting feeding and a lot of patients where we're still treating the diseases, and so the approach, which I think you're alluding to, is education. It doesn't mean that you sit at the bedside and you say, "You are now palliative." What it means is we are trying to control your heart disease, your lung disease or your kidney disease, but, at the same time, you've got all these symptoms: How can we improve your quality of life? If we are unable to control that, what, for you, is important moving forward? Is it aggressive treatments that prolong life or is it more important for you to have quality of life?

Those are the skill sets that we train people with, and the research tells us once they've got those skill sets, they're able to have those conversations and, no matter what the cultural background is, the faith background, most families and patients get it. Obviously, every now and again there may be someone who says, "No way," and that's what we work with. We respect that.

So education is extremely important for health care professionals and also for the public for exactly that reason. Thank you for the question.

**Ms. Rima Berns-McGown:** So you don't believe that it needs to be reframed in the way that it's put out in the legislation? That's really the question.

**Dr. José Pereira:** No, I think we should call it palliative care, and we should educate on what palliative care is, because if we change the name because people don't like the name, in 10 years' time, you'll be trying to change the legislation to change whatever name you changed to. The issue is it's about living when one has got illness, and dying. Let's call it what it is. This is about optimizing living in whatever time there is. For some people, it's months, and sometimes it's many months or years, and sometimes it's very, very short.

**Ms. Rima Berns-McGown:** Thank you so much. I would like to pass it now over to my colleague MPP Gretzky.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Gretzky.

**Mrs. Lisa Gretzky:** Thank you. I appreciate the time to ask a question. My question is also around palliative care. To the team from Pallium Canada: I really appreciate the work you're doing and the advocacy you're doing.

I will tell you that I didn't know an awful lot about palliative care until I had the pleasure of meeting and becoming friends with Dr. Darren Cargill, who is the palliative lead down in Windsor–Essex. I've learned a lot from him. One of the things I learned from Dr. Cargill is that when you're talking about palliative care, it is not just about the patient; it is about the caregivers, the family members, and including them in the journey and making sure that the needs of the patient are being met, whether those are the medical needs, the spiritual needs, the emotional needs, but also that of family members and caregivers. It's an important part of the journey.

I'm just wondering if maybe you could talk about some of the barriers that we found that people have experienced during the pandemic around having that meaningful access, that your patients had around having meaningful, consistent access to their family caregivers during their palliative journey through this pandemic.

Do you believe that this bill could be strengthened—full disclosure, I do have a bill that has been tabled around caregiver access. Do you believe that this bill could be strengthened in language around patients having that meaningful, consistent access to their caregivers during their palliative journey?

**Dr. José Pereira:** I'm going to answer that from a personal perspective, having worked on a palliative care unit during the height of the pandemic. It was very difficult. It was dreadful for patients. It was dreadful for families. I know when we're supporting long-term care homes, it's the same situation. We were stuck in a situation of families being so important, as you so, so rightfully highlight, but at the same time, protecting everyone else around.

I worked on a unit where there was an actual outbreak of COVID within our unit. A lot of the patients were more long-term care type of patients. You're stuck with this awful situation of having to protect everyone, and we're learning on the fly about the disease, and it's easy in hindsight to say things—it was this dreadful situation where we're hearing the pleas of patients and the pleas of families to be with the family members.

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We also see the pandemic and the virus killing other people on the unit when things spread. I just hope we learn a lot from all of this. I hope we are better prepared for the next pandemic and that we find ways where there can be accompaniment.

I had to sit at the bedside of many patients, not just being a doctor but actually being a companion, and learning their stories because family members weren't able to do that. I don't know the answer to it.

**Mrs. Lisa Gretzky:** I appreciate the perspective and I agree that, in the beginning, it was very difficult as far as making sure everybody was safe.

I would like to point out that my bill is about developing a strategy, so bringing the doctors, the patients, the caregivers and the workers to the table to develop a strategy going forward, so if we ever face this, we can ensure that those visits, that time together, can be done safely.

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Mrs. Lisa Gretzky:** Would it be safe to say that you would agree with that, that there needs to be a strategy in place so that if we ever go through this again, those interactions and those visits can continue in a meaningful and safe way to ensure that everybody has all the PPE they need, and so that you, your patients and those families aren't winging it, so to speak, should we, heaven forbid, ever go through something like this again?

**Dr. José Pereira:** I very much agree.

**Mrs. Lisa Gretzky:** Thank you. That's it for me. I'm not sure if one of my colleagues has any questions they wanted to add.

**The Acting Chair (Mr. Amarjot Sandhu):** We only have 20 seconds so we will come back to you in the third round.

**Mrs. Lisa Gretzky:** All right; thank you.

**The Acting Chair (Mr. Amarjot Sandhu):** We'll start the third round with the government. MPP Ghamari again?

**Ms. Goldie Ghamari:** Thank you. I just wanted to continue on the line of a conversation that we had, Mr. Cashman. And my apologies, I'll be speaking French and English combined, but feel free to respond in French; I fully understand.

One of the investments that we made was in La Cité, in l'Université d'Ottawa and also Hôpital Montfort. As you know, La Cité est le plus grand collège d'arts appliqués et de technologie de langue française en Ontario and l'Université d'Ottawa est la plus grande université bilingue au monde. Elle offre plus de 450 programmes dans ses facultés, y compris une école de médecine.

So I guess my question for you is, with the historic investments that our government has been making into French-language services and French-language training and education to ensure that the francophone community is being supported, whether it's French-speaking seniors who are living in long-term care homes or whether it's making sure that long-term care homes are being staffed by people who are bilingual so that they can properly communicate with long-term care residents, is that not enough? What else could we be doing at this point to further support French-language programs, given that the investments we've made and the programs that we've announced, no other government prior to us has done?

**M. Edward Cashman:** Madame Ghamari, si vous cherchez des fleurs, ce n'est pas mon style. Moi, je suis plutôt du genre—les francophones représentent 30 % de la population en Ontario. Où sont leurs justes parts dans le tout? Je vous félicite sur le programme que vous proposez de commencer, mais ce n'est pas assez. Les francophones ne sont pas juste à Ottawa. Votre collègue d'Oakville a

parlé aussi du Collège Boréal à Sudbury—donc, là aussi. Bravo. Mais ça ne suffit pas—

**Ms. Goldie Ghamari:** And we also have the French-language university in Toronto as well.

**M. Edward Cashman:** Et on attend l'annonce du financement pour les autres collèges.

**Ms. Goldie Ghamari:** But you don't think that's enough.

**M. Edward Cashman:** Ça ne suffit pas, simplement parce qu'il y a un tellement grand besoin à travers la province.

**Ms. Goldie Ghamari:** But would you not agree that it takes time to properly train staff and to make sure that the people who are working in long-term care homes have the training they need and have the experience they need prior to working?

**M. Edward Cashman:** C'est un début, mais vous n'avez pas aussi abordé la question des gens qui viennent de l'extérieur du Canada, qui sont francophones et qui ont des compétences qui ne sont pas encore reconnues ici dans la province de l'Ontario.

**Ms. Goldie Ghamari:** I think you'd be very, very happy to hear, then, that recent legislation that the minister of labour and skilled trades introduced was precisely to accommodate the skilled workers—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Goldie Ghamari:**—that are coming in from other countries, who may not necessarily have Canadian experience but they have experience in their respective countries. That includes a lot of new Canadians who do speak French.

This is something that was ignored by previous governments, where a lot—and I'm an immigrant myself. My family immigrated here from Iran when I was a child. Something that immigrants have faced has been this sort of Catch-22 barrier where you have experience, but because it's not Canadian experience, you can't get work, but how can you get experience if you don't work? So that's something we've recently introduced in legislation to get rid of some of the bureaucratic red tape for skilled newcomers so that they are able to enter the workforce much more quickly and to take advantage—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize to cut you off, MPP Ghamari. That is all the time we have for the questions.

We have to move to the opposition now. MPP Singh?

**Ms. Sara Singh:** My first question is for Mr. Moat and Dr. Pereira. Just following up on the importance of palliative care, I think it's well noted and understood. I think one of the concerns we have, however, with Bill 37 is that there's mention of a palliative care strategy and plan, but there isn't staffing, resources or adequate training being provided to ensure that the specialized folks that are needed in the health care profession are going to be there to provide the services that folks are looking for.

Just very briefly, because I would also like to ask Ms. Stewart a question, can you share with me if you think there's a staffing strategy here to help provide the

palliative care support that is needed in our long-term care homes?

**Dr. José Pereira:** We've been speaking about spreading the palliative care approach so there are core competencies across all health care professionals, but the issue of specialized training is also important because we don't have enough physicians with specialized palliative care training—physicians like myself, nurses, etc.

But one of the problems that has been—I've been in this province since 2008, and I've been making this case over and over and over again, and I'll do it again. The funding model has to be addressed and different motives have to be put aside. When I say the funding model, I've just been asked, just a few days ago, to help in a long-term care home to provide consultation support. I'm fee for service. I can't get paid through that route.

I keep saying we need more alternative funding plans, proper AFP for palliative care in this province. It's been ignored by previous governments, and I hope it gets addressed by this government, because it will profoundly improve, in many areas, the ability for specialist teams to deliver it. I can't even have an AFP in my own area of Hamilton because there are no more AFP positions and because there are ridiculous criteria put into those AFPs. I hope there's a solution before I retire on this one. It will remarkably change the ability for us to build system capacity.

**Ms. Sara Singh:** Thank you, Dr. Pereira. And just very quickly, if you can answer with a yes or no, does this bill actually address that concern?

**Dr. José Pereira:** I think there's work that can be done to improve that area.

**Ms. Sara Singh:** Thank you, Dr. Pereira.

My next question is for Ms. Stewart. Thank you so much for your presentation. I think you really highlighted some key concerns that we have when it comes to the staffing and health care professionals that are needed in the sector and the fact that this bill does nothing to actually address the current crisis or conditions in long-term care. You also highlighted the fact that the government is moving forward with renewing licences for bad actors and not transitioning our long-term care sector to one that is primarily, predominantly not-for-profit delivery or municipally operated.

Ms. Stewart, can you speak to the importance that we need right now in terms of that transition to not-for-profit or municipally operated homes and why this bill favours, in fact, the private care sector?

**Ms. Sharleen Stewart:** Yes, thank you for the question, and that is a really good question. Why does it favour the for-profit sector? That's been a concern of many asking the questions throughout the last couple of months.

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**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Sharleen Stewart:** It is disappointing that there is no human resource plan in there, and I couldn't agree more with both the language issue and the palliative care. There's much more heavier care happening in long-term



care, and the plan does not have a long-term sustainable plan. By putting these workers, our people, through education and not correcting the conditions of care, you're just going to have a revolving door.

We need specialized care in long-term care. We need to educate them, but we also need to keep them when they come in the front door. Right now, they are lasting no longer than six weeks. After investing all of the money that the government is putting in, there is a lack of a sustainable long-term care plan to provide good conditions of work which will provide tremendous conditions of care for palliative care, for dementia care, for everyday last years of living. That's what is missing in this bill.

**The Acting Chair (Mr. Amarjot Sandhu):** Ten seconds.

**Ms. Sara Singh:** Okay. Thank you. Sorry, I was muted there.

I saw some head nods across all the panellists. I appreciate that, and I think that this bill really does fail to address the staffing crisis that we have in long-term care—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize to cut you off. That's all the time we have.

I want to thank all three presenters for your presentations.

#### PERLEY HEALTH

HAMILTON HEALTH COALITION/  
COUNCIL OF CANADIANS

WeRPN REGISTERED PRACTICAL  
NURSES OF ONTARIO

**The Acting Chair (Mr. Amarjot Sandhu):** Moving along to our next group, I would first like to call upon Perley Health. If you can state your name for the record, and you will have seven minutes for your presentation.

**Mr. Akos Hoffer:** Good afternoon. This is Akos Hoffer. I am the chief executive officer at Perley Health in Ottawa, and I want to say thank you for inviting me to your meeting. It's an honour to be here.

I'm guessing at this point you've heard what a lot of people don't like about Bill 37. I'm here to tell you what I do like about this bill. Specifically, I'd like to draw the standing committee's attention to section 44, which deals with the Long-Term Care Quality Centre. I'd like to highlight the potential of having a quality centre dedicated to long-term care, led by long-term care and supported by long-term care. While we support section 44, I will suggest a nip and tuck to the bill's wording, but I'd like to begin with a few words about Perley Health.

A number of things make us unique. Perley Health is one of the largest non-profits, with 450 long-term-care beds for both seniors and veterans here on our campus in Ottawa, along with a range of other seniors' services and accommodations. We're also one of the few long-term care homes with a research institute and a research chair. During the pandemic, we were one of the few long-term care homes asked to support other homes struggling with COVID outbreaks, and we pride ourselves on being

fanatical about the quality of care we provide and the safety of both our residents and our staff.

Now let's turn to Bill 37 itself, and specifically section 44, which deals with the Long-Term Care Quality Centre. To refresh everyone's memory, the functions and purposes of the quality centre stated in the bill are "to support mission-driven organizations" and "to advance and share research on innovative and evidence-informed person-centred models of care." In other words, the quality centre is there to support the sector to achieve not just compliance but excellence.

From our perspective, section 44 has opened the door to a phenomenal opportunity. If you ask most people on the street, they would say that long-term care is totally broken. And if you will permit me to use language that is unbecoming of a standing committee, our staff—we have 800 staff here, who are super proud of the work they do—have had the shit kicked out of them in the media during the pandemic. So no one would think to turn to long-term care for expertise and support.

But if you know where to look, there is so much expertise and excellence. Ontario is no ordinary province. We have a treasure trove of experts just waiting to be asked. In fact, you heard from one of them yesterday. His name is Hugh Armstrong. And a world-renowned expert in quality improvement is right around the corner from Queen's Park, at U of T. His name is Ross Baker.

There are high-quality operators like Perley Health that are eager to help other long-term care homes succeed. Here's just one way we can help: Pressure injuries—or, as a lot of people know them, pressure ulcers—are a huge problem in long-term care. Using a quality improvement approach here at Perley, we have slashed our pressure injury rate by 75%, which is almost half the provincial average. This kind of improvement matters massively to our residents. The question we ask ourselves is, why shouldn't residents of all long-term care homes enjoy the same good outcomes?

Through the quality centre in Bill 37, we now have a chance to tap into this expertise and help long-term care residents all across Ontario. How do we accomplish this? We have two recommendations. Bill 37 authorizes the minister to establish a quality hub by stating that "the minister may establish a long-term care quality centre." We recommend changing the word "may" to "shall" or some other word to make sure this happens.

Our second recommendation is to engage your partners. Yes, the system has problems. We and others across the province are here to help the government engage long-term care to help govern and lead the quality centre. We and others can help implement the quality centre and tap into the deep expertise that exists in research and practice across the province. What we are proposing is long-term care helping long-term care. Sure, you can ask hospitals to help—and they have, in a big way—but we and others have the expertise to solve problems that are unique to long-term care. We are uniquely positioned to help solve those problems. What we're talking about is a made-in-Ontario, made-in-long-term-care solution.

Thank you again for the opportunity to attend your meeting today. I'd be happy to take any questions.

**The Acting Chair (Mr. Amarjot Sandhu):** We'll now move to Hamilton Health Coalition. Please state your name for the record, and you will have seven minutes for your presentation.

**Ms. Janina Lebon:** Janina Lebon along with Rolf Gerstenberger. We are the co-chairs of Hamilton Health Coalition, and we also are speaking on behalf of the Hamilton chapter of the Council of Canadians.

Thank you for the opportunity to present some comments and observations on the bill. There are several areas we will note. We'll start with the preamble and the basic principle of—we support the commitment of “the promotion of the delivery of long-term care home services by not-for-profit” and public—and that exists as a result of the efforts back in 2007.

The words “mission-driven” are causing confusion. For most, we look at it as you're supporting for-profits. Just as an aside, transitioning to not-for-profit from profit, I suggest we look at Saskatchewan that is transitioning five Extendicare homes into the government's support.

The residents' bill of rights is our second point. We make a complaint and if we're not happy with the result, there should be an external mechanism, a third party, such as a seniors' advocate, an ombudsman or a tribunal, who would hear the complaint, resolve it and could actually enforce it, with no reprisals to the family, to the resident—and we'll come to the whistle-blower part later on.

You've heard comments on the four hours of care. It should be a requirement, not a target, because a target can be changed. It should be averaged per home, not over all the homes, and the reporting mechanism should show up in at least two places: One would be on the Ministry of Long-Term Care website that has the long-term care reporting information, and also posted at the home, usually in the foyer, which most people would see.

