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# Official Report of Debates (Hansard)

E-15

## Standing Committee on Estimates

Ministry of Long-Term Care

1st Session
42nd Parliament

Tuesday 6 October 2020

# Journal des débats (Hansard)

E-15

## Comité permanent des budgets des dépenses

Ministère des Soins de longue durée

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42e législature

Mardi 6 octobre 2020

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

Président : Peter Tabuns
Greffière : Thushitha Kobikrishna

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON ESTIMATES

# COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 6 October 2020

Mardi 6 octobre 2020

*The committee met at 0900 in room 151 and by video conference.*

## MINISTRY OF LONG-TERM CARE

**The Vice-Chair (Mr. Wayne Gates):** Good morning. The committee is about to begin the estimates of the Ministry of Long-Term Care—

**The Clerk of the Committee (Ms. Thushitha Kobikrishna):** Mr. Chair, the gavel.

**The Vice-Chair (Mr. Wayne Gates):** Oh. It's my favourite thing to do, by the way, just for the record. I don't get to be Chair that often, and that's my favourite thing to do. It gives you that power, right? It's kind of fun. Anyway, that's just me.

As this is the first ministry before the committee, I would like to take this opportunity to remind everyone that the purpose of the estimates committee is for the members of the Legislature to determine if the government is spending money appropriately, wisely and effectively in the delivery of the service it intended.

As Chair, I intend to allow members to ask a wide range of questions pertaining to estimates before the committee, to ensure they are confident that the ministry will spend those dollars appropriately. In the past, members have asked questions about the delivery of similar programs in previous fiscal years, about the policy framework that supports a ministry approach to a problem or service delivery, or about the competency of the ministry to spend the money wisely and efficiently. However, it must be noted that the onus is on the member asking the questions to make the question relevant to the estimates under consideration.

The ministry is required to monitor the proceedings for any questions or issues that the ministry undertakes to address. I trust that the deputy minister has made arrangements to have the hearings closely monitored with respect to questions raised so that the ministry can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by our research officers.

Before we begin, we have the following members in the room—I've already done that. The following members participating remotely—which is already done. We are also joined by staff from legislative research, Hansard, interpretation, and broadcast and recording.

To make sure that everyone can understand what is going on, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak.

Are there any questions from the members before we start? Seeing no questions, I'm now required to call vote 4501, which sets the review process in motion. We'll begin with a statement of not more than 30 minutes from the Minister of Long-Term Care, followed by a statement of up to 30 minutes by the official opposition. Then the ministry will have a further 30 minutes to reply. The remaining time will be apportioned equally among the parties.

Minister, the floor is yours.

**Hon. Merrilee Fullerton:** Thank you, Chair. Good morning to all of you and the members of the committee, those of you who are here in person and those of you who are joining us virtually. I really appreciate this opportunity to appear before you this morning.

Long-term care is a key priority for our government, and, as Ontario's aging population continues to grow, seniors and their families expect that when they move into a long-term-care home they will receive the kind of care that is always mindful of their needs, in a caring, comfortable and dignified environment.

Like many other people across the province, I have experienced long-term-care homes first-hand, both as a physician and with my own family. In my experience as a family doctor practising medicine for almost 30 years in Kanata, in Ottawa, I witnessed the challenges inherent in Ontario's long-term-care system.

We all want the best for our aging loved ones, and our government, reflecting that universal truth, has prioritized long-term care. That's why on June 20, 2019, the Premier announced the creation of a stand-alone ministry dedicated to long-term care in Ontario.

Much work has been done since the creation of this ministry. We have been working diligently across government and with sector stakeholders. We visited homes across the province and talked with residents, their families, loved ones and staff and the organizations that represent them to help inform a path forward in the development of a strategy to modernize our long-term-care sector, and to make it one that puts residents at the centre of care, ensuring that they receive access to the quality care they deserve in a safe, home-like environment—and to know that they can have the care they need, when and where they need it.