**1510**

The implementation of the four hours should not be left to 2025. The length of life in care in long-term care for a resident is not much, and by 2025 most of them will be dead. We need to have the four hours now.

Comments on the allied health care: That is a necessity for people to be healthy and survive and keep going. The target, again, should be a requirement, and 36 minutes is not very much. An hour would be preferable. You're looking at occupational therapists, physiotherapists, recreational services—I have a member of our committee whose husband is in a home here in Hamilton, and she is battling with the home to have recreational services for her husband with dementia.

The issue of enforcement, compliance and inspections: We suggest you reinstate the unannounced annual surprise visits, and maybe even make them biannual. The articles I've been reading have said that there have been no annual RQIs for at least three years, but the inspectors have been responding to complaints or critical incidents. As for the surprise visits, there should be no warning given to the home because they will prepare it and it will look perfect.

With all the deaths in long-term care—the ministry indicates 3,824 deaths and 13 staff, although that's not the same as the public health stats, which are over 4,300—did any home get fined? Did they have penalties? Did they have their licence removed? No. Instead, they're being awarded new beds and larger homes—that's not acceptable—and actually being protected by legislation from lawsuits.

Staffing: The homes are losing staff, and recruitment—the government has indicated offering programs etc., but retention is going to be the problem. Health care workers need to be recognized for what they have done. They need to be valued. They need to be respected. They need good working conditions, full-time employment, salary and benefits. That's how you're going to retain them. As has been said by a few people, conditions of work are the conditions of care.

Conflicts of interest, or, as the Ontario Health Coalition calls it—well, we won't go there. There is a Federal Accountability Act that governs—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Janina Lebon:** One minute? Okay—that governs members of Parliament when they leave. They're not allowed to lobby or work for a company for at least a year. There shouldn't be politicians on long-term care boards.

Whistle-blowers need to be strengthened, and protections given to people.

And my last comment: We appreciate giving our comments; however, the concerns on the shortness of time and the deadlines—those are very difficult. Again, thank you.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you so much.

We will move to our next presenter, WeRPN, Registered Practical Nurses of Ontario. Please state your name for the record, and you will have seven minutes for your presentation.

**Ms. Dianne Martin:** Hi. My name is Dianne Martin. I'm the CEO at WeRPN, Registered Practical Nurses of Ontario, and I want to thank you for the opportunity to speak on providing more care, protecting seniors and building more beds.

WeRPN supports the intents of the proposed act to improve staffing and care, protect residents through better accountability and transparency, and build modern, safe, comfortable homes for our seniors. Our hope is that it goes far enough to actually give the transformation to the long-term care system that our older Ontarians deserve.

While all of these intentions of the act are vitally important, to the 50,000-plus RPNs in Ontario, improvements to staffing in long-term care have been a major priority. Nurses are the backbone of our health care system, and WeRPN has long advocated for standardizing nursing workloads.

The establishment in law to increase the average hours of care per resident per day to four hours by March 31, 2025, and to increase care provided by allied health care professionals to an average of 36 minutes per day is commendable. While some may criticize the interim

annual targets and want the four hours of care to come into effect sooner, the reality is that Ontario does not currently have an adequate supply of nurses and allied health care professionals to deliver this level of care per resident. But we at WeRPN have plans that would be able to speed up the process of making those health care professionals available.

In the limited time I have with you today, I want to talk to you about the shortage of nurses in Ontario and the challenges ahead if we do not address the recruitment and, more importantly, the retention issues facing the nursing profession.

At this point, we are all aware of the nursing shortages, and we know it is an issue. In fact, in a recent survey, 95% of Ontarians expressed a desire to see more nurses hired to meet the growing needs of the province, especially for this aging population.

What I would like to talk about is a solution—a made-in-Ontario solution—for managing nursing recruitment and retention. WeRPN has created a variety of solutions that will work in tandem to solve the puzzle of what makes nursing an attractive career opportunity. The puzzle is made up of many small and large pieces, but today I want to address the three most important pieces: pay, workload and educational supports.

Let's first address pay. RPNs were excluded from the ongoing pandemic top-up of \$3 an hour awarded to personal support workers, leaving many RPNs making a wage that is very close to the colleagues they supervise. RPNs support fair compensation for our PSW colleagues. They are our closest and most treasured colleagues that we have. However, this policy, intended to support PSWs, unintentionally risks RPNs feeling that their knowledge and significant level of accountability is unrecognized, pushing RPNs to leave the profession. In fact, a survey of our members earlier this year revealed 34% are considering leaving the profession.

What we propose is making permanent the pandemic top-up while restoring and making retroactive the same ongoing pandemic top-up for RPNs to resolve the wage compression that has occurred. We further propose establishing a provincial minimum wage for RPNs that is appropriately proportioned to RNs. This could also be stated as a maximum differential between RNs' and RPNs' pay. After all, RPN work is much closer to an RN's than a PSW's.

The next piece of the puzzle is workload. Nurses have always worked hard and expected to work hard, but today's nursing shortage creates a workload that leads to moral distress in nurses when they feel they cannot compassionately meet the needs of their patients and residents. It's important that we are matching care provider numbers and competencies with resident needs to ensure that manageable nurse workloads and job satisfaction happen while creating a work environment that is conducive to attracting and retaining staff and excellence in care.

In order to achieve this goal, we recommend legislating staffing and workload standards that promote a culture of

safety for our patients, residents and nurses, and moving to 75% full-time positions for the RPNs in long-term care.

The last piece of the puzzle is education. Recent government announcements—like the career-laddering BEGIN initiative, which will bring more nurses available and return service in long-term care and home care—and the opening of additional seats in college education programs are important first steps.

We have two additional recommendations, including streamlining the education processes from RPNs to RNs to grow nurses into their new roles faster and investments in a preceptorship incentive program for RPNs who take on a student on top of their already heavy workloads.

**1520**

When these three distinct pieces are assembled together, we will have created an attractive work environment for Ontario's RPNs, and Ontario's human resource goals will be met.

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Dianne Martin:** And, of course, the quality of care for our patients and residents will be greatly improved.

I thank you, and I am happy to take your questions.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you so much.

We will get to the questions now, and we'll start the first round with the opposition. Who would like to go first? MPP Berns-McGown.

**Ms. Rima Berns-McGown:** Thank you so very much. My question is for the Hamilton Health Coalition. Janina, you were talking about the need for improved whistleblower protections, and I'm wondering whether you have in mind what you would like to see in order for whistleblowers to feel safe coming forward?

**Ms. Janina Lebon:** I do have some suggestions. One, get rid of the non-disclosure agreements with both long-term care homes and the retirement homes. We have a lady in Hamilton, Ashley Jenkins, who was quoted in the paper, who raised the issue of expired meds, all kinds of problems. She was subsequently fired. She did settle, but again, that was a confidential agreement.

I would say that we need to make some process that people can access, be it anonymous, and that there are no repercussions and not even apparent repercussions for making observations of "There are problems in the workplace," and things like that.

**Ms. Rima Berns-McGown:** And I wonder if anybody else would like to chime in on this question?

**Ms. Janina Lebon:** My co-chair.

**Mr. Rolf Gerstenberger:** Hi. Yes, I would just like to say, for us, it's a very serious question because, first of all, a lot of the patients in long-term care aren't even, you know, capable of complaining about what's wrong. So then it's up to their caregivers or their family members, let's say, and even the family members are hesitant to complain or raise complaints because they're worried that it will affect the treatment of their loved ones in the home. It's a real problem just for that, not to speak of what we've run into with the actual workers in the long-term care

homes. They're very hesitant, and basically some are even told they had better not say anything or their jobs would be in jeopardy. So it's that combination. There's no mechanism.

And then, as you know, COVID brought out the actual situation that can exist in these homes. There's no way for the patients, their families or the staff to complain. It's quite a serious problem, in my opinion. This is why a lot of this disaster that happened, with the 4,000 deaths and the horror stories, they only came out once the patient was dead. Then the families felt, okay, well, now they should raise it, but they were worried about it beforehand, that their loved ones would be punished.

Now, how to deal with it? I mean, I'm going to leave it to the politicians to come up with a solution there, because it's quite serious. And then that, along with the fact that there are no surprise visits and all that that used to happen back three, four years ago—once in a while, you would have the visits. There's no mechanism of checking and making sure that the patients are safe.

**Ms. Rima Berns-McGown:** Absolutely, thank you.

Akos, I'd love to hear your thoughts also, if you wanted to say something.

**The Acting Chair (Mr. Amarjot Sandhu):** I see Mr. Hoffer has his hand up as well.

**Ms. Rima Berns-McGown:** Mr. Hoffer, yes.

**Mr. Akos Hoffer:** I'm muted.

**The Acting Chair (Mr. Amarjot Sandhu):** Unmute, yes.

**Ms. Rima Berns-McGown:** There you are.

**Mr. Akos Hoffer:** I'm unmuted—thank you. Okay.

I want to reinforce the comments that were just made by Janina and Rolf. What you're describing is fundamental to a culture of safety in a long-term care home. I recently heard an expression that, as a leader, silence is your enemy. So really, the last thing we want to do is give any impression that we don't want to hear about problems. In fact, we want to reward people who identify problems and risks and near misses and mistakes and bad things that happen that nobody saw, because it's only then that you can start to look at, "What's going on here? Is there a problem in the system?" Oftentimes, there is. It's often not the fault of the individual that something has gone wrong.

In the bill as well, there's language about increasing qualifications and leadership capabilities. I think there's an opportunity there around driving culture and making sure that you have an environment where people feel safe to come forward. Otherwise, we're never going to improve.

**Ms. Rima Berns-McGown:** Thank you. Dianne, please go ahead.

**Ms. Dianne Martin:** I just wanted to add that, as I'm sure you all know, nurses are fearless. They fear very little. But in my 42 years of nursing, I can assure you that the one thing that strikes fear in the heart of a nurse is wanting to report something unfortunate, something that needs to be fixed, and knowing that it will likely end badly for them if they do. So I really support the idea of having something that protects people who might not be in that culture that

was just described, that is, that encourages those sorts of comments to come forward.

**Ms. Rima Berns-McGown:** Thank you. I'd like to now pass it back to MPP Singh.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Singh.

**Ms. Sara Singh:** Thank you, Chair. How much time is remaining?

**The Acting Chair (Mr. Amarjot Sandhu):** One minute and 30 seconds.

**Ms. Sara Singh:** Thank you. Perhaps I can ask a question to Dianne. Ms. Martin, thank you so much. Just elaborating on the culture of fear in terms of reporting instances with RPNs, can you maybe share what types of mechanisms we then need here in Ontario to ensure that whistle-blower protection is in place, but also that there is an independent mechanism as well to address those complaints?

**Ms. Dianne Martin:** We have small mechanisms that are within our practice. If we make a med error, we have no blame, no shame sorts of situations where we go forward and work to fix the problem. We don't have any such mechanisms in terms of—those are all led by the people who set the policy for the organization. We have no such mechanisms that really can grow the protection for people who are acting in the best interest. I don't even have an example to give you.

It would need to be legislated, is what I'm saying.

**Ms. Sara Singh:** And does this current legislation offer those mechanisms?

**Ms. Dianne Martin:** I don't think as fully as it should. I don't believe it describes a mechanism that would make the nurses I work with feel safe to do that sort of thing.

**Ms. Sara Singh:** Thank you. Just in the time that I may have remaining, Mr. Hoffer or Ms. Lebon—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize to cut you off. We'll come back to you in the second round.

We will go to the government side now. MPP McDonell.

**Mr. Jim McDonell:** I wanted to thank the groups for coming in today. I know it's a busy schedule you have.

If we go back, I know we hear a lot about staffing, and I know that it has become a huge problem. It was a huge problem before the pandemic hit. The Minister of Long-Term Care at that time had taken steps to increase the number of PSWs going through colleges, but before it took effect the next September, COVID hit that previous March, and it certainly put us in a tough position.

But since then I know, just in talking to some of the universities, nursing has been increased. At Queen's, in the discussions there, 25%—so significant increases to try to address the issue going forward. But as everybody knows, education takes a while. Those increases will work their way through the system, but nurse practitioners are three years, RNs are four, and PSWs are slightly less.

Anyway, I've got a question for Mr. Hoffer. First of all, I wanted to thank your staff on behalf of the government for the great work you do. I'm also wondering if you could

please let us know how the quality centre can help staff homes like yours and what you think the centre should do to help the sector in general.

**Mr. Akos Hoffer:** I think the role we would see for Perley Health and some other organizations or long-term care homes across the province would—you could think of it as a coaching function or a peer-support function. During the pandemic, a lot of the assistance that was provided came from hospitals because they have the capacity to do it, and they did a lot of good. The issue is that they don't always have an appreciation of our context, because we care for residents and this is their home, and we have a very different philosophy of care from a hospital setting.

1530

So, hospitals certainly have a role to play, but we see an opportunity again for Perley Health and others to work with long-term care homes to help them identify where they need to improve, which is really—if you have a coach helping you, that's what they should be doing. They should be working with you to say, "What really are your priorities? Where are your highest areas at risk? Let's work together on a solution that meets you and your residents' needs." There are all kinds of methods to do that.

Just like in sports, you have different coaching methodologies that work. There is such a thing as quality improvement in science, the methodology that's proven to work. There's a lot of literature out there, a lot of expertise that you can bring in. I would see this as being an essential complement to the compliance and enforcement piece—which, to be honest, none of us really likes, but we understand it's not going anywhere. It's a necessary part of long-term care.

But what we're talking about is going from compliance to excellence. There's a chance to shift that culture, because I think when you talk to staff—we talked about fear a lot. One of the things they're afraid is being caught at doing something wrong. It's difficult to work in that environment.

I hope that answers the question.

**Mr. Jim McDonell:** Yes, and thank you for that.

Perhaps for Dianne Martin: We appreciate all the hard work you're doing as a partner of the government to help the government's recruitment and retention strategy in retirement homes. We're wondering if you could expand on the work the RPNs are undertaking to help bring more quality staff to these homes.

**Ms. Dianne Martin:** Are you referring to the retirement homes or the long-term care homes?

**Mr. Jim McDonell:** In retirement homes.

**Ms. Dianne Martin:** Okay. In retirement homes, the resident population has become quite a bit more—I would say they have chronic illnesses far more and they need far more care than they did 20 years ago, when I was a nurse. So what we're working with the government on is an initiative that provides an incentive support for nurses who have not worked in the last six months. We're very careful to make sure that that's part of it in our agreement with the

government so that we don't take nurses away from areas that need them, but to take PSWs and nurses of both categories to retirement homes where they are paid an incremental incentive piece while they work there. What we're doing with that is we are driving nurses who previously might not have chosen that but are excellent in providing care to accept jobs in retirement homes.

When this initiative started and the homes began to apply for the funding for their people they were hiring, we received about double the number of applications than we have the funding for, so we know that this was much needed and that continuing investment in this way is going to really enhance the lives of those people who live there.

**Mr. Jim McDonell:** As you know, the Ontario government is investing in substantial staffing increases in long-term care, particularly in nursing and care staff. Can you let us know how you see this improving the conditions for those living in long-term care? That's for Dianne again.

**Ms. Dianne Martin:** To start with, we need to continue to attract our brightest go-getters to all sectors, and that will include long-term care. The new initiative by the government, \$100 million to help people move forward in their careers—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Dianne Martin:** —but keep them in the care-providing careers: The most important thing the government did in that was they made it so the return of service for support for education must be in long-term care or home care. There's an amount for each. That is going to drive our brightest to experience the gifts of long-term care that they might not have experienced.

**Mr. Jim McDonell:** Okay, that's good to hear. How much time do I have, Chair?

**The Acting Chair (Mr. Amarjot Sandhu):** Thirty seconds.

**Mr. Jim McDonell:** Oh. Anyway, I just again wanted to thank you for your work. I know that staffing is always the biggest problem in long-term care, or any job. Attracting our youth is something we're hearing right across the province. In long-term care or in the skills jobs, we're trying to encourage students to get more involved earlier. Thank you for all your work.

**Ms. Dianne Martin:** Thank you.

**The Acting Chair (Mr. Amarjot Sandhu):** We'll go to the opposition side now for their second round. MPP Singh, I guess. Yes?

**Ms. Sara Singh:** Thank you, Chair. I appreciate it. Maybe we can just continue on the thought around enhanced whistle-blower protections and the need there to strengthen legislation. I think I was asking the question to Ms. Lebon. Perhaps if you could pick up on that conversation, and then, Mr. Hoffer, I have some questions for you as well.

**Ms. Janina Lebon:** In order to make complaints or suggestions—it's very difficult. It's diplomatic in the place of work, because to whomever you make the complaint, they can either accept it or they can get defensive. The process to make that complaint has got to be

something that they feel safe to do. As I suggested, “anonymous” doesn’t necessarily work; maybe a third party who will take the complaint, keep it confidential and follow it up, because we don’t want people to live in constant fear, that “If I make this comment, I’m going to get fired.” We have seen that in a few places.

**Ms. Sara Singh:** Thank you so much for sharing that. I know we’ve certainly heard that from many of the staff in long-term care homes. We’ve also heard from families and residents who don’t feel that family and resident councils have enough leverage—to make complaints but also have those complaints addressed. Is this something that the Hamilton Health Coalition also has heard, and do we feel that the current legislation strengthens or empowers families or residents to share their concerns more effectively?

**Ms. Janina Lebon:** We have heard the complaints. I know of one particular one who made the complaint and is now a little bit apprehensive that she might be sued by the owners of the home. Again, it’s a very tricky situation. We want the complaints heard. To use Mr. Hoffer, we want it positive. So I go back to some method in the act that says, “We will say this,” “You can say this,” “You won’t be fired or punished.” That’s the big thing.

**Ms. Sara Singh:** Thank you so much. I think what we have heard from presenters in previous presentations, as well, is that those additional mechanisms are simply not present in this legislation—

**Ms. Janina Lebon:** No, they’re not.

**Ms. Sara Singh:** —to empower those families—their voices—the residents, or also the workers. I appreciate that perspective being shared here again, so thank you.

In the time I have remaining, I’ll ask Mr. Hoffer a few questions around the centres of excellence that are being created here. I think we can agree that there is a need to build capacity and have a centre of excellence for the sector. I think one of the concerns that has been raised by many is the focus on mission-driven organizations, and the lack of a transition to the not-for-profit sector and investing adequately and building capacity in the not-for-profit sector.

Mr. Hoffer, do you feel that, even with a centre of excellence, the capacity that is needed to increase the number of not-for-profit providers is something that is going to be enabled through this legislation, or do we see more of the same in terms of the pattern of favouring for-profit providers?

**Mr. Akos Hoffer:** That’s a great question. It’s hard to predict the future, but I think there’s an opportunity to integrate. One of the advantages that for-profit operators have is their scale. It really, really matters, and it’s going to matter more and more as time goes on, because residents’ and families’ expectations are increasing, and they have every right to increase. But when you look at the non-profit sector, it’s extremely fractured. There’s a lot of very small operators and I don’t think it’s reasonable to expect them to be able to meet the standards without some greater support.

**1540**

That’s why this quality centre is such an important idea. There are models like it both in the US and in Canada. There’s the Institute for Healthcare Improvement in the US that’s there to serve health care organizations and to improve, and they always tap into the expertise that’s already there in the sector. In Canada, there’s an organization called Healthcare Excellence Canada that is doing similar work. Some of our own staff are coaches in that organization. I think what you do by creating something like that specifically in Ontario to support long-term care is you’re actually giving non-profit operators greater scale. You’re giving them access to a quality improvement department that they wouldn’t otherwise have.

Another example is: We, even though we’re a fairly large organization, don’t have our own ethicist on board. There is a regional ethicist that is on call for all health care organizations, and it works really well. So it’s another example like that.

**Ms. Sara Singh:** Thank you so much. One of the concerns that we hear is that, while we can’t predict the future, current trends in terms of the renewal of contracts for for-profit providers do signal a dangerous trend in terms of continuing to move forward with profit-driven models of care here in Ontario, when we know that, as you said, many of the best practices that we see in long-term care actually do come from the not-for-profit and municipally operated homes. I think of the butterfly model at one of our local homes that is operated municipally. And it’s frightening, I think, for many, that we see that the government, despite language around creating balance in the sector, continues to reward for-profit providers.

I think one of the other challenges is the staffing in those homes and the impacts that Bill 124 is having, specifically to the municipal sector.

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Sara Singh:** With that, in my final minute, I’ll just ask my last question to you, Ms. Martin: In terms of the capacity that’s needed around staffing to meet the four hours of care even that the government has outlined, do you feel that, even with the extended targets and timeline, the government will actually be able to deliver on the four hours of direct, hands-on care if they aren’t actually keeping up with hiring based on the growth in the sector?

**Ms. Dianne Martin:** My thoughts on that are that it’s going to be much, much harder than anyone thinks it’s going to be and that there is no one magic panacea that’s going to solve it. We have put many small and large initiatives in place to help us retain people and grow them. It’s not going to be cheap, but it’s going to be important—the most important thing to do. We have a lot of ideas, as do others, and we look forward to working with—

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. Apologies to cut you off. We have to go to the government side now for their second round. Who would like to start? MPP Ghamari.

**Ms. Goldie Ghamari:** Sorry, no, it’s not me. I’m going for the third round. My apologies.

**The Acting Chair (Mr. Amarjot Sandhu):** MPP Wai?

**Mrs. Daisy Wai:** I just want to thank all the presenters for coming in and sharing your insights as well.

I would like to have a question for Mr. Hoffer. Thank you very much for your insights and your care about palliative care. I would like to ask you, with what you have been working on, especially in supporting the veterans as they age in long-term care, can you let us know how this will help you to achieve the goals of your organization of protecting the dignity of the veterans living in your facility?

**Mr. Akos Hoffer:** Thank you for the question. Yes. Perley Health is very fortunate because we have a relationship with both the Ministry of Long-Term Care and the Ministry of Veterans Affairs, where roughly half of our 450 long-term-care beds are occupied by veterans of World War II, the Korean War and now by modern veterans as well.

It's a really unique arrangement and the resources from Veterans Affairs Canada are also somewhat unique. For example, we are able to operate a therapeutic recreation and creative arts program on our site. This is a program that is deliberately named a therapeutic program, because while the care that's provided there deals with, for example, arts and woodworking and so on, it is done as part of the care plan and it is done to support functional independence and health and mobility and so on. It's not just there to keep people busy. What we're seeing is that—of course, we offer that program to the civilian residents we have here as well, and we have data to support its merit.

So what's in Bill 37 in terms of increasing the allied health component I believe will be hugely important, because it will help other organizations implement similar types of programs.

**Mrs. Daisy Wai:** Thank you very much. That is important too. Now, how can we prepare those who are entering the sector, prepare them to care for veterans? How do we have to do that differently? How can we support you on this?

**Mr. Akos Hoffer:** I think one of the things to look at is the type of training that all staff in long-term care are receiving—PSWs, RPNs, RNs, physicians. If you speak to a lot of physicians in long-term care, I think they see an opportunity—we certainly do—to have physicians who are training to spend more time in long-term care and in geriatrics. The reality is, a large portion of their patients in the future are going to be people who are either eligible for long-term care or they're dealing with frailty or other issues like that, so I think it's really important.

One innovation that we have on our campus as well that may be beneficial to others is something called a living classroom. MPP Wai, you asked about preparation. Right now, for a PSW, typically the training takes place in a classroom somewhere but not in a care centre. We partnered with Algonquin College and we located a living classroom right on our campus where, from day one, the PSWs are on site. They get to see if this is really where they want to work and if it's something they would enjoy.

We're able to involve families and residents in the instruction and other staff.

It's a model that has actually resulted in a much better retention rate. My understanding is the retention rate across the province for PSWs is something like 50%. When we train PSWs in this setting, we retain 80% to 90% of those, so the government's investment goes a lot further.

**Mrs. Daisy Wai:** Thank you very much. It is important for us to have the retention rate for our workers, and especially it is important for us to not only just care for our seniors, but to especially care for those veterans.

Now, I'd like to have a question for Dianne as well. The four hours of care have been legislated and will improve the quality of life for the ones that we are serving, especially in long-term care. I'd like to see particularly why you believe this rollout will help. How do you see these four hours supporting what we are doing?

**Ms. Dianne Martin:** In our plan, we think it's important to have the four hours be the appropriate types of care providers for the residents, matching their needs, particularly PSWs, who deal with quality of life, and the right kinds of nurses at the bedside. But the more care that can happen is not only going to provide better care to the residents, which is first and foremost the goal, but will also provide a much, much greater job satisfaction for care providers, who are motivated by the difference they make in people's lives. I really think this is going to be a retaining factor, not just because nurses are physically exhausted, but because they become very satisfied with the difference they're making and, in fact, energized by the difference they make in people's lives.

**Mrs. Daisy Wai:** So our action of doing these four hours—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Mrs. Daisy Wai:** —and the way we are implementing it is going to help the nurses and also inspire them. Am I correct?

**Ms. Dianne Martin:** It's absolutely going to do both of those things, but we have to be very careful how those four hours are spread out. It's going to take a lot of visionary leadership to make sure that that works in every single home with every single resident. But yes, it will achieve those two things.

1550

**Mrs. Daisy Wai:** Great. And have you some suggestions for us on how we can work within the different homes to make the best of the four hours? Would you mind sharing that with us?

**Ms. Dianne Martin:** I'm quite sure that we'll be able to create some sort of guidance for leadership on describing how that care is provided to people, because not everybody needs the same care. People need different amounts of PSW care, different amounts of nursing care, depending on their illnesses, all of those things. We're going to need expertise from the field to help drive how that is applied.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you. I apologize to cut you off. The time has come up.

We'll go back to the opposition for the third round. MPP Singh.

**Ms. Sara Singh:** I just want to pick up on some of the questions I was asking earlier. Perhaps we can start again with Mr. Hoffer. I know in your presentation, you mentioned the importance of actually engaging the partners in the development of the centre for excellence. Can you elaborate on the importance of engaging the not-for-profit sector in municipally operated homes in creating a centre for excellence? And can you please share whether the government has done so as of yet?

**Mr. Akos Hoffer:** Thanks for the question. What I'd like to say in response is: One of the fundamental principles in quality improvement is that the people at the front lines often have the best ideas about how to improve care. This idea actually comes from manufacturing. The Toyota motor manufacturing company started with this in Japan, where they empowered their workers to put up their hands and say, "Actually, there's a more efficient way that we can produce a higher-quality vehicle, a part" or what have you. That has, over the decades, translated into health care and into long-term care.

We have an opportunity now, if you take that analogy, to say, "Okay. Who is on the front lines? It's long-term care homes themselves." And if you ask them, they have some great ideas for how to improve care. Often, they just don't have the resources to do so.

There have been efforts in the past, but they weren't really scaled. For example, I've never seen an organization in Ontario where, let's say, it's dedicated to quality improvement specifically in long-term care, and you would have a board of directors or some equivalent body that is staffed by, yes, experts in long-term care but also long-term care operators, families and so on who can help direct the work of the centre. So, to answer your question, I have not seen that to date. But this, I think, again, opens an opportunity to do that.

**Ms. Sara Singh:** Thank you so much, Mr. Hoffer. I think that much of the parameters around the centre for excellence have been left up to regulation. Many have shared with us that they would have liked to see that enshrined in legislation prior to this bill coming forward. Many presenters have also raised concerns around the process here in committee around the ability to share that feedback in a timely and fulsome way. So I appreciate what you've been able to share with us today, and I know there are several submissions that also highlight the need to actually have those partners at the table as we develop the legislation and not just after the fact as we move it forward. So thank you for that.

I think my next question is for Ms. Martin, just going back to the conversation around meeting targets and whether or not the government will, in fact, even meet its own targets that it has outlined. I know you mentioned and were alluding to the need for a variety of staffing arrangements and a mix in staff in long-term care. Can you perhaps elaborate on that and also speak to the importance

of having ratios in terms of full-time and part-time staff as well?

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Ms. Dianne Martin:** Absolutely. We know that full-time jobs are better at retaining people—that's one factor—and government initiatives that are created should be directed towards full-time recipients as an incentive to create full-time jobs. We have a document that describes all the pieces of the puzzle and how they need to go together, which I'd be happy to share, but it's going to take all of us paying attention to an ever-evolving situation and being both reactionary when we need to be, but thinking ahead of time and anticipatory about what might be coming in terms of nurses. We certainly feel like we have a good handle on that with our members, and we pivot very quickly based on what's going on in the workplace.

**The Acting Chair (Mr. Amarjot Sandhu):** Thank you so much. That's all the time we have for the opposition.

We'll move to the government side for their third round. MPP Ghamari?

**Ms. Goldie Ghamari:** Thank you, everyone, for your presentations. As an Ottawa-area MPP, I, of course, have a soft spot for the Perley, as does my colleague MPP Jeremy Roberts, who I know has visited the Perley quite a bit. I haven't had an opportunity to visit the Perley yet, but I did attend an unveiling—this was back in 2018—at the CFS Leitrim All Ranks Mess. It was the fallen leaf art piece which was done sort of as an homage to the veterans at the Perley.

I know that if my colleague MPP Roberts could have been here, he would have been, but I wanted to thank you for joining us today, Mr. Hoffer, and providing your input and insight on this. It's something that we all care about very much. I know MPP Roberts always calls the Perley the jewel of Ottawa, but that's in his riding. I'm a little bit biased, because I have the Osgoode Care Centre in Carleton, and for me, I consider the Osgoode Care Centre the jewel. But I think they're both jewels, really.

I just wanted to maybe get an opportunity to get your thoughts. I know you spoke a little bit about the bill and your support for it, but I'd like to give you an opportunity to maybe speak a little bit more about that and how the changes in the legislation that we have proposed are going to benefit the veterans and seniors at the Perley Centre.

**Mr. Akos Hoffer:** Okay. Thank you. I think that if you think about a lot of the changes that have taken place in the sector, an observer would assume that maybe the government was going to take the whole sector and kind of mash it all together or integrate everything. That has happened in other provinces, where hospitals, long-term care homes and community service organizations were all integrated, and the evidence is mixed as to whether that really works or not.

The idea there is a vertical integration. The opportunity we see with the quality centre is a horizontal integration, where it's long-term care helping long-term care. I really appreciate your kind comments and I think you're absolutely right to point out that we're not the only game



in town; there are other excellent care providers and there are other long-term care homes like the Perley who are doing research. We have a centre of excellence here in frailty-informed care, and the whole point of the research we're doing is to develop actionable knowledge that you can implement at the bedside quickly, specifically in long-term care, for the residents that we serve.

The opportunity in front of us is to scale that and to make sure that our veterans and seniors at the Perley are not the only ones that benefit from that. So getting this language in the bill—again, we respectfully made the suggestion to obligate the minister to establish the quality centre. We and others will be there—

**The Acting Chair (Mr. Amarjot Sandhu):** One minute.

**Mr. Akos Hoffer:** —to help make sure that it happens, but we see that as a really important move forward.

**Ms. Goldie Ghamari:** Thank you so much. I know I only have a minute left, so I'd love to learn more about this, and if you haven't already spoken with her, I'd love to introduce you to Lori Norris—she is the executive director of the Osgoode Care Centre—because she also has a lot of experience with this. I think that this is something that she would be very interested to learn about and be involved with, because they also have a lot of seniors there.

But I think this is also an opportunity to maybe get involved with the health organizations that our government created a few years ago and see what those local health organizations can do to support long-term care, because—you're right, there are different—

**The Acting Chair (Mr. Amarjot Sandhu):** I apologize to cut you off. That concludes our time for the presentations.

I would like to thank all three presenters for appearing before the committee. We appreciate your presentations.

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DR. AMIT ARYA

UNIFOR

KINGSTON HEALTH COALITION

**The Acting Chair (Mr. Amarjot Sandhu):** Moving along to our next group of presenters, first I would like to call upon Amit Arya. Please state your name for the record, and you will have seven minutes for your presentation.

**Dr. Amit Arya:** My name is Amit Arya. Can I get started?

**The Acting Chair (Mr. Amarjot Sandhu):** Yes, please.

**Dr. Amit Arya:** Okay, perfect. All right, so I'll get started. My name is Dr. Amit Arya. Thanks so much for the opportunity to present today in front of the standing committee about Bill 37.

I am a palliative care doctor who works in long-term care facilities. I've worked in long-term care since 2014 in the greater Toronto area. I also work in hospital and home

care. I have extensive experience providing palliative care consults in long-term care and supporting family doctors and nurses through education and in-person palliative care consult services and 24/7 on-call.

During the COVID-19 pandemic, I actually led my hospital's response team into local long-term care facilities. In addition to this, I'm an academic physician, so I have faculty appointments at the University of Toronto and McMaster University. I serve in leadership roles at the local, provincial and national levels and also do research on improving palliative care in long-term care, and have several research projects which are funded by the Canadian Institutes of Health Research. I'm invited to speak at provincial and national academic conferences on palliative care in long-term care, and often speak in the media as well.