But the conditions when we started that work were dire. The reality of long-term care in Ontario is that homes were

operating at 99% occupancy, with over 38,000 people on wait-lists. From 2015 to 2018, the wait-list for a long-term-care bed grew by more than 10,000 people. The current wait time for a placement in a long-term-care home is 145 days, on average. That's almost five months that someone is waiting for a safe place to call home. This unmet demand created pressures in hospitals, contributed to hallway health care and left many Ontarians feeling unsupported.

And to add to this reality, the COVID-19 outbreak has created unprecedented challenges across the health sector, and particularly in long-term-care homes. Our government's top priority since the beginning of this pandemic was and remains to protect the health, safety and well-being of our most vulnerable residents. We acted swiftly to urgently address the outbreak and the dire situation that quickly surfaced. Working with ministry officials and on the advice of the Chief Medical Officer of Health and local public health units, we implemented critical protocols to ensure a safe and secure environment for residents and staff. And we did so early. The first guidance to the sector was sent on January 31 of this year. Emergency orders were put in place to help homes tackle the COVID-19 outbreak by addressing some of the more time-consuming restrictions around staffing, reporting and documentation, to help ensure that staff were focused on caring for residents.

We enhanced measures to enforce social and physical distancing, such as increased bed availability, so homes could provide isolation rooms. We put into place a temporary order that gave homes the flexibility they needed, and in some cases continued to need, to deploy staff. We introduced directives that focused on keeping residents safe, which meant quickly and decisively limiting the flow of people in and out of homes.

From the spring economic statement, we invested $243 million to assist the sector, to prevent and contain the spread of infection by introducing and supporting 24-hour-a-day, seven-day-a-week screening and more staffing to support infection control, emergency capacity and supplies and equipment to help tackle COVID-19 and protect our most vulnerable.

We launched the COVID-19 action plan for long-term-care homes to create a road map and ramp up the protection of long-term-care residents and staff. The action plan includes aggressive measures for more extensive testing, screening and surveillance, leading to virtually all residents and staff in long-term-care homes being tested for COVID-19.

Today, we can see that the system is working. The surveillance testing is catching asymptomatic cases which otherwise would have gone unnoticed until an outbreak existed—and that's the usual scenario: A staff member picks up COVID-19 through community spread and unknowingly brings it to the home.

So the testing regime is making a clear difference, and that's why the majority of currently declared outbreaks in long-term-care homes are a single staff member who's isolating at home.

**0910**

In addition to the action plan, we enabled hospitals, public health and the home care sector to deploy health professionals to homes experiencing clinical staffing shortages. We called on the Canadian Armed Forces to provide temporary support at seven long-term-care homes to ensure the ongoing safety of residents and maintain effective staffing levels. Since May, we have also appointed temporary management at 13 long-term-care homes to help them manage resident care in response to COVID-19 outbreaks. And in a number of homes province-wide, local hospital partners continue to work with the homes to help them contain the spread of COVID-19 and return them to normal operations. But it doesn't end there.

COVID-19 demands a culture of continuous learning. The more we learn, the better we can plan and adapt for future waves. As the situation continues to evolve, our government is committed to applying what we have learned at the beginning of the outbreak to build and strengthen the long-term-care sector, to work in the best interests of our residents and the people who work so hard to keep them safe. We are taking action to address the challenges brought sharply into focus by COVID-19 and prioritizing a number of actions and investments to stabilize the sector to meet residents' needs this fall.

As part of the province's COVID-19 fall preparedness plan, Keeping Ontarians Safe: Preparing for Future Waves of COVID-19, Ontario is investing close to $540 million to protect residents—and I'll repeat that: $540 million to protect residents, caregivers and staff in long-term-care homes. That's more than half a billion dollars.

The new investments include:

—$405 million to help homes with operating pressures related to COVID-19 for prevention and containment measures, staffing supports and purchasing additional supplies and personal protective equipment;

—$61.4 million for minor capital repairs and renovations in homes to improve infection prevention and control. These repairs and renovations may include upgrades to support physical distancing, plumbing or water supply cleaning, updating HVAC systems or repairing or replacing furniture and equipment that cannot be deep-cleaned;

—$40 million to support homes that have been impacted by the changes in occupancy numbers due to COVID-19. With the restriction of new admissions to three- or four-bed rooms, the funding will help stabilize the homes through the transition to lower-occupancy rooms and take away an operating pressure;

—$30 million to allow long-term-care homes to hire more infection prevention and control staffing, including $20 million for additional personnel and $10 million to fund training for new and existing staff, enabling homes to hire over 150 new staff;

—$2.8 million to extend the high wage transition fund, and I remark that that is "extend" the high wage transition fund, to ensure that gaps in long-term-care staffing can continue to be addressed during the pandemic.