I wanted to focus my presentation today on palliative care. Specifically, when people first think about palliative care, they often think about end-of-life care, but those two terms are actually not synonymous. Because suffering does not just begin at the very end of life, palliative care should also not begin at the very end of life, but should be considered from the time of diagnosis.

Palliative care is an approach to care which involves management of symptoms—so treatment of pain, shortness of breath and anxiety—and ensuring treatment is provided in line with resident wishes, their expectations about quality of life and stage of illness. Palliative care can and should be provided alongside life-prolonging treatments when appropriate. An easy example would be if someone has pneumonia. The pneumonia can be treated with antibiotics, if it's the right thing to do, but the shortness of breath with the pneumonia can be relieved with medications like opioids so someone does not suffer.

Palliative care is there for active care. It does not mean that we're hastening death at all, but actually it's about improving the quality of life for the time that remains. So why is this important in long-term care? Well, in long-term care, the vast majority of residents are admitted with advanced life-limiting illnesses such as end-stage dementia, frailty, and heart and lung disease. The median survival after admission to long-term care is just 18 months.

It's very normal in long-term care that every week, there may be one or two people who die: someone who suffers a significant decline and can't get out of the room anymore, or someone who has a critical infection and starts to have swallowing difficulties. These people are actually very sick and have very complex medical needs. That has nothing to do with the pandemic. We would expect that palliative care services would be a given here, but yet we know, as per the Canadian Institute of Health Information, that just 6% of long-term care residents have documentation of receiving palliative care in their last year of life and about 21% of residents—about one in five—are transferred to acute care hospitals for palliative care needs.

In my front-line work, I regularly see people who are profoundly suffering, and this is not limited to the pandemic. I'm seeing people in long-term care who have

severe pain or shortness of breath or agitation which is under-treated, or sometimes not even treated at all. During the pandemic, as someone who worked on the front lines, I can tell you that the failures were not just limited to infection control, but there was a huge failure to provide a palliative care approach and to treat suffering. That was something that should be considered for people who survived with COVID-19, or people who did not survive, because, once again, palliative care is not just end-of-life care.

What are some of my suggestions about how we can provide better palliative care in long-term care and how we can change the culture? Well, firstly, we know palliative care doesn't work in a silo. We need to address many of the long-standing structural inadequacies, including improving working conditions and, of course, moving towards non-profit care delivery. I'd be glad to speak about that later, but I'll speak about palliative care now.

I can tell you, I work on a regular basis with well-meaning, compassionate and caring staff who actually don't have much training in palliative care. So firstly, we need to ensure that all staff, including physicians, nurses and nurse practitioners, have training in palliative care. The analogy I use is: Well, I'm a palliative care specialist; you wouldn't allow me to step foot in the emergency department and pick up shifts or work on labour and delivery and deliver babies, because it wouldn't be safe. So how can we allow people, staff, to work in long-term care without training in geriatrics and palliative care?

Secondly, of course, we have a big issue with understaffing. I especially want to focus on nursing, because I know the ministry is hiring PSWs. To give you an example, I work in a really good not-for-profit long-term care facility. In that facility, there is one nurse for 25 residents in the day, and one nurse for 50 residents at night. But the hospice just down the road has one nurse for five patients. Obviously, if a resident is short of breath or in pain, we would expect it to be much better managed in the hospice. This disparity is just not fair, because everyone has a right not to suffer.

I do commend the ministry for including a new right of residents in long-term care to be provided with care and services based on a palliative care philosophy, but I also have very significant concerns about this because there's no definition of palliative care and no elaboration on how we're going to provide this.

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

**Dr. Amit Arya:** Firstly, I would recommend the act be changed to include language to support early integrated palliative care so we don't just think that palliative care is end-of-life care.

Secondly, we should include language to ensure that residents receive early identification and treatment of symptoms, including physical, psychological, social and spiritual causes of suffering.

Thirdly, every resident should have a goals-of-care conversation with their physician or nurse practitioner to ensure that people are provided with the right care that is

in line with their wishes. This should be included as a right of residents in the act.

And fourthly, although we're speaking about establishing a long-term care quality centre, it's important that there are quality standards for palliative care which are included in the act. We need to make sure that we're including metrics like monitoring of pain and symptoms, frequency and quality of goals-of-care discussions, as well as hospital transfers and place of death.

Thank you very much for the opportunity to present.

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

I will now ask Unifor to speak for seven minutes, please.

**Ms. Katha Fortier:** Thank you very much. Good afternoon. I'd like to acknowledge that we are all working and living on unceded land. I am on the unceded territories of the Haudenosaunee and the Mississaugas of the Credit First Nation.

Unifor welcomes the opportunity to share our views with the committee regarding the proposed Bill 37. Thank you very much for the invitation to appear. I am an assistant to the national president of Unifor, Jerry Dias, and I'm joined today by our health care researcher, Mike Yam.

Unifor is Canada's largest private sector union, with 315,000 members working in virtually all sectors of the economy. Over half of our members live and work in Ontario. Despite our footprint in various private sector industries, Unifor represents a significant number of workers in the public services, including in the health care sector. We represent more than 26,000 health care workers in Ontario who work in hospitals, long-term care homes, retirement homes and health clinics.

Bill 37 has been tabled at an unprecedented time—a time when our health care system and health care workers have been stretched to the limit. We've tragically lost so many Ontarians to COVID-19, especially those in our long-term care system, including several health care workers who have been on the front lines. Two of those workers, tragically, were Unifor members, PSWs, and we mourn their loss while we continue to fight for change.

I must acknowledge the tireless work that long-term care workers in this province have been doing throughout the pandemic. They've worked through a humanitarian crisis and put their lives on the line to do so. I wish I had time to tell you the stories of a PSW who worked 56 days straight of 12-hour shifts while living in a trailer outside her nursing home; of an activity aide whose job became to make Zoom calls to loved ones as they said their final goodbyes; of the workers who had to—I don't like this term, but it is what it is—bag the bodies of the residents, the residents they loved, because funeral home staff could not enter a home in an outbreak. So when I call it a humanitarian crisis, please know there is real evidence of this.

**1610**

Unifor and its long-term care members have several concerns regarding Bill 37, a piece of legislation that

doesn't properly address the systemic issues within Ontario's long-term care system.

First, the legislation does not adequately address the staffing crisis in the sector. We know that literally thousands of workers have left the industry, and we should be doing everything possible to get them to return.

It's no secret that there is a serious recruitment and retention problem in long-term care. This government must help create the conditions of work, including compensation, that will attract workers back to the sector. The temporary wage enhancement for personal support workers was welcomed when it was introduced, but it continues to exclude so many front-line workers in long-term care and other health subsectors. This pay should be expanded to all front-line workers, and wage enhancements across the sector should be made permanent.

Bill 124, the wage restraint legislation, has also suppressed rate increases for many front-line health care workers, including those working in not-for-profit long-term care homes. Despite all the sacrifices they have made, they've been arbitrarily treated differently compared to their for-profit counterparts. This legislation simply needs to be repealed.

Second, the average of four hours of care doesn't belong in this legislation, but we must ensure that it is a mandatory requirement, not just a target. The four-hour care standard must be vigorously measured through mandatory public reporting based on hours worked and required for each home. A province-wide target will be completely unenforceable and essentially meaningless.

This government should also fast-track progress on the four hours of care. Our seniors simply cannot wait until 2025 to get the care they desperately need. Operators should publicly disclose not only the hours of care but overtime, agency use, percentage of full-time workers and all shifts worked short.

Third, care standards must be enforced with real consequences. While the government has emphasized new enforcement measures in this bill, the context for these changes is important. Doubling the amount of fines that can be levied on homes, for example, is fine, but they are not useful if the violations are never enforced.

Over the last number of years, the government already had powers in the existing act to hold homes accountable for negligence or non-compliance. They simply chose not to act and enforce these measures. We need a strong compliance, inspection and enforcement system that includes annual surprise inspections, hefty fines, licence suspensions and even revoking of licences for non-compliance.

Fourth, this government must focus on not-for-profit long-term care. The preamble in this legislation should emphasize the commitment to not-for-profit providers without the inclusion of "mission-driven organizations," which in our view is an undefined term in the act that alludes to for-profit providers.

During the pandemic, this government has rewarded for-profit long-term care chains by awarding them licences for thousands of new beds, despite the devastating role

they played both before and during the pandemic. According to scientists advising the government, for-profit homes had nearly twice as many residents infected with COVID-19 and 78% more deaths than non-profit homes. This is simply unacceptable and unforgivable.

We must work to remove the profit from the long-term care system by ensuring new bed licences are given to public and not-for-profit entities that can provide more resources to deliver better care for our seniors and more effectively attract workers back to the sector by improving their working conditions and compensation.

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

**Ms. Katha Fortier:** The government has an opportunity to make meaningful changes in the public interest with regard to long-term care. As such, a bill of this magnitude should require full public hearings across the province, instead of this expedited process that leaves out so many important voices.

Once again, I thank you for your interest in our views. I do invite you to read our written submission, which is more extensive, and I welcome your questions and your comments.

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

We will now go to the Kingston Health Coalition for your seven-minute presentation, please. When you're ready.

**Mr. Matthew Gventer:** I'm ready. Thank you. My name is Matthew Gventer. I'm co-chair of the Kingston Health Coalition. With me is Faye Boden, a participant in the health coalition and a front-line PSW worker. I hope that if there is a chance to ask questions, you will be asking her questions to get a clear idea of the situation that justifies some of our comments.

Kingston Health Coalition has been diligently defending public medical care for over 30 years. We have a wide, supportive community with over 200 people who follow our activities.

In the past three years, we have put much energy into addressing concerns about long-term care. Two years ago, before the pandemic, we engaged in a public report on the critical conditions of long-term care. If a body makes predictions and the predictions come true, you should give some credibility to that body that it has some justification in its observations. We said the system was in crisis. We talked about the violence. We talked about the failings in support. We talked about the breakdown in staff, inadequate staff. And we advocated for four-hours-per-day care. We said the situation was depressing and on the edge.

Well, the pandemic came along and we had a catastrophe—and it was a catastrophe. We had more people prematurely die in long-term care than died in the World Trade Center. That is a catastrophe.

Now, I think we recognize that the long-term care act amendment, Bill 37, reflected some of these concerns, in part. However, the changes are not adequate to meet the need. In fact, in some ways they're inhumane.

We owe you an explanation for the assertion that they're inhumane. The reforms needed in long-term care

comprise elements of essential care. People working in long-term care or family of residents in long-term care in Kingston have observed conditions of care that harm residents: for example, people on hydration protocols being given drinks but not monitored for consuming the drinks, then the drinks being removed before they've been consumed; or people needing to get to a washroom, on fall protocol, being forced to wait beyond reason. Staff report they have no time to communicate with the residents who need such support and who have no family visiting.

The bill has finally recognized the legitimacy of our call for a standard of four hours of care per day, but this government has proclaimed over the years its concern with minimizing budget deficits, so it wouldn't have included such a change unless it recognized that such a care standard is vitally important. If that standard is essential to the well-being of residents, it is essential now—not four years from now, not three years from now. We urge the government to amend the act to put a deadline for accomplishing this change within a year and to make it a requirement, not a target.

We also note that we need a capacity to measure this target. This measurement should be public, so it is visible to all. Operators need to be open to public scrutiny as to their meeting the essential target. And by the way, it's not a standard across the whole province. Every operator, every facility needs to meet that standard.

The most immediate measure of effort to meet the target is staff ratios. The act should provide for absolute standards of staffing. Maintaining reporting staffing should be in the act.

We also expressed concern that annual surprise inspections were cancelled when the government took office. In fact, our experience in Kingston reinforced the importance of inspections. It was the proactive intervention of the Kingston, Frontenac, Lennox and Addington Public Health unit in the long-term care sector at the start of the pandemic that helped Kingston avoid the tragedy other facilities experienced. This was the case even though we had facilities with four-bedded rooms. The intervention was inspection and direction on infection control procedures that paid off so well. However, we also warned that inspections without consequences were ineffective. Unfortunately, the inspection regime promised in the act is years in the offing because you need to train the staff, and you have not shown us the commitment in the past to enforce the standards.

While we're underlining many of the recommendations that you will find in the Ontario Health Coalition submission, these commitments are based on our observations in Kingston. We agree that the OHC's concern that the inclusion of "mission-driven" operation in the preamble undercuts the emphasis on not-for-profit delivery in long-term care. However, we don't expect to get far with this criticism, given the government party's bias toward for-profit care. I'm not saying that to attack the government; I'm just saying this is a reality.

1620

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

**Mr. Matthew Gventer:** Oh, okay. I'll go very quickly then.

The city of Kingston has seen the municipal facilities moving towards a higher level of care. For example, Fairmount Home had moved to four hours of care before the pandemic. The city pays higher wages. Municipal facilities have a special role. We think that the government and the act should find ways of providing capital assistance so that municipal facilities and non-profit facilities can take advantage of the opportunity to take a greater share of the number of beds that are available.

Also, the word "mission" raises a problem. The commission of inquiry criticized the current model of private care, because so much of it was based on investment—

**The Chair (Ms. Laurie Scott):** I'm sorry, but the time has run out. I apologize. Sorry.

We will now move to our first round of questions with the government at seven and a half minutes. I believe MPP McDonnell—please go ahead, to start.

**Mr. Jim McDonnell:** Okay. First I want to thank the presenters for their time here today. Certainly, other than this bill coming forth, it is an important topic that should have been addressed over the past years.

The first question will be going to Unifor. You represent many PSWs and nurses working in long-term care, and I was wondering if you could tell us if you know how staffing that this government has funded will help improve working conditions for the front-line heroes you represent. We're talking about significant, if not massive, funding increases to—of course, as we develop more and more of a workforce—allow us to move to four hours per day, which is really what reports over the last 10, 12 years have been asking for.

**Ms. Katha Fortier:** Thank you for your question. It's very important, of course, and we do appreciate the government's commitment to putting money into the front-line care. Our concern mostly is about—I mentioned some of this briefly in my report—the challenge: Is that money going to be used effectively?

First of all, we know we have to bring up the percentage of full-time. I think the long-term care commission recognized that 70% is a good number, and I bet that most homes are not even above 50%. It's really important that PSWs and others who work in long-term care have access to a full-time job so that they don't have to work in two and three different places to earn a living. There are very good reasons that employers like to keep people part-time and casual—not only the fact that they don't get access to benefits and sick leave, it also takes them longer to move up the scale. So, if you can imagine, they might start at \$19 an hour and, after three years, work up to \$22 an hour. But if they're working part-time or casual, it could take them six years to get to the top of the scale. So there are very important reasons that employers would like to keep people part-time and casual longer and have multiple jobs, and that's something that the government should be tracking.

As well, we need to improve the wages. Unfortunately, the arbitration system—they are not legally allowed to

strike. The arbitration system has not been generous to them. Over the last decade, they have had not an increase that has kept up with inflation, and that includes a two-year wage freeze imposed by an arbitrator, so they've fallen behind in inflation very significantly over the last decade, and we need to course-correct that. In fact, there's a very simple way to do that. It's called proxy pay equity and maintaining a pay equity system. That might be a conversation for another day, though I'm happy to tell you all about that.

**Mr. Jim McDonell:** We know that attracting young, new entries into this field has been difficult. Do you feel that this four-hour mandate will help? Part of that will be, to attract or to get to the minimum, that of course wages will have to go up. When there's a demand, that becomes a requirement. Do you see that having an impact going forward?

**Ms. Katha Fortier:** Absolutely. I mean, I think we've seen, even pre-COVID, a revolving door of people working in long-term care. Sometimes they stay for six weeks, sometimes six days and sometimes six hours. Orientation is very minimal, and orientation, when you work in a nursing home, is just simply following another overworked personal support worker or nurse around, watching them do what they do. When a personal support worker is assigned to 12 residents and has to get them up and dressed for breakfast in a little over an hour, you look at that work and you think, "This isn't what I signed up for. This isn't what I wanted to do."

Once we start to get those care hours into the home, and we make sure that they're transparent and that they are going to nursing and personal care, then it definitely will make a difference in attracting people, because you don't become a personal support worker—by the way, I shouldn't just talk about personal support workers; it's a whole team of workers in long-term care. Most of these homes would not have gotten through code-red outbreaks if housekeepers, dietary workers, activity aides and everybody—and, of course, the nurses—hadn't all stepped up and pulled together as best they could, as their co-workers were falling around them.

Improving those conditions; making full-time work; making employers accountable, to make sure that they're providing and offering full-time work when you're funding them for it; making sure they're not relying on overtime and agency use, which is completely out of control—agency workers can be paid sometimes double what the workers who work in that home are making. Even the long-term care associations, I think, will agree it's not an ideal solution to fill homes with agency workers.

So, yes, we've got to get there. I think that the ideal would be to get there as quickly as you possibly can. In fact, if there is a home that could staff four hours of care tomorrow, I think they should be allowed to do it and funded to do it. It's really critical that we do this as much as we can. When we create those conditions, people will come back to the sector, and there are thousands of trained workers who can do this work.

**Mr. Jim McDonell:** I know that nobody likes the part-time work that goes along with that, but it's funny, because I got a call from a resident of mine who had worked in long-term care and was then retired—so like I said, there's no motive in it. But it's just to say that many of her co-workers wanted to work part-time. They had a family. Being able to work three or four hours in a day was really their goal, and of course it works well with long-term care, because generally there's a lot of work in the morning to get patients up and then at night back to bed.

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

**Mr. Jim McDonell:** So it's a little bit contrary to what we're hearing, but you said you will have a hard time staffing, because many—not all, but many—of the part-time workers actually want to work part-time because it fits their schedule. Sometimes it's in the evening, when their spouse gets home, or vice versa in the morning if one's spouse puts them on the bus or that type of thing, but with busy families and somebody looking for something that's not full-time but something a little more, it can be a career that works very well—until their family grows up, of course, and they have a little more time.

That's just something I hadn't heard of before, but it was a point of view she put across that I thought was important to hear.

**Ms. Katha Fortier:** I would just say that there's a very small percentage of part-time workers who are not looking for full-time work. It's very important that they have full-time work with benefits and sick leave, and this is really critical.

**Mr. Jim McDonell:** Okay.

**The Chair (Ms. Laurie Scott):** Thank you very much. We'll now move to the opposition for their seven and a half minutes. MPP Gretzky, please go ahead.

**Mrs. Lisa Gretzky:** I want to thank the presenters today. Before I move to the presenter I wanted to speak to, I'm just going to address what MPP McDonell said and echo what Ms. Fortier said in her response. I would say the workers wanting part-time jobs are the exception, not the rule. There are some who want part-time; the vast majority would like stable full-time hours.

When it comes to attracting new entries into the field or retaining workers, as Ms. Fortier had stated, if you give them decent wages, if you ensure those are full-time jobs and you ensure that they are supported through full staffing complements, I think you will find that not only is it easier to retain those workers but to attract new workers into the field.

**1630**

That being said, my question is to Dr. Arya. I want to talk about palliative care. We had presenters from Pallium Canada, who had presented previously, and I had asked about palliative care and the importance—I had noted then that I didn't know a lot about palliative care until I got to know Dr. Darren Cargill, who has taught me a lot about palliative care. One of the key pieces that he taught me is the importance of caregivers, to families, when we're talking about a palliative journey for a patient. What we've seen throughout the pandemic is that those family

caregivers, those essential caregivers, were completely locked out for many, many months. If you look at other congregate care settings, they're still being locked out.

I'm wondering if you could talk a bit about your experience and how important those caregivers are when it comes to the palliative journey for our patients or residents, and if you see anything reflected in this bill—I know you're aware of my bill I tabled around building a strategy around caregiver access, but do you see anything in this bill, or how do you see this bill could be strengthened, to reflect the importance of caregivers to your patients?

**Dr. Amit Arya:** Thanks for that question. I'd be glad to share what I see on the front lines and what my daily work as a palliative care physician involves. That is basically centred around how family caregivers are essential care partners. They are essential to provide good care to residents. What that means is, specifically when we talk about understaffing in long-term care, for a long time I have seen families coming in and doing a lot of the work that staff does. I really think of them as I think of health workers. What that means is they will come in, they will be feeding their loved one, and they will be helping with bathing, helping them get to the bathroom.

Oftentimes, because family members of course know their loved one, they're often the first to identify symptoms like pain or shortness of breath, or some change in their medical status, and they'll bring it to the attention of the medical team, so the nurses or the physician. To add to that, family members—often, for people in long-term care who have cognitive impairment, they often have dementia, and they may not be able to speak for themselves about their wishes and what they would want with treatment. I spoke about goals-of-care discussions. Most of the time we are relying on family caregivers as substitute decision-makers. They are the ones who are providing consent to treatment plans. So that tells you the breadth of how much we rely on family caregivers.

I will mention that the vast majority of family caregivers that I see are women as well, so this is a gendered role. These are people who are unpaid for their labour. I think, through the pandemic, we've seen a devastating consequence of locking out family caregivers, which should not have happened, because residents were left doubly vulnerable. Not only were there not enough staff to care for the residents, but then there weren't enough family members to look after the residents either. That undoubtedly contributed to the suffering and led to the disaster that I saw through my own eyes in long-term care. I'll never forget. I saw people dying, crying out for their daughter, or their loved one. That memory, to be honest, is scarred in my mind forever.

But now, moving on, I really think it's important that we recognize the essential right of family caregivers to not only gain access in long-term care, but to be treated with respect and to be included in goals-of-care conversations.

I'll add that unfortunately not everybody I see in long-term care has family, so we need to make sure that we have staffing levels that are not dependent on a revolving door

of staff and precarious working conditions, but stable staff who are working at a single site who know the residents well. Often, I see they develop family-like relationships. They should, of course, take the lead in providing the care.

But at the same time we have to provide more support for family caregivers. I actually would say that we need to provide some compensation for the work they do, to be very honest. It should not be unpaid labour simply because it's "women's work." Of course, we need to make sure that we provide support for caregiver burnout. I often see people who are in crisis when their loved one is admitted to long-term care, and that's not reasonable. We need supports for caregiver burnout.

We need to make sure that we provide grief and bereavement supports, because I talked about how for the vast majority of people, when their loved one is admitted to long-term care, let's be honest, death is the inevitable outcome. The median survival is just 18 months. A lot of people are suffering and a lot of people are experiencing that grief and bereavement, and they deserve those supports.

**Mrs. Lisa Gretzky:** Thank you. I appreciate that. I'm going to hand it over to my colleague, MPP Berns-McGown.

**Ms. Rima Berns-McGown:** Thanks to all the presenters. My question is also for Dr. Arya, and I'd like to follow up on the question of palliative care. Palliative care and its successful implementation is one of my passions, and we were hearing yesterday from some residents and residents' associations where there was some real misunderstanding about what would be a part of that framework and approach.

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

**Ms. Rima Berns-McGown:** Given the general, I would say, lack of education as well as the lack of training, what would you suggest needs to be in this legislation in order to make this real?

**Dr. Amit Arya:** As I spoke about, absolutely the number one thing I see is that palliative care is confused with end-of-life care; it's confused with giving up life-prolonging treatments, and that's not the case. Palliative care should be provided early and in a timely fashion, and it should be integrated along with other treatments.

Because we're running out of time, I'll just briefly add that in my clinical experience, I've almost never had resistance from patients and families when I tell them what palliative care is. Really, to be honest, the resistance sadly comes from other health workers, who sometimes don't have the training, don't have the experience and don't understand what palliative care is.

**Ms. Rima Berns-McGown:** Part of my question is about what training needs to be embedded in order for this to become a real thing. I wonder if you can maybe pick this up the next time as well.

**Dr. Amit Arya:** Sounds good.

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

We will now move to seven and a half minutes for the government, and I give that to MPP Triantafopoulos.

**Ms. Effie J. Triantafilopoulos:** Thank you to all the presenters for being with us today. These are long sessions that the standing committee is having, but they're all very, very important, to hear from as many presenters as possible.

I've got a couple of questions that I would actually like to direct to Katha and Mike. The government, as you know, has been increasing direct care for residents to four hours of average daily care per day, and we think this will make a real difference in the quality of care and the quality of life for each resident. To accomplish this, the government has also been investing \$6.4 billion into the development of new homes and beds, in addition to redeveloping the old homes that are not up to the modern design standards.

Between 2011 to 2018, the previous government had only built 611 net new beds. That's really quite an astonishing number when you think that in my own community of Oakville North-Burlington, the Minister of Long-Term Care, a few weeks ago, was with me when he announced that 640 net new beds are going to be going into the community of Oakville. So our government has a plan to build 30,000 net new beds by 2028, and we are making good progress right across the province. We have over 20,000 new and 15,000 upgraded beds in the pipeline—more than 60% of our total goal.

We also know about the past challenges and, frankly, the lack of funding by previous governments to build these new homes. We have a very long wait-list, as you know: 38,000 people today waiting to get into long-term care. I'd like to ask you what you see as the significant impediments to being able to build more homes, and what measures you would actually consider that we should consider as a government to speed up the construction of more homes.

Katha, go ahead.

**Ms. Katha Fortier:** Thanks for your question. While the building of new beds is critical, we understand that the bigger challenge needs to be making sure that we have the staff to operate those facilities. And so, I think what's very relevant here is that the conditions of work are the conditions of care.

Speeding up the four hours: Again, I understand that it's a target and it's a provincial average, but I would suggest that that, in my mind, is very unenforceable. I don't know how you would actually enforce a provincial average in any specific home, so I think it needs to be targeted to individual homes and those conditions.

1640

I also would think that the new development of beds is critical. There's no *[inaudible]*. We do need new beds. We've got some failing infrastructure and those older homes are at quite a disadvantage when it comes to newer homes. They've got significant challenges. They have longer-serving staff who have more vacation entitlement and such. They're also not physically attractive, so people don't want to go there. The reality is that sometimes those older homes take residents that other newer, brighter, fancier facilities would reject. It's no secret that we have a

lot of psychiatric-needs younger residents living in long-term care, and sometimes those get mixed into the older homes more so, and I think that's a conversation for another day.

But we do think it's important that your government is building beds. We think that it's great that you're fast-tracking. We've seen some of the announcements. It's no secret that we would prefer those beds to be municipal, run by hospitals or run by not-for-profit agencies; again, the for-profits have been rewarded and none of them have been fined for the atrocities that have happened through the pandemic. Our direct preference would be that your government work with municipalities, work with hospitals and work with charitable organizations, church groups and cultural groups that want to build nursing homes, and that that's who is operating those homes. Of course, it doesn't negate the need for standards, but we think that's really important.

**Ms. Effie J. Triantafilopoulos:** Thank you, Katha, for that. I agree with you. I think it takes a partnership across all of those sectors in order to be able to move quickly to address the growing gap, given the aging demographic of our population and, frankly, the lack of adequate new builds.

I also wanted to speak to you about some confusion that has come up among some of the presenters around this concept of the four hours of direct care and how it's actually being calculated across Ontario. I know some people are suggesting that because of the approach our government is taking to make an across-the-province approach, that somehow means that some long-term care homes are not in fact going to have the care that they need.

These commitments to four hours of care aren't aspirational targets or nice to have, but have significant investments being provided to each home to increase its staffing and care levels. There's \$270 million by the end of this fiscal year, and by year four it will be \$4.9 billion, by 2025.

As well, we recognize that the care needs of individual seniors at particular homes are highly variable, and it's really very much based on the resident's acuity. Some residents may actually need more than four hours of direct care, and some may actually require less. That is why we've taken this approach on the four hours as an average across the province.

As well, this funding I'm talking about can only be used to pay for salaries, wages and benefits of personal support workers, nurses and allied health professionals.

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

**Ms. Effie J. Triantafilopoulos:** Minister Phillips committed to making hours-of-care data publicly available on a home-by-home basis, so Ontarians can see clearly how those investments will actually translate to the four hours of care that residents across the province deserve.

I wanted to put that to you and see if you might actually have any response to this comment I just gave you.

**Ms. Katha Fortier:** Sure. I appreciate that, and I appreciate that the reporting will be public. We haven't

had data. We haven't seen data on nursing home staffing in some time, so that's a really critical piece to this.

My concern is that I actually don't think there's that much significant difference in nursing homes in the level of care that they require. We aren't where we were 25 years ago, where people drove cars who lived in nursing homes, or went out for walks on their own. This is a very frail community with very, very complex medical needs, and I really don't think that there's going to be too much variance—

**The Chair (Ms. Laurie Scott):** I'm afraid the time is up. I'm sorry.

We will now move to the official opposition for seven and a half minutes of questions. MPP Singh, please go ahead.

**Ms. Sara Singh:** Thank you to all the presenters for your presentations today. I really appreciate you being here.

I think I'd like to start my questions off with Katha, just perhaps elaborating on the concern that many have raised around the four hours of direct, hands-on care and the average that this is provincially. I know the government members want to act as though this metric is one that's achievable and that an average is the right way to go, but can you perhaps elaborate on why this is problematic and why this might actually mask bad actors and allow them to carry on without providing the care that residents need?

**Ms. Katha Fortier:** Thanks for that question. Obviously, this is something that the government has said, that they're going to increase compliance officers, which is good, but I think it has got to be the compliance officers that enforce the standard of care. What they need to do is that when they go in—I mean, this has always been a problem in long-term care. A compliance officer can go into a home and point out a hundred things that aren't being done, but if there isn't enough staff working that day to provide adequate care, there's not a darn thing that they can do about it.

So this becomes the challenge: We need to make sure that when a compliance officer goes into a home, that that home is adhering to the staffing plan, the staffing model that has been approved by the government, that they say they're providing. If they're not providing that care, if they're not providing the four hours, then there should be consequences for it. But this should happen in real time, and it's not impossible to do.

We have formulas. We can work out the four hours of care. It is good that it's nursing and personal support workers; another conversation is the watering-down of who's working in some of our nursing homes right now under the emergency orders. But again, this four hours has to be enforceable, and it has to be enforceable by compliance officers. Otherwise, it won't be real, and then what is the government going to do? Find out a year later that they've not been providing the care that they are contracted to do?

**Ms. Sara Singh:** Thank you so much. I think that's part of the challenge, that there really isn't an enforcement mechanism here to hold homes accountable. But I think,

as you and many presenters have outlined throughout the duration of this committee, that the staffing resources are simply not there to meet these targets, and I think that that underlines the fundamental issue here and why this legislation is so flawed in actually creating the change we need to see in long-term care.

Katha, just before I move on to Dr. Arya, I would like to hear a little bit more from you with respect to the staffing needs that are required here to actually meet four hours of direct, hands-on care.

**Ms. Katha Fortier:** I think that, conceptually, four hours of care is hard for people to imagine. We often think better in terms of ratios or time, which is why our union did the Six Minute Challenge a few years ago. You might have seen it; if you haven't, please google it. But it talks about how if we assume a PSW is assigned 12 residents on a day shift—which, by the way, is normal; it could be higher if they're short-staffed—and they come into work, they have a certain amount of time. You've got 12 residents, and some of them take two-person lifts, so that cuts down more of your time. You're going to want to wash your hands between each resident. They literally spent about six minutes with each resident in the morning. Our challenge to people was to try to get ready in six minutes, because we want people to visualize this.

We think of a daycare where there's a ratio of 1 to 4, or we talk about hospital beds. Dr. Arya talked about the ratios in palliative care and how they differ. Long-term care, again, has to be a little different, but the goal is to get those ratios down. The goal is to say: Instead of 12 residents I'm caring for, maybe it's eight or maybe it's seven. Wouldn't that be ideal? It's about giving them the time to provide the care, and it's just not there with the current formula. When we're going to make these changes to the four-hour standard, again, we need to make it enforceable. It's really, really an important piece of it.

**Ms. Sara Singh:** Thank you so much. I appreciate you sharing that.

Just picking up on the theme of adequate staffing and training and the resources, I know, Dr. Arya, that we are happy to see that there is a mention of the palliative care plans in this legislation, but it's simply not backed up by any real resources or definition or additional training for staff in building that capacity that's needed. Do you mind shedding some light on the specialized care and training that is needed in order to actually provide palliative care in our long-term care homes?

1650

**Dr. Amit Arya:** So to be very upfront and honest—thank you for this very important question—palliative care, exactly as you've said it, is a specialized field of work. Regular medicine just doesn't work for the care of older adults. It doesn't work for people who have life-limiting illnesses like dementia, heart and lung diseases, kidney disease, frailty. These are the people who live in long-term care, and that's why we have specialist fields like geriatrics and palliative care.

I can tell you a personal anecdote where, just a few months ago, I was talking to a nurse practitioner who was



newly hired to work in a long-term care facility, was not provided much orientation—and actually had 15 years of previous experience working in obstetrics, working in labour and delivery—and then was just asked to start seeing patients. That's absolutely not appropriate. It's not safe. It's not safe for, actually, the person who's practising, because it's their licence on the line, and of course it's going to lead to more burnout and people won't be satisfied with the job.