These investments will help the province quickly identify, prevent and respond to any scenario in order to

ensure the continued health, safety and well-being of long-term-care residents, visitors and staff.

Other measures being implemented include a temporary wage increase of $3 per hour for personal support workers working on-site in licensed long-term-care homes, and partnering with the Ministry of Health to expand the pool of available personal support workers and registered clinical staff through targeted programs being implemented immediately.

Beyond COVID-19, our government is moving forward on a number of initiatives to help bolster this sector. The pandemic exposed deep cracks in our long-term-care system and amplified the need to repair, build and advance long-term care in Ontario.

From day one, I have taken the task at hand extremely seriously, and so has our government. We will continue to fight until our province's long-term-care sector is one that all Ontarians know they can rely on if they need it.

With a vision of ensuring that our long-term-care sector has a clear path forward to address the care needs of our constantly growing elderly population, we are working to create a 21st-century integrated long-term-care system that is well resourced, puts residents at the centre and is ready to welcome our most vulnerable when and where they need it.

In support of our ministry's vision, we are taking historic steps to improve capacity and conditions in Ontario's long-term-care homes. In April, we introduced a new minor capital program valued at $22.8 million to maintain the safety and quality of long-term-care homes. The new program will help long-term-care home operators improve or extend the life of their homes through minor capital projects that could include upgrades like sprinkler system installation, wireless nurse call system installation or lighting upgrades. To design the program, which replaces an obsolete, outdated model that ended in March of this year, we worked closely with long-term-care stakeholders to identify and solve funding gaps to ensure we are building a 21st-century resident-centred system for our loved ones.

We are also moving quickly to redevelop aging long-term-care homes to modern design standards—some of these homes have not been rebuilt since 1972—and to build the new long-term-care capacity that we need. To date, the ministry has allocated 8,937 beds, or over half of the first 15,000 new long-term-care beds.

However, many expansions and redevelopments were stalled. Between 2011 and 2018, only 611 new beds were built, despite the aging population of the province. After taking a closer look, we learned that this was in large part because the old funding model was out of date; it just didn't work to get homes built. We needed incentives to encourage faster development. We needed more than a one-size-fits-all approach. Our consultations and research showed that the way forward required addressing barriers to development and redevelopment, like the high cost of development charges in urban areas.

That's why, in July, the Premier and I announced a new, modernized funding model for long-term care that we are applying to the creation of the new capacity and to the redevelopment of older homes to modern design standards. This new funding model is designed around the specific needs of different market segments: rural, mid-size, urban and large urban. It removes barriers to building and redeveloping long-term-care homes in Ontario so that more seniors can receive the care they need in their communities. Putting our previously announced $1.75-billion investment to work, the new funding model will increase upfront funding and cover development charges, making it easier for operators to get long-term-care programs off the ground.

By making smarter investments like this to unstick projects that have been stalled for years, and owing to how funding flows, we can jump-start the construction and renovations we need, to ensure that we have enough modern long-term-care capacity to support Ontario's seniors now and into the future.

As such, our government has committed to building 30,000 new long-term-care beds over the next decade.

To help expedite the building of new capacity this summer, we launched the Accelerated Build Pilot Program, to enable the construction of four new long-term-care homes in the greater Toronto area—of great need—beginning immediately. In partnership with Infrastructure Ontario, Trillium Health Partners, Humber River Hospital and Lakeridge Health, the new homes will be located at sites owned by those hospitals, at Mississauga, Toronto and Ajax, respectively, with the intention to build up to 320 new beds for each project, for a total of 1,280 beds by 2021.

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The pilot program is part of the government's plan to create new long-term-care beds across the province—beds that meet modern design standards, including features such as air conditioning and private or semi-private rooms. The program will be evaluated on an ongoing basis to determine whether it can be extended beyond the pilot stage to further accelerate the development of even more beds across the province.

And this is just one way we are using innovative ideas and modern solutions and working together with our long-term-care and health system partners to help end hallway health care and increase long-term-care capacity in communities across the province, while repairing the cracks in the system to help more seniors receive the care they need, when they need it.

Another way our government is working to build healthier and safer communities is by managing the growing demand for long-term care. Given the current lengthy wait times, it's critical that we do our part to help people remain in their homes for as long as possible, where they want to be.

This is something community paramedicine for long-term care can support. Traditional community paramedicine programs, in which paramedics use their training and expertise in non-emergency care roles, have been demonstrated to reduce 911 calls and avoidable emergency room hospital visits. That's why, after much con-

sultation and engagement with the sector and municipalities, our government has created an innovative, 100% provincially funded community paramedicine for long-term care program. We're looking to partner with several selected municipalities across Ontario that will build upon their existing community paramedicine programs to provide additional and appropriate care for seniors in their own homes. This could include access to non-emergency support, 24 hours a day, seven days a week, through home visits and remote monitoring that is more responsive to changes or escalation in their health conditions.

The communities where this pilot project will run have not been finalized, but that work continues at a good pace and will be announced shortly. The criteria being looked at are municipalities that have long median wait times for placement into long-term-care homes, as well as reflecting different regions of the province, which each have very different challenges.

Along with having existing community paramedicine programs and demonstrating expertise and experience with integrating community paramedicine services into existing services for primary care and home and community care, the program will work alongside home care, primary care and community care to help ease hospital capacity pressures and end hallway health care. This is particularly important now, given the impact of COVID-19 safety measures on long-term-care capacity across the province, given the restriction of new admissions to three- or four-bed rooms, which limits capacity.

And that brings me to another critical element of our government's efforts to modernize long-term care in Ontario, which is ensuring that proper staffing is in place to improve resident quality of care and quality of life.

Ontario's long-term-care homes currently employ over 100,000 staff across this province, and residents rely on them each and every day to meet their needs. This can often be challenging, as a result of residents with responsive behaviours associated with dementia and complex mental health or other neurological conditions, particularly during these unprecedented and challenging times with COVID-19.

The increased capacity, with the development of new and upgraded homes on the way, will require a pool of well-trained staff, including nurses and personal support workers, and we've been working on this since the beginning of our ministry in the summer of 2019. Since receiving a final report from our expert-led staffing advisory group at the end of July, our ministry's team has doubled down on our work on a comprehensive long-term-care staffing strategy, tracking to be delivered later this year. Its focus will be on training, recruitment and retention of a strong workforce, which means more jobs and better care for local communities across Ontario.

Additionally, we continue to work with our partners to implement recommendations made by Justice Gillese in 2019 for the safety of long-term care. As we reported in late July, 80% of the recommendations are complete or under way. Our government is committed to making long-term care safer and stronger now and in the future.

The ministry has 140 inspectors who are deployed to inspect every long-term-care home at least once a year. Using a risk-based inspection framework, as recommended by the Ontario Auditor General in 2018 and validated by Justice Gillese in her recommendations in the report of her public inquiry, that framework prioritizes homes based on the risk from complaints, critical incident reports, histories of non-compliance and other risk factors, subjecting those homes at higher risk to closer scrutiny and monitoring. This enables the ministry to respond more quickly to urgent concerns and better manage inspection volumes. Upon completion, inspection reports are made available to the public. During the COVID-19 pandemic, ministry inspectors continued to inspect issues with a risk of potential harm to residents and to respond to concerns of residents and families.

Last year, inspectors completed over 2,800 inspections and addressed more intakes than in previous years in several key categories. We are working with all our effort to ensure that every senior who needs long-term care in Ontario has a comfortable and dignified place to call home. We will continue to collaborate with our partners across government to make this happen and to ensure our long-term-care system is sustainable for years to come.