Obviously, I think this starts with training. We have a serious problem where, here in Ontario and in fact across the country, you can be a family doctor, you can be an internist, you can be a geriatrician even, and not have any standardized rotation or experience in palliative care.

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

**Dr. Amit Arya:** I speak to many of my nursing colleagues and their experience is the same, where they don't have education or training in palliative care. So, of course, that is a must. We have to start with that.

As I explained, we need enough staff and we need to make sure that the staff have permanent jobs at a single site so they know the residents. Care is a relationship and of course providing palliative care—it's so sad that we're talking about rationing care and talking about four hours. From my perspective, these people are human beings. It's more than just bathing people, getting them to the bathroom and giving them their medication; staff should have time to provide psychosocial and emotional support. They should have time to sit down and actually give people happiness, joy and meaning. That should be the purpose of living in long-term care.

**Ms. Sara Singh:** Thank you so much, Dr. Arya. Just in the final moments that we have, do you feel this bill helps to address that and provide that level of care in any way?

**Dr. Amit Arya:** It's too little, too late, to be very honest. It doesn't address working conditions, and it comes too late for the patients that I care for today. So I have serious concerns about that.

**The Chair (Ms. Laurie Scott):** Thank you very much. We will now go back to the government for the final round of four and a half minutes. MPP McDonell, please go ahead.

**Mr. Jim McDonell:** This bill is going forward in this system, so we are looking at modifying or changing the system so that we're not talking about this in another 10 years. We can't change history, but we can change the future. That's what this bill is about.

I just was more on the retirement home philosophy that this bill also touches. We were up in Kingston a couple weeks ago announcing, for the veterans, a process, or basically a tiny home project, to build tiny homes that are connected together. There's a common room area, plus there is also—in their case, many of the people are dealing with PTSD, but that would not apply in our case. But common room areas, so there's some socialization.

I look at an installation that was built in Lancaster in my riding, probably about 40 years ago. It's kind of a joke, but if you want to get in there, you have to apply when you're about 40 because there's such a lineup for it. But

what it is is assisted living: small apartments that are connected in the rear with a hallway that joins a social area that has a community space and room for dining. It just seems very popular and it's probably very economical for people—people that don't need to go into long-term care yet. But we find and I think studies show that if you can keep people socially happy, well fed, that everything you do likely will delay their need for long-term care.

It's not something I've seen very much talked about here, but I'm just wondering, maybe talking to or asking Ms. Fortier what her idea maybe—well, that practicality, would that be an option, going forward?

**Ms. Katha Fortier:** Assisted living and retirement homes certainly do as well as long-term care, quite frankly. I know that we all have this vision that we want to stay in our homes as long as possible, but for many people, home can be very, very isolating and very lonely, and we just don't have the home care resources to provide—we provide some physical care, but, quite frankly, the care that people need, assistance doing dishes or with meals or laundry and these types of things they can't physically do, is really not provided and can be very expensive.

Retirement home and assisted living can also be very costly, though it certainly does relieve some of the isolation that people feel. It's a good stepping ground. Our experience is, where not-for-profits operate these sorts of facilities, the costs are better contained for people so that they can afford it. But the reality is that in today's retirement home, there's about 25% or so of the population that's actually waiting for a nursing home bed and just can't get into one. So some of the care levels in retirement homes are really, really rising as well, so—

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

**Ms. Katha Fortier:** —that's something we need to look at. But are they part of a solution of continuing care? Yes, I would agree, but again they have to be something that's affordable, and generally, that means that it's not-for-profit.

**Mr. Jim McDonell:** Well, in this case here, it is a not-for-profit, but the same thing would apply. It's a lower level of service, really, because you're providing them with a home, a small home, but also providing meals, which for many people I know who are getting older, that's a major problem—being able to make sure they have an adequate diet. It's just one of the various options that are there that's part of the total picture, and I think that's what we're looking at. Thank you. I guess my time is up.

**Ms. Katha Fortier:** Thank you.

**The Chair (Ms. Laurie Scott):** We will now turn to the official opposition for their final four and a half minutes of questions. MPP Singh, please go ahead.

**Ms. Sara Singh:** Thanks again to the presenters. In the last round here, I'd like to focus a little bit on the importance of transitioning our long-term care system from one that favours private operators to one that focuses on non-profit delivery. Each of you have highlighted the importance of that transition, and I'd like to use this opportunity for each of you to share why, right now, at this

point in time in the history of Ontario, it is critical that we start to transition our long-term care sector to one that is not-for-profit and to stop relying on for-profit care.

I see that Matthew has his hand up. If you could speak to the importance of not renewing licences for bad actors, which is something this legislation doesn't address, I'd really appreciate that. Each of you can take a turn to do so in the final three minutes.

**Mr. Matthew Gventer:** I appreciate the question. I'm going to slightly vary what I say, for precision, to be precise in what you said, and that is, I want to talk about the culture of long-term care. By having the for-profit motivation, the whole long-term care system is biased towards the issues in the way of saving money: How do you do it in the cheapest way, rather than the best care? By having so many for-profit deliverers, operators, it is biased in that direction.

Municipal homes, for example: The local communities bring pressure to bear on the operators—because operators in the cities are not-for-profits—to provide care first. We see that in Kingston, where Rideaucrest was built 30 years ago with single-bedded rooms. Therefore, when you look at the functioning of the long-term care association, which has been dominated by the for-profit sector, they pushed for the end of inspections, when the inspections were critically important. So it is a cultural issue right at the start.

Now, in the case of Kingston, we encouraged the city, and the city passed a motion, to look at providing more beds. But it's going to be a problem for the city, in ways, to finance it because it has to be done out of residential taxes. We will do—

**Ms. Sara Singh:** Sorry, Matthew. I apologize. Not to interrupt—I appreciate that, for sharing your perspective. I'd just like to have some time with the other presenters as well, as we have a very small amount of time.

Dr. Arya or Katha, could you please share why it is important that we transition to not-for-profit homes and not rely on rewarding bad actors?

**Ms. Katha Fortier:** Oh, I'm sure we both could do that. But I think part of the challenge has always been that profit is a goal, and the reality is—here's what happens on the ground, here's what front-line workers will tell you happens in a for-profit home: They make their profit from the accommodations envelopes. That's all of the administration, the dietary work, the housekeeping, the maintenance of the building, the facility. That's where they make their profits in every long-term care facility, almost without a doubt, that's run for profit. If it's run not-for-profit, that excess that they would make goes back into care. If it's operated for-profit, what happens is we see that the work that should be done by those other areas—

*Interruption.*

**Ms. Katha Fortier:** —PSWs and nurses. So they're cleaning fridges, they're—

**The Chair (Ms. Laurie Scott):** Sixty seconds.

**Ms. Katha Fortier:** —putting away laundry, they're inspecting mechanical lifts. It's just a system that—you know, easy to hide.

**1700**

I'll hand it over to Dr. Arya for the last comment.

**Dr. Amit Arya:** We don't have much time, but I'll basically say that, of course, long-term care should not be a business. It should not be focused on these financialized models of care where we cut corners and then we're extracting millions of dollars in dividends for shareholders. All of the taxpayer money that we're using to subsidize long-term care should be invested into care. That's the bottom line.

**Ms. Sara Singh:** Thank you so much, and I think we even have five seconds left on the clock. I appreciate all of you sharing these perspectives.

**The Chair (Ms. Laurie Scott):** Thank you again to all the presenters. That ends this round.

ONTARIO RETIREMENT  
COMMUNITIES ASSOCIATION  
ONTARIO MEDICAL ASSOCIATION  
ONTARIO NORTH  
FAMILY COUNCILS NETWORK

**The Chair (Ms. Laurie Scott):** We will now move on to the final group of three, which is going to include the Ontario Retirement Communities Association, the Ontario Medical Association and the Ontario North Family Councils Network.

You each have seven minutes to present. I will give you a warning when one minute is remaining. If we could start with the Ontario Retirement Communities Association, please.

**Ms. Cathy Hecimovich:** Thank you very much. Good afternoon, Madam Chair, and through you, good afternoon also to the members of the Standing Committee on the Legislative Assembly. My name is Cathy Hecimovich, and I am the CEO of the Ontario Retirement Communities Association.

I'm joined here today by two of my member colleagues: Andrea Prashad, the senior vice-president of resident experience and risk management at Amica Senior Lifestyles and vice-president of our board, as well as Mike Lavallée, former board chair and CEO of Seasons Retirement Communities. They're going to offer you the perspective and provide the insight into the real-world impact of the proposed amendments on seniors.

We are supportive of the principles underpinning the modernization of the Retirement Homes Act, particularly when the proposed changes increase resident well-being and choice, decrease cost to seniors, cut red tape and really enable the care of seniors in retirement communities.

I would also like to commend the government's implicit recognition within this bill of the significant differences in experience between those seniors living in retirement communities and those who resided in one of Ontario's publicly funded long-term care homes during the pandemic.

We encourage this committee, when considering this bill, to take a close look at our sector's outcome data and

to use a risk-based, right-touch regulatory lens to address any problems caused by outlier operators, rather than take a broad brush around sector-wide compliance or enforcement powers that may be red-tape heavy and heavy-handed.

I'm now going to pass things over to Andrea, who can speak first-hand to the sector's pandemic response and the outcomes for our seniors.

**Ms. Andrea Prasad:** Hi, everyone. Thank you, Cathy, and thanks again to Madam Chair and, through you, to the committee members here today.

As you know, retirement homes are 100% privately paid for by the seniors who choose to live in them and overseen by an independent regulator, whereas long-term care is publicly subsidized for seniors who usually require 24-hour support and are regulated directly by our government.

Our pandemic outcomes are also significantly different. Since the declaration of the global pandemic, more than 94% of our seniors living in retirement homes have remained free of COVID. All confirmed COVID cases in Ontario retirement communities, both seniors and our staff, represent less than 1.03% of all cases in the province.

In addition to these outcomes, our recent RHRA review of COVID impacts in retirement homes made really great key findings when comparing outcomes from the first and second waves. Infection rate was and remains very low. More than 80% of homes that had outbreaks had an infection rate of less than 5%. Throughout waves one and two, total cases per 100 residents were more than three times higher in LTC. During the second and third waves, the retirement home sector did far better than the general public when we looked at minimal outbreaks and effective outbreak management.

Leading into and in response to the pandemic, retirement communities have worked to find balance to ensure a sense of community, social connection and meaningful interaction, while providing peace of mind to seniors and their family members who have entrusted us with the health and well-being of their loved ones. As a result of that equilibrium, of a sample size of 13,500 seniors living in retirement homes, more than 95% said they felt really safe and were overwhelmingly satisfied with their retirement home services and care during the pandemic.

I'll now pass things over to Mike on the finer parts of ORCA's submission. Thank you.

**Mr. Mike Lavallée:** Thanks, Andrea, and thank you, Madam Chair and committee members, for providing this opportunity to speak to this legislation. As you've heard, we're generally very supportive of the modernization of the Retirement Homes Act. However, we do have some areas of concern on two proposed amendments that we believe are too broad in the scope and open to too wide an interpretation.

The first amendment that concerns us is the RHRA's ability to issue emergency orders in "extraordinary circumstances." As currently drafted, the legislation provides no definition whatsoever to what "extraordinary circumstances" might be. We believe this language is open

to broad interpretation and, quite frankly, unintended regulatory overreach. To put it in perspective, the amendment would make the RHRA the only regulator in the province to possess such powers over privately funded businesses and result in this regulator having more powers than the Ontario government has over publicly funded hospitals, as an example. That's a really powerful statement: more power than the Ontario government itself. And the Ontario government already has the power it needs to manage an emergency pandemic or otherwise under the Emergency Management and Civil Protection Act.

The COVID-19 pandemic has demonstrated that the current system is reasonable and effective, where operators were more than collaborative. You need look no further than some of the facts that Andrea was just speaking to.

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

**Mr. Mike Lavallée:** The second amendment of concern is that of collecting contact information from residents as frequently as they choose, and for the regulator to use that in whichever way and however they wish to use it. This is the very definition of unwanted additional red tape, and we do not consider this level of direct involvement by a regulator with respect to the collection of contact information to be appropriate in a private, unfunded sector. Quite frankly, we believe this level of data collection is unprecedented for an Ontario regulator.

Throughout the pandemic, retirement homes have kept our seniors and families continuously informed and up-to-date about orders and changes from the Ontario government, the Chief Medical Officer of Health, public health units and the RHRA themselves. The relationship between the operator and its residents is one that is based on trust, transparency and integrity. So we are left to question, what is the significant problem that this amendment is proposed to change and solve?

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

We will now move on to the Ontario Medical Association for their seven-minute presentation. You can start when you're connected.

**Dr. Adam Kassam:** Good afternoon, Madam Chair and committee. On behalf of Ontario's 43,000 doctors, thank you for the opportunity to be here today. My name is Dr. Adam Kassam, and I'm the president of the Ontario Medical Association. I'm joined by Dr. Hugh Boyd, chair of OMA's section on long-term care, and Lynette Katsivo, director of policy at the OMA.

Let me start by saying that the OMA applauds the government and Minister Phillips for seeking to improve long-term care delivery in this province. Bill 37 is a good first step; however, more improvements are needed through regulation and policy. COVID-19 tragically exposed the weaknesses in our long-term care system, and we can no longer wait to address the decades-long, system-wide issues that have plagued Ontarians. Having said that, we also must recognize the tremendous work of the majority of long-term care homes to elevate resident

dignity and to provide the best possible care within the landscape of current system restraints.

1710

In the lead-up to this bill, the OMA was an active participant throughout the long-term care commission process overseen by Justice Marrocco. This included providing two written submissions and appearing before the commission to discuss where physicians feel improvements can be made.

On October 26, I was at Queen's Park to launch the OMA's Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care, a road map comprising five key themes and associated recommendations to fix our health care system. Long-term care features prominently.

Prescription for Ontario is informed by the largest consultation in OMA's 140-year history and included input from 8,000 Ontarians representing 600 communities through a survey called [betterhealthcare.ca](http://betterhealthcare.ca). When asked, "What is your top priority for health care?", 19% of respondents selected improvement to seniors' health, including long-term care. This priority ranked second only to improving wait times, at 30%, and was tied with "We need more doctors."

The OMA believes that in order to improve long-term care, immediate focus is required in four key areas: (1) the role of the physician; (2) infection prevention and control; (3) long-term care capacity; and (4) palliative approaches.

Dr. Boyd will now provide a brief overview of these topics; however, a more fulsome description can be found in our written submission. Dr. Boyd?

**Dr. Hugh Boyd:** Thank you. Hugh Boyd, chair of the Ontario Medical Association's section on long-term care. Thank you, Dr. Kassam. Thank you, Madam Chair, for this opportunity.

The medical director has a critical role to oversee the delivery of medical care. A clearly defined and consistently understood role description with expectations is needed. Unfortunately, there is limited support currently available for medical directors. While they're motivated by a strong desire to care for those requiring long-term care, factors that promote retention and recruitment must be addressed. This isn't just about funding. Medical directors must be enabled, with proper training, education and mentoring.

Attending physicians also provide vital medical care delivery and leadership. They are available 24/7 to provide care or medical guidance to staff, but report challenges with remuneration and being stretched thin as they balance multiple clinical duties. Therefore, the OMA recommends that Bill 37 maintain the requirement that the medical director role must be held by physicians to ensure all homes have access to the medical leadership needed to positively transform the sector, and that the role, as well as that of the attending physicians and nurse practitioners, should be clarified and adequate supports provided.

Infection prevention and control practices and procedures play a critical role in preventing or reducing transmission of infectious diseases. Currently, there is no clear guidance as to who is accountable for the leadership role in developing the IPAC program and which authority

should oversee the IPAC activities. The OMA recommends that funding be provided by the ministry to develop and implement mandatory infection prevention and control education programs and opportunities within all homes, and that Bill 37 should maintain the requirement designating a role that focuses on infection prevention and control within each home.

Long-term care exists within a broader health care system. However, that system and that connection has been overlooked. Creating a home-like environment is central to the philosophy of long-term care, so we must strengthen linkages across the system to deliver as much on-site care as possible. This will be more comfortable for the residents, more efficient for our health care system and decrease the potential for infectious disease spread.

To improve medical care delivery, homes need sufficient equipment and better access to specialized care when needed. This can be accomplished in several ways, including better connections with specialists who have long-term care knowledge, enhanced communications or connections through electronic medical records, appropriate use of virtual delivery models and an increased understanding of long-term care parts of the rest of the system. Our system has learned a lot and we can go a lot more about understanding long-term care.