We recognize the persistent staffing challenges identified through Justice Gillese's public inquiry and, most recently, the COVID-19 outbreak, which have highlighted the need for action to improve care for residents, as well as worker health and safety. Our government is committed to meeting this challenge. As part of COVID-19 emergency funding, we announced additional support for front-line workers fighting COVID-19, including long-term-care clinical and support staff, through the temporary pandemic pay, an increase of $4 per hour, plus a lump sum payment of up to $1,000 for eligible staff working in all Ontario long-term-care homes—an investment which totalled $320 million.

We also increased funding to this sector by $102 million to maintain the overall quality of care. This includes a 1.5% increase in the level-of-care funding, an investment of $78.2 million provided to all homes for staffing and other care needs.

These efforts and investments have positioned the ministry, working in collaboration with the sector, to develop and move forward on plans for reform in the months ahead.

To further support these plans, our government launched an independent commission into COVID-19 and long-term care. The COVID-19 outbreak has disproportionately affected residents and staff at long-term-care homes in Ontario, and the people of Ontario deserve a timely, transparent and non-partisan investigation. The commission's role is to investigate how COVID-19 spread within long-term-care homes; how residents, staff and families were affected; and to analyze the effectiveness of measures taken by the province and other parties to prevent, isolate and contain the spread. Three independent commissioners have been appointed for the expertise they bring to addressing the commission's mandate. An

accomplished counsel and legal author, who was appointed to the Superior Court of Justice in 2005, Associate Chief Justice Frank N. Marrocco serves as chair of the commission. A former senior executive with the Ontario public service, Angela Coke, is a recipient of the Public Sector Excellence Lifetime Achievement Award from the Canadian Public Sector Quality Association and Excellence Canada. And last, but not least, is Dr. Jack Kitts, former president and CEO of the Ottawa Hospital. Through their work, the commissioners will help identify ways to prevent the future spread of disease in Ontario's long-term-care homes.

Despite the challenges COVID-19 has presented, our government has been responding to the long-term-care sector's needs in an effort to fulfill our commitment to build a 21st-century long-term-care system that meets the needs of Ontario's most vulnerable people. We will only be satisfied when we have accomplished our goals.

**0930**

So we will continue to work with our partners in long-term care and across the health sector to look at innovative ways to provide service and build up the infrastructure that we need to support Ontario's growing population of seniors. Together, we can improve long-term care for all Ontarians.

Once again, thank you for the opportunity to highlight the critical actions that our ministry has been taking to transform long-term care in Ontario today and into the future.

**The Vice-Chair (Mr. Wayne Gates):** Thanks very much, Minister.

I'd like to ask the person who has called in to confirm who they are.

*Interjection.*

**The Vice-Chair (Mr. Wayne Gates):** Okay, thank you.

We'll now move to the official opposition for 30 minutes. MPP Armstrong.

**Ms. Teresa J. Armstrong:** Good morning to all my colleagues on Zoom and in person this morning.

Thank you, Minister, for your presentation this morning. I'm going to make some brief comments, and then I have some questions I want to integrate into my 30 minutes that I have here this morning.

The minister mentioned that she is a physician and has had long-standing experience in long-term care. That's a very big part, I believe, probably, of your role in the long-term-care file. So you must have, over the years, seen some very concerning things in long-term care. I'm sure you were able to understand that the long-term-care system was already in a problematic state before you became the Minister of Long-Term Care.

I appreciate some of the things that you have talked about this morning, but there are lingering, ongoing concerns in long-term care. I have, just today, heard from my staff about someone waiting for quite some time, well over the 145 days that you mentioned, for a long-term-care bed. It doesn't feel, to constituents who are on those wait-lists, to caregivers who have to leave their jobs to look after their families, to those who were in ALC beds for months and months waiting for a long-term-care position in a long-term care system, that these things were being addressed. It's been a chronic problem for decades.

I think what really bothered me as an MPP—I've been the critic for long-term care for quite some time, bringing up constant issues with the Liberals and the Conservatives and, at times, being dismissed—that those things aren't really happening, that they're not actually the reality of what's going on. And it truly is the reality of what's going on.

I think if governments really paid attention and dealt with the problems, we wouldn't have this escalation of pandemic here today. Having lost over 1,800 lives in long-term care and counting is quite disturbing. What happened globally is something that we should have been paying attention to. SARS was another pandemic that taught us many lessons about PPE, about presumption of safety. We can say that we've heard this before, where it's "We shouldn't be pointing fingers"—and looking to the future. Absolutely, that's something that needs to happen, but we also need to learn lessons from what happened before. I think that's what governments fail to do—they don't learn from the lessons that happened before.

You did talk about the funding that you're putting into long-term care. It is, of course, long overdue.

The other milestone, I think, that we've failed to recognize was—you mentioned Justice Gillese and the public inquiry. Again, when that happened, it was a lead-up to many stories—workers calling on conditions around the workplace, reports that were filed. There were even flags around inspections and the conditions. When that public inquiry was called at that time, the Liberal government decided to specifically focus on the deaths and the murders, which is something that absolutely had to occur. No one disputes that. But we lost an opportunity to expand that into a more systemic way of looking at the problems in long-term care. The government of the day dismissed our call for a broader public inquiry. If, in hindsight, those things had been addressed, we would have had some proactive measures happen that could have prevented some lives being lost today.

The commission that you mentioned—again, we asked for something more robust, a public inquiry into that. The reasons given for not allowing that public inquiry were that it would be too long and too costly. But given the number of deaths and the circumstances that happened—even the Canadian Armed Forces that were called in—again, I think it's another failing of government, that didn't take the opportunity to really address the systemic problems. We have said, as the NDP, that we can find the problems and fix the problems. It doesn't have to take years.

The Minister of Long-Term Care, of course, has repeatedly made many of the same points that the government has made throughout the pandemic. We have heard this time and time again, many times. So I need to make it clear that from the number of emails I've received from families and across the province, the level of funding to provide

quality of care to long-term-care residents doesn't seem to meet their needs. It doesn't seem to be enough—and that's before the pandemic, and even more so now.

We are in a crisis. Half of what I've heard just now is spending money for projects in the future. What about the care needs today? Do the families, advocates and the media have the wrong understanding of what's happening? We have heard stories very publicly about the failings of what happened before the pandemic to help their loved ones, and during the pandemic. The media has reported on it. I recall going to Villa Colombo a couple of years ago and talking about the PSW shortage, and there were family members there and the media was there to cover it. After the interview was over, I said to the media, "Thank you for coming, but please, continue to push these issues, because that's how they're going to get into the mainstream of government and changes." The media has done good work, but now, because of the pandemic, it seems to be, again, what's being talked about the most. It should never have fallen off the radar at that point.

I'm receiving emails from families saying that they have to supplement their care by hiring a private PSW because there are not enough publicly funded PSWs to provide the care in a long-term-care home. That is a story that's actually come to my office. So I ask the minister not to answer, but just as a rhetorical question—if this is really acceptable to you, and is it acceptable to the quality of care of Ontarians? And if it's not, long-term care should be your number one priority. We should see the priority reflected in the level of funding provided. Though we've seen your $5.5 million—was it $5.4 million?

**Hon. Merrilee Fullerton:** It's $540 million.

**Ms. Teresa J. Armstrong:** So $540 million; excuse me. We've seen that, and of course, people in the sector welcome it. There's been the transition fund you talked about, and the capital operational fund. At one point, your ministry was going to cut that. Again, from pressures from the sector, you've extended those things, so that is something that's appreciated.

**0940**

But we've seen cuts to levels of funding—and this, for people who don't know, is the amount of funding that residents receive every day for care in long-term-care homes. The Conservatives have spent the last two years—there was an intent of cutting it, and now you've had to backtrack with regard to long-term care. It wasn't enough that we wanted to see it survive; as the NDP, we wanted to see it thrive.

There have been statistics, there are demographics—and we know that seniors are going to explode in population, and along with long-term care, there's obviously home care and community care that are a part of that whole piece. But when people get into their golden years and they require that long-term-care home, people tell us that they're afraid of going in—and more so. If you look at what's happened during the pandemic, it's truly a valid perception that they have.