Anecdotally, we've heard that long-term care homes that had existing relationships with hospitals and system partners or were embedded within the Ontario health teams fared better throughout the pandemic. This was due to immediate access to resources, including specialized health human resources, when a home's resources were strained or depleted. The OMA therefore recommends that funding must be available to ensure homes have the necessary number of trained staff to safely support and keep residents at home. Where possible, homes should have access to medical equipment to deliver urgent care services, like labs, IVs, X-rays and medications, to meet patients' and residents' needs, and a required physical space to provide that care.

We are really pleased to see the integration of a palliative approach to care within this. Most Ontarians with life-limiting illnesses prefer to be cared for in their home rather than the hospital. In this case, the long-term care home is their home. Given these residents are likely to remain in a long-term care home until the end of life, palliative care needs to play an essential role for those who have a life-limiting illness. When residents receive in-home palliative care, they experience better symptom management, have shorter or fewer hospitalizations—

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

**Dr. Hugh Boyd:** —and have better overall experience and quality of life. Providing high-quality continuous palliative care in the home requires both dedicated resources and appropriate training and education, which is lacking.

The OMA is keen to work with government to define the palliative philosophy in long-term care. To support this palliative approach, the OMA recommends that all long-term care homes should have access to 24/7 in-house palliative care and expertise throughout the trajectory of a resident's journey. Thank you.

Dr. Kassam?

**Dr. Adam Kassam:** Thank you very much for the opportunity to present. We look forward to taking your questions.

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

I now call on the Ontario North Family Councils Network. Please go ahead.

**Ms. Nancy Johnson:** Hi. My name is Nancy Johnson. I'm the chair of the Ontario North Family Councils Network. We really appreciate this opportunity to be able to express the ideas and the concerns and suggestions of our members. We have given a written submission, so we urge you to look at that. Today we have Roma Smith, the co-chair, who is going to tell you a little bit more about the network; Terry Martyn, who is going to comment on some of the aspects of the bill we like; and finally Debbie Cecconi, whose mother has been in care throughout the pandemic and who will talk about some of the challenges of staffing.

Roma?

**Ms. Roma Smith:** My name is Roma Smith. I am the chair of a family council here in northern Ontario. I'm also the co-chair of the Ontario North Family Councils Network.

You may wonder, what is the Ontario North Family Councils Network? Well, we're a collection of ordinary people who simply want the best for our loved ones who are or were in long-term care homes. Our completely unfunded network was formed to give voice to family councils in a geographic area reaching from Manitoba across to Mattawa and from Parry Sound northward. While we come from varying backgrounds and diverse interests and leanings, we are united in our resolve to ensure quality of care for residents living in long-term care.

If any good came from the pandemic, I would say it was a fact that the pandemic drove family councils to bond tighter together, to speak with a louder and stronger voice.

Family councils are the eyes and the ears on the ground. They know first-hand what is and what isn't working and have valuable insights, information and suggestions on how to move forward in each home and across the system. Our network has engaged in a number of efforts at various levels of government and community to give families a voice, to share valuable insights and offerings with people like yourselves who have the power to make authentic improvements.

Thank you for giving me and us this opportunity to be here today to give a voice to our members who have family living in long-term care.

Terry, you're next.

**Mr. Terry Martyn:** Good afternoon. My name is Terry Martyn. I'm a co-chair of a family council in northern Ontario and a member of the Ontario North Family Councils Network.

We're pleased to see some of the changes in this bill, particularly a need for the minister to regularly consult with family councils. As Roma said, we are the eyes and

the ears on the ground, with valuable insights and suggestions for improvement in each of our homes.

I would like to make three points about family councils. The first one: The licensee of each home has an obligation to help in the establishment of a family council. During the pandemic, this role has been pushed aside and forgotten. It is time for them to renew their commitment and leadership and make greater efforts to ensure that there is a functioning family council in each home.

Secondly, in the wording in the act in subsection 65(5), it should be made very clear that family councils of each home decide who can be a member of their family council.

The third point: It would also be very helpful if a small amount of money were allocated to family councils as part of the total funding to each home. This would allow family councils to attend workshops, to bring in speakers as part of their ongoing educational component or otherwise spend to further their advocacy on behalf of the families.

**1720**

Thank you. I'll now turn it over to Debbie to speak about staffing issues.

**Ms. Debbie Cecconi:** Hello. My name is Debbie Cecconi and I'm a family council chair and a member of this network. My mother has been in care prior to the pandemic but also through this pandemic and continues to be there.

Our network has been working on staffing shortages for years. Our submission says "long before COVID." It has just simply magnified the problem for all to see.

The present allotment of direct-care staffing to 2.5 hours of care per resident is grossly inaccurate. Over far too many years, this has resulted in a shortage of PSWs who provide the vast majority of hands-on care for our loved ones. I have seen this first-hand in the year prior to the pandemic and exacerbated by it, evident when families were allowed to be back into the home in September 2020. Families supplement and augment care. They assist the PSWs who are overworked, exhausted and feel that they are not providing the best or even adequate care because there aren't enough of them.

Because we are pressed for time, I was going to actually give you a little bit of a scenario from my home about how short the number of positions are for PSWs in the home. I've seen PSW-to-resident ratios at best 1-to-7 and at worst 1-to-15 or greater, and that will depend on the time of day and the unit. PSW retention and recruitment will not improve until the hours of hands-on care are in place. Four hours of direct care is a good starting point—now, not in 2025, please.

The paid PSW program is actually a great start. Of the small number that successfully completed the program, two thirds were actually hired by our organization.

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

**Ms. Debbie Cecconi:** The question is, how many of them will be left in a year? Because they are not provided with full-time work. Staffing levels—PSW-to-patient ratios have improved—and access to secure full-time jobs with paid sick leave will not keep them.

This leads me to the calculation of direct care. Aside from the fact that it's all about just a target of average hours—PSW, RN, RPN and allied health providers—it's not clear who is included in the direct provision-of-care formula and at what percentage, which of course will be critically important. For instance, does the proposed calculation mean that there will be four hours of direct care provided by personal support workers and nurses and an additional 36 minutes by allied health care professionals? Or is that 36 minutes included in the four hours once it's complete to four hours?

Another question—

**The Chair (Ms. Laurie Scott):** I'm sorry. Time has run out for your presentation.

We'll now move to questioning. We're going to start with the opposition for seven and a half minutes. MPP Singh, please go ahead.

**Ms. Sara Singh:** Thank you to all the presenters today. I appreciate you sharing your perspective and taking time out to be here. Although I know time is limited, I'll start with my first questions to the Ontario North Family Councils Network. Thank you so much for the important work you do as a family council to amplify the voices of residents and concerns of family members in the north.

What we've heard from many family councils across the province is that while they are the eyes and ears, as you all have indicated, on the ground, often the feedback that they are providing is not taken into consideration and their voices are being silenced. We were hoping that this legislation would actually empower family councils and leverage some of their expertise. Do you feel that this bill does that in any way, shape or form?

**Ms. Nancy Johnson:** It's a step in the right direction to indicate that the minister has to consult, but the devil is in the details. With respect to our voice, we are unfunded, we are unrecognized by the government and if any consultation happens, it will probably be through Family Councils Ontario, which is a good organization but doesn't represent us. It represents the government's voice.

Somebody mentioned before about compliance and ensuring compliance. It's one thing to think inspectors are going to come in and do all the work and make everything work, but if you empower your family councils to do more than just meet and you support them, then they can be the eyes and ears on the ground that can be utilized to enforce, recognize or trigger some action, if it's done right. Obviously it's underutilized right now.

I don't know if Roma or Terry or Debbie has something to add to that. Does that help?

**Ms. Roma Smith:** Sara, I just wanted to point out one thing: It's very important that every home has a family council. This does not necessarily happen. I get reports about homes here in the north who tell me that the administrators and managers of the homes are running the family council. That should not happen. I tell them, "You report that to the inspection branch"—and it doesn't follow through, and it doesn't happen. I ask myself why. The reason, I believe, is that they fear retaliation on their loved ones, so they won't force the issue to get a family council established.

You say family councils are reporting to you that they're not listened to. That's right: They're not. It's because they don't have the confidence to know that whatever they say will not fall back on them. In other words, they fear retaliation.

**Ms. Sara Singh:** Thank you, Roma and Nancy. I think you highlight some really important concerns here with respect to the voices of family council members to actually critically inform. I'd be curious to understand why, also in this new legislation, family councils are no longer involved in the development of the survey, as they once were as well, that will be conducted.

I know Terry touched on some important points around training as well. I know that in some of the work I've done in the past, the importance of mobilizing families through training opportunities to become advocates for their family members was critical. There's nothing here that really does that, and there's nothing here that empowers your voices through an independent body.

Roma, I think that, as you highlight, the need for that independent person outside of the home is critical to really making sure that the concerns that are raised by family councils are actually addressed. Would you say that there are any mechanisms in this bill that help create an independent seniors' advocate, for example, or an independent body to have these complaints effectively addressed? Nancy or Roma, feel free.

**Ms. Nancy Johnson:** We didn't see any. If they're there, they're buried somewhere. We haven't seen any. It's paying lip service to family councils.

I do want to say that some of our family councils work very well with their administration, and some don't. In order to make sure that they all do, then you need what you're suggesting.

**Ms. Sara Singh:** And just to be clear, Nancy, an independent advocate for families and residents is what we need in order to have their voices actually heard?

**Ms. Nancy Johnson:** That's a larger question, and I could speed-speak here, but the independent advocate is one way to do it. Another way is to have enabling legislation to pay attention to our networks, to give powers to the actual family councils and have a mechanism through which they can report any problems they're having. None of that exists right now. We kind of exist because we need to exist. We are not paid, we are—I mean the network. And the family councils on the ground are struggling. It's not recognized in terms of structure enough. So an independent advocate is maybe another bureaucrat to add to the mix. I don't know. I think there are things that should happen, and I think that if you consulted people like us in building your bills, then we could come up with those ideas. They're not there right now.

**Ms. Sara Singh:** Thanks, Nancy, for that. As New Democrats, we believe in the importance of consultation with community members before we bring a bill to the floor. We've heard from many stakeholders through this committee process. They haven't been adequately consulted in what has been brought forward, so that is deeply troubling.

I just wanted to check in with the Chair to see how much time I have left before I ask my next round of questions.

**The Chair (Ms. Laurie Scott):** Very timely. I was just about to say there's one minute left.

**Ms. Sara Singh:** Thank you so much, Chair. I suppose with my minute here I'd just like to ask a quick question to Cathy from the Ontario Retirement Communities Association. I know that within the Retirement Homes Regulatory Authority, there is a mechanism for families to raise concerns, but what we've seen time and time again, as the family councils have pointed out from long-term care, is those concerns are not adequately addressed.

1730

Do you feel that another mechanism is needed to actually empower families to have their concerns addressed through the retirement homes?

**Ms. Cathy Hecimovich:** The families living in retirement homes and the seniors who choose to live there are there by choice. If they are, for any reason, not happy with the care that they're receiving, because we're not a government-funded agency or organization, because they're there out of choice, they can vote with their feet and they can go. So we are very consumer-focused—

**The Chair (Ms. Laurie Scott):** I'm sorry, we're out of time for this round, but there will be other rounds.

I go to the government for seven and a half minutes. MPP Sandhu, please start.

**Mr. Amarjot Sandhu:** First of all, I would like to thank all three presenters for appearing before the committee. We appreciate your presentations.

I will direct my question to the Ontario Medical Association. First of all, thank you for being an important stakeholder, and thanks for providing your feedback on issues related to health and long-term care.

How can we do better in providing seniors with the quality care they deserve? You would all agree that our government inherited a broken, underfunded long-term care system. We're putting forward bold new solutions to turbocharge the development of long-term-care beds across the province and ensure our seniors get the quality care they deserve.

As a rookie MPP, I was amazed to know that from 2011 to 2018, there were zero beds allocated in Brampton. We can see how much investment they made in long-term care. Since 2018 to 2021, we have already allocated 680 net new beds in Brampton, and we recently, in the budget, announced two new long-term care homes in Brampton. That was very well received in the community. Those two long-term care homes are culturally based long-term care homes, because we understand the need for culturally based long-term care homes in the community.

My question to you, as the representatives of Ontario's medical doctors: Can you please let us know how this legislation and its focus on improved working conditions in long-term care homes will help your members provide a better quality of care in homes across Ontario?

**Dr. Adam Kassam:** Well, thank you very much for the question, member, and thank you once again to the committee for the invitation to address you. The bill is a good start, and we know that this has been decades in the making.

Speaking as someone who actually works in long-term care, in addition to my very esteemed colleague Dr. Boyd, who I'll pass the mike over to, we know that there have been long-standing and system-wide issues in long-term care. We also know that the system-level changes that physicians have been advocating for with our platform, but also throughout the pandemic itself, are areas of opportunity to improve the patient care that you're describing. We know that it requires not only bricks and mortar, but also health human resources, so we look forward to working with government, working with other stakeholders, working with institutions and organizations in the sector to make sure that we have the adequate resources to do our jobs safely but, more importantly, meaningfully for the patients of Ontario. But, Dr. Boyd, if you'd like, happy to have you chime in as well.

Oh, I don't see Dr. Boyd anymore. He might no longer be here. He might have dropped off, folks. I apologize. I think I've covered it, but I'm happy to follow up a question, if you'd like.

**Mr. Amarjot Sandhu:** Thank you so much for that response. My next question is: As clinicians, you have a unique perspective on the needs of our seniors and their increasingly complex needs. Can you please also let the members of the committee know how the legislation improves the quality of care and delivery of services medical directors will deliver to residents in long-term care homes?

**Dr. Adam Kassam:** Thank you again for the question. I see Dr. Boyd has come back to the committee, so I'll happily—I don't know if, Dr. Boyd, you got that question. Were you able to hear the question? Can you hear us?

**Dr. Hugh Boyd:** Yes. Sorry, I just heard the last half.

**Dr. Adam Kassam:** Member, would you mind—

**Mr. Amarjot Sandhu:** Yes, I can repeat the question. My question was, can you please let the members of the committee know how this legislation improves the quality of care and delivery of services medical directors will deliver to residents in long-term care?

**Dr. Hugh Boyd:** The proof will be in the pudding. We're really excited to work with the government to look further into the regulations, the O. Regs. This has been the heart of the previous legislation, and we expect it will be the heart of this one as well. We are very pleased about solidifying the role of the medical director remaining as a physician to provide that expertise, to provide that system navigation and to build that community and networks. But we are looking for a little bit more around improved support and training for that medical director.

Exceptional leaders are not born; they are trained and supported. While every single other person in long-term care has a course—it's the administrator course, the infection control course, the nursing director of care course—medical directors are not paid to take their course, the medical director course. We strongly believe—and it's not just us; this showed up in Justice Gillese's report from

several years ago—that every medical director must receive the training of the Ontario long-term care medical director course or a similar version within two years of taking that position. I can tell you, it’s incredibly powerful, and if this legislation accepts this long-awaited request, it will massively improve care. It will equip medical directors with opportunities to support better care by guiding their own physicians and nurse practitioners, better system coordination, better communication. Most critically, around quality indicators and quality control, it equips them with phenomenal skills around how to take those numbers and deliver better bedside care. It has revolutionized my love of my job and my effectiveness in my job. We have research showing that, and we truly believe that patient care will be improved when that medical director has the training support they deserve.

**Mr. Amarjot Sandhu:** Thank you so much for that response. Is there anything else you want to add? I don’t think we have much time.

**The Chair (Ms. Laurie Scott):** One minute 30.

**Mr. Amarjot Sandhu:** One minute and 30 seconds. Anything else you want to add, or anything else you want to highlight?

**Dr. Adam Kassam:** Sorry, I was just—go ahead, Dr. Boyd, please.

**Dr. Hugh Boyd:** I think the palliative approach to care is game-changing as well, and we’re really looking forward to working with the government around what that looks like. We do acknowledge that not everyone living in long-term care has a terminal illness, and so we cannot apply this blankly to everyone living in long-term care. But those who do have a life-limiting illness would benefit from better-quality palliative care, and this will move mountains for us. We truly believe we can provide better resources and better palliative care, and residents and families and the care team will all see the differences very quickly.

**Mr. Amarjot Sandhu:** Thank you so much.

**The Chair (Ms. Laurie Scott):** Thank you very much. We will now move to the official opposition for seven and a half minutes. MPP Gretzky, please begin.

**Mrs. Lisa Gretzky:** I want to thank all the presenters. I’m going to ask a question for the Ontario North Family Council Network. It may go directly to Debbie, because she did touch on this in the first round. When we’re talking about four hours of hands-on care for residents—and I think you were talking about an average of four hours of hands-on care versus a minimum standard of four hours of hands-on care. I know that in a previous round one of the Conservative members had said that with an average, every resident in long-term care would get the hands-on care they need and that it would ensure the proper levels of hands-on care; whereas our thinking as New Democrats is that if you have a minimum mandated standard of hands-on care, you negate the risk of residents not getting the care they need, and anyone that needs additional care—homes are welcome to provide that and should be above the minimum standard.

I’m just wondering if you could tell me, which do you think is a, I suppose, stronger measure: having an average

of four hours of hands-on care or having a minimum standard of four hours of hands-on care?

**Ms. Debbie Cecconi:** In my opinion, I believe it should be the minimum, not the average. There may be instances where if you put everything into the pot, the homes that have the more complex patients—because in my area, we know which homes end up with the patients that are more complicated, either physically or from a cognitive point of view. If you say four hours as an average, then it may not help them out as much.

1740

I’m going to defer this to Nancy, if you wanted to add a little more to it, please.

**Ms. Nancy Johnson:** Sure. I was actually looking at some of the speaking notes of Debbie which she didn’t have time to get to, but our families are crumbling under the pressure of understaffed homes. People like Debbie are going in and actually providing the care. If you’re averaging, you’re not taking into account that extra stuff that these people are doing. It’s a minimum. From our position as family councils who are on the ground, who are seeing what’s actually happening on the ground with the pressures on the PSWs and the pressures on everybody and the pressures on the families that are going in and trying to carry the load that isn’t being carried by the homes, who don’t get the support from above and whatever—absolutely, a minimum four hours of care. Anybody who has had a loved one in care thinks that’s the least that they deserve. If we don’t establish it as that, rather than this averaging of different people and different support services and whatever, you’re still going to have people left lonely and untended to.

It’s very important that we humanize this bill so that it’s not just numerators and denominators. That’s not what residents are. Residents are people who need human contact. If there’s any way of developing a formula that talks about how much human contact a person has, a resident has, that’s the starting point, not all the rest of this stuff. So yes, we’re left with this number. If we’re left with the number four, then the number four has to be the minimum.

**Mrs. Lisa Gretzky:** Sorry, I want to correct something that I said. I didn’t mean it would negate the risk. It would help mitigate the risk; it certainly wouldn’t negate the risk.

Jumping from that, I appreciate also that Debbie touched on the fact that current staffing levels are not always based on patient- or resident-facing hands-on care. Oftentimes managers or others that are in the background of the operations of long-term care are considered part of the staffing complement, and certainly we need to ensure that there is a minimum standard to ensure that PSWs and nurses are actually providing hands-on care, rather than a manager who may never leave the office.

I just want to ask, because you are a family council: We saw through the pandemic that many residents—all residents, frankly—were denied that consistent, meaningful access to their designated or family caregivers. I have tabled a bill twice now calling on the government to develop a strategy along with residents in congregate care,



the families, the front-line workers to ensure that that never happens again, that there is a strategy in place to ensure that everybody can have that safe, meaningful access. I'm wondering if you see anything in this bill, or would like to see anything in this bill, that would ensure that those voices are brought to the table, that a strategy is in place to ensure that residents in congregate care are never again denied that access to their caregiver of choosing.

**Ms. Debbie Cecconi:** I think that family councils need to be a part of anything that's going to be developed, because they are there because they want to ensure that the care their family member is being given and who is providing the care is heard and appreciated.

I would like to go back to when we were talking about the calculations of how they're going to get this four hours of direct care. Central to that is the majority of the care is provided by personal support workers. They have to be the bulk of that equation, whatever the numeric value is. The other thing is, there are nurses that are there—

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

**Ms. Debbie Cecconi:** —and I'm excluding the ones that are completely administrative, so I'm talking about your administrator, your ADOC, your DOC. I'm talking about nurses, RNs, who have other roles that are not direct, hands-on provision. There needs to be a calculation of what percentage of their time that they actually provide direct, hands-on care. Part of that hands-on care, if they're looking at the direct provision—are they including things like documentation time, or is that over and above what that four hours would look like?

So, that's just a couple of things there. I don't know if, maybe, Nancy, you have anything more to add quickly.

**Ms. Nancy Johnson:** No, there isn't a strategy. The question is, "Does it look like we're being involved in the strategy?" The only lip service is that the minister has to consult family councils once a year. What does that mean? So we don't see it as a meaningful strategy at this point. It could be, but it's not yet.

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

We will now turn to the government for seven and a half minutes of questions. MPP Wai, please go ahead.

**Mrs. Daisy Wai:** Thank you very much to all the presenters for coming in and sharing with us. Before I start asking a question of ORCA, I want to just clarify one thing. I thank Family Councils Ontario for coming in and sharing and presenting to us. You support a lot of the family councils across the province. However, they do not represent the government. But thank you for being there for us, but I just want to clarify that.

I thank you, ORCA, for coming in to share your presentation with us as well today. Can you please tell us and share how your membership has been operating to help keep the residents safe? We want to have the seniors safe. Can you share with us what you have done? Thank you, Cathy.

**Ms. Cathy Hecimovich:** I would actually like to refer this to Andrea Prashad, because that is her area of expertise within the time at home.

**Mrs. Daisy Wai:** Oh, okay. Thanks.

**Ms. Andrea Prashad:** Hello. In terms of keeping them safe, despite all the aggressive testing we did across the province for retirement homes, the data and the outcomes were phenomenal. We fared much, much better than the actual general public, I think, which is really different than what the media stories believe. Certainly it peeled the onion on the differences between retirement homes and long-term care, as well.

I think what was interesting is the amount of families that shared—I think it was Nancy Johnson who said this so well: It's around starting to count the number of human connections. I think that's what we really valued over this period and what we heard from families and residents, was, "Gosh, thank goodness my mom wasn't alone."

**Mrs. Daisy Wai:** Okay. Great. Thank you very much for sharing. I'm thankful for you working together with us and keeping our seniors safe.

Now, how will these amendments that we have align with the commitments that retirement homes have made to put the seniors first and deliver the top-notch service that they need?

**Ms. Andrea Prashad:** I'm going to turn this over to Cathy.

**Ms. Cathy Hecimovich:** Thank you. We're very pleased for any changes in the act that will reduce red tape and enable a strong focus on care directly to seniors. So we're very pleased about amendments to the act such as prohibiting borrowing of funds from any senior's account. It's not something we would do, but we're very, very pleased to see those abuse provisions in the act. We think that's very, very important, and I think it's a great example, MPP Wai, of where the government is really acting to better protect seniors.

**Mrs. Daisy Wai:** Thank you very much, Cathy, for dwelling on that as well. We are revising the RHRA, the act, and especially giving more authority just to make sure that our seniors are protected. It's exactly what you say: We've seen a lot of cases, and we have expression from the family members letting us know some seniors are going through a tough time, whether it is fraud or they are being pushed or urged into giving some extra funds or sharing something. What we're doing to the RHRA: Is that a good, supportive act that's in the direction you want us to go as well?

1750

**Ms. Cathy Hecimovich:** Well, certainly in regard to protecting seniors' funds, if you look at Canadian statistics, up to 10% of seniors are subjected to abuse or fraud by caregivers. That's the Canadian statistic, so I think you're on the right track there.

Where I would caution the government is just to make sure that when you're giving additional powers to the regulator, those powers are reasonable and appropriate to fit with the regulator. As Mike said earlier in his presentation, there is one aspect of the emergency powers that are proposed in the act that, without appropriate boundaries or qualifications, would have that regulator have more power over retirement homes than this government has over publicly funded hospitals—more power than the government has itself. We think you just need to

put some brackets around that to make sure that those are appropriate and reasonable powers.

We also very much value the privacy of our residents and their family members. We are private businesses. They're not in receipt of government funding when they come to us, so releasing their personal information and contact information to a third-party regulator needs to be under appropriate and exceptional circumstances, not routinely. Can you imagine if every doctor in this province was asked to release their list of contact names and information for every patient they treated? I don't think that they would see that as reasonable. I just think we have to put some appropriate parameters around some of this, just to make sure that these powers are used appropriately and reasonably.

**Mrs. Daisy Wai:** We understand where you're coming from, but you can also see that during the COVID times, the urgency for us is that if we don't even have the data, we cannot really help enough of the members and the seniors, which is why we have to put that in place. It is not something that we will be reviewing all the time and that will intrude into somebody's privacy. But I hear you. We listen—

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

**Mrs. Daisy Wai:** —and we know what your concerns are, but I also want you to understand where we are.

I just want to quickly say one more thing: Could you please share how retirement homes staying independent helps to match their care offerings to the needs of the local seniors across the province? And how does your independence help you to deliver the unique needs of the local seniors?

**Ms. Cathy Hecimovich:** I'll go back to the comments that were made by the family councils and others about hours of care. There is absolutely no limit to hours of care provided in retirement homes. Andrea recently shared with me a wonderful story which I think she should share with you about a couple of seniors who left to go to long-term care and came back.

**Ms. Andrea Prashad:** Yes, it was really interesting. One of the interesting data points over the course of this pandemic is that the average time that a resident spends in a retirement home has increased. It's increasing—

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

We will go to the next round of questions for the opposition, for four and a half minutes. Who's it going to be? MPP Singh.

**Ms. Sara Singh:** My first question is for the OMA and for either Dr. Boyd or Dr. Kassam. I know that many are feeling that having a palliative care strategy or mention of this in the bill is headed in the right direction in terms of providing that continuity of care for residents in long-term care, but I have heard from many that there are several concerns with the lack of staffing supports and training for the specialized skill set that is required to provide palliative care. Just briefly, because I do want to get some questions in to the other presenters as well: Do you feel that there is adequate investment being made to help train

the staffing resources that are needed to provide palliative care in long-term care?

**Dr. Adam Kassam:** Dr. Boyd?

**Dr. Hugh Boyd:** Thank you very much. Excellent question, MPP Singh. Thanks for the opportunity. I think there can be. I think the legislation itself isn't going to have that—I don't think it's supposed to have it. In the O. Regs is where we're really going to see the details of it, so it could.

I think better coordination is going to be huge. I think you can improve the value and quality of care that we have with the existing resources way more just through better coordination and system integration, and then adding in investments where we make sure that the palliative approach to care is throughout, that the circle of care, which includes physicians, nurse practitioners, nurses, PSWs, families, residents themselves—that we all understand what that palliative philosophy of care means; not the old thing, not the old definition, but the modern palliative philosophy of care. I think that is needed. And making sure that our palliative specialists, who aren't always in long-term care, are better connected and are able to lead that, will make a huge difference. It can be.

**Ms. Sara Singh:** Thank you so much, Dr. Boyd. I appreciate that. You know, we'll wait to see what's in the regulations. But I think as it stands right now, just mention of palliative care is not enough to actually ensure that it's entrenched in the philosophy of care that's in long-term care. So, thank you for that.

My last question: We'll just go back to the Ontario Retirement Communities Association. Cathy, just before I ended my round with you, you had mentioned that if residents in retirement homes don't like the service they're receiving, they can just get up and go. I find that deeply troubling, for a number of different reasons. You said that you're in the business of providing a service to consumers; well, in any business, customer feedback is important and critical and should be taken into consideration, and improvements in service should be provided. We don't see that in our retirement homes and that's part of what the regulatory authority's role is. Do you not feel that that role should be strengthened and that families' voices, residents' voices should be listened to and taken into consideration in the service that they are paying a premium for?

**Ms. Cathy Hecimovich:** Thank you, MPP Singh, for the question. But I'll remind you, actually, that we did a survey of quite a significant number of residents living in retirement homes throughout the pandemic and, as you were told earlier, 95% of those residents were extremely satisfied with the care that they've received and felt safe and well cared for.

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

**Ms. Cathy Hecimovich:** So absolutely, we compete for business. People pay us out of their private dollars. We are a customer service-oriented business and we are there to serve our residents and serve their families, because we know they won't come to us if we don't.

**Ms. Sara Singh:** And so, how is that feedback taken into consideration to improve the outcomes or ensure that

homes are held accountable? I mean, for example, through the pandemic, we saw a home where doorknobs were removed, frankly, from the doors.

How should mechanisms be in place? What mechanisms do you think should be in place to ensure that those families' and the residents' voices are actually heard, legitimized and that there's accountability in place for the homes that are bad actors?

**Ms. Cathy Hecimovich:** So, we have resident councils as well, and their feedback is absolutely heard and incorporated.

The home you mentioned, that was an outlier, and that individual was fired quite promptly after that incident. We take these situations very seriously and we act accordingly.

**The Chair (Ms. Laurie Scott):** Thank you very much. We're out of time. We'll now move to the government for their final four and a half minutes of questions. I look to MPP Wai.

**Mrs. Daisy Wai:** I just want to say one quick thing, and I will quickly go to ORCA and come back to OMA, because I have only got four and a half minutes.

I just wanted to clarify that the RHRA—we are changing the act, which is part of this Bill 37, to allow and promote the awareness of the residents. They have the right to that protection, and then they can express if there is anything they want to express to us. They should not be concerned about retaliation or the protection.

Now, the one question I have for Cathy is, can you please elaborate on the input? I know that you have meetings with Minister Cho, and you have provided him with some of your ideas as well. How has that helped in preparing this legislation?

**Ms. Cathy Hecimovich:** Yes. I'd like to actually bring Mike Lavallée in with this, because Mike participated in our meetings with Minister Cho throughout the pandemic. Mike?

**Mr. Mike Lavallée:** Thanks, Cathy. First and foremost, thank you for giving us a voice. We have felt that our relationship with the minister has been very collaborative. There's a very open and two-way dialogue that goes on constantly. Our concerns are usually very well received because we all have the same intention: We are keenly focused on making the lives of the seniors that live with us the best they can possibly be.

We don't have short-term relationships. It's not like you come into my store, I sell you something and you're gone and hopefully you'll never have to use the refund policy. It's very, very different. The relationship that we have with our residents is very long-lasting and it's built on trust. If we don't have the trust of families and if we don't have the trust of the residents that live with us and even the trust of the regulator and the ministry that oversees the regulator, we really have a fundamental problem.

We see through the annual reports from the regulator themselves that there's a very low incidence of unresolved

complaints or unresolved problems that we're not able to work through with either the ministry or with the regulator themselves. So there's a built-in incentive for operators to be really good operators, because if you're not a good operator, your reputation and the viability of your business is really at risk. That incentive is at the crux of why most operators—why the outcomes that Andrea has talked about have been very, very good is because we want the very best for our seniors and for our staff members that work for us. We don't want them to feel like they're at risk and therefore it's a bad place to live and it's a bad place to work. So the two-way street is to our regulator, to the minister and to our commitment to our residents.

**Mrs. Daisy Wai:** Thank you very much, Mike. I have one last question for the OMA. With the role of the physicians, how do you see them becoming more engaged in the care of the residents? And how is the OMA working with the members to ensure that they are working on enhancing care for the residents through the medical director of care?

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

**Dr. Adam Kassam:** Dr. Boyd, do you want to field that?

**Dr. Hugh Boyd:** Yes, I'm happy to. I was a medical director before I was trained, and afterwards I learned phenomenal communication skills. I learned about audit and feedback. I learned about tools of engaging physicians to identify better care. This Parliament likely remembers the antipsychotic changes from 2013 to 2019. The physicians were heavily involved with that, obviously. But collaboratively with residents, with families, with nurses, we developed skills that just completely dropped our antipsychotic rate lower than community, lower than hospitals, lower than retirement homes. We showed that with leadership skills we can make real bedside changes, and that was just one project. We can make differences when it comes to pressure injuries. We can make differences regarding sedation, with pain, with comfort, with social engagement—

**The Chair (Ms. Laurie Scott):** Thank you very much. I appreciate everyone's time.

**Mrs. Daisy Wai:** Thank you very much to all of you.

**The Chair (Ms. Laurie Scott):** Thank you to all the presenters. This wraps up our session for today. The Clerk has distributed committee documents electronically through SharePoint.

A reminder that the deadline for written submissions on Bill 37 is 7 p.m. on Thursday, November 25, and the deadline for filing amendments to Bill 37 is 12 p.m., Friday, November 26.

That concludes our business for today. I want to thank everyone again. The committee is now adjourned until 9 a.m. on Monday, November 29. Thank you again.

*The committee adjourned at 1804.*

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