We're going in the wrong direction. Every single association says this. They've told us that we are going in the wrong direction. Family members talk about it going in the wrong direction. Just building more for-profit homes is also something that people say—they want to see public dollars go into publicly delivered long-term care.

It's our job to assess the funding that you've provided so far. Let me tell you, some of it is encouraging, but it's also disappointing. I'm concerned about the future of residents during the second wave.

Minister, I do have some questions that I would like to ask. I know that you had gone in front of the cabinet at one time and asked for funding for long-term care. I just wanted to ask you, when you went in front of the cabinet, what was the amount you were asking for, and did you receive a sufficient amount of what you were requesting at that time? Can you talk about that?

**Hon. Merrilee Fullerton:** I'm just wondering about the format of the committee. Are we doing questions now? Are we following the schedule?

**The Vice-Chair (Mr. Wayne Gates):** Yes, during her presentation, she can ask you questions. You can do that. I just checked with the Clerk to make sure that was okay.

**Hon. Merrilee Fullerton:** Thank you so much.

I can tell you that the Premier, the cabinet and Treasury Board have been listening. They have been supportive. There have been many asks that I have been to cabinet and Treasury Board with, and they have been supportive, and that is why we've been able to put out over half a billion dollars in the most recent announcement and hundreds of millions of dollars to support our sector. Our work is not done, clearly, so we will continue to repair and rebuild and advance long-term care, and that will require more dollars. I will continue that work, and I appreciate the support that I've received from the Premier, the cabinet and Treasury Board.

**Ms. Teresa J. Armstrong:** I want to ask a few more questions, if I could, to take that time to help us understand—especially the staffing piece. I understand that OPSWA met with you earlier this year and they had mentioned that about 10,000 people had some foreign credentials but needed some additional certification. I'm just wondering how you received that information, and some of the actions that you may have taken to possibly look at staffing levels around that.

**Hon. Merrilee Fullerton:** Thank you for the question.

There is absolutely no doubt that staffing is a priority. The staffing was in a crisis as we became a new ministry, and had been for many years, according to the sector. So we're looking at multiple mechanisms to stabilize our workforce on an emergency level, also in a medium-time level and also long-term, understanding that as we build capacity, we are going to have to have more staffing. So it's not just dealing with the right now, which we're doing on an emergency basis, but as we move forward in looking at not only the foreign pipelines, it's also about retention.

When we look at the dollars that we put into PSW training—$14 million to the PSW training funds to continue training PSWs; an additional $10.3 million for the new Personal Support Worker Return of Service Initiative to recruit and retain graduates in long-term care.

Another college has a $5,000 amount that will encourage PSWs to sign on to the program if they are agreeable to spending six months in a long-term-care home after they graduate.

So there are multiple mechanisms that we're using, understanding the immediate needs, the medium-term needs and the longer-term needs. And it really is about recruitment and retention.

I'll ask the deputy if he wants to comment on that as well.

**Mr. Richard Steele:** Thank you, Minister. I'll just note, in addition, that in terms of, specifically, internationally educated health professionals, there's no question that that is a source of potential labour for the sector that—

**The Vice-Chair (Mr. Wayne Gates):** Excuse me. Can you identify who you are for Hansard?

**Mr. Richard Steele:** My apologies. I'm Richard Steele, Deputy Minister of Long-Term Care.

**The Vice-Chair (Mr. Wayne Gates):** Thank you, sir.

**Mr. Richard Steele:** Internationally educated health professionals are definitely one of the sources of potential workers for the sector that we are interested in pursuing. In the context of the pandemic, specifically, through the spring a variety of conversations and steps were taken to reach out to the settlement sector, to really promote that there were opportunities available in long-term care. We did create some flexibility that would make it easier for internationally educated health professionals to actually come into the sector in essentially a resident aide type of role that could then serve as a stepping stone to becoming a PSW or potentially another regulated health professional. Certainly, we did see, through the matching portal that was established, a number of individuals come forward for that opportunity.

As the minister has noted, as we look forward to continuing that work—because again, as the minister said, there's definitely lots more work to do—we're continuing to look at a range of innovative training solutions, through the colleges and with other partners, which again would make it easier for internationally educated health professionals to take the steps to actually finding work in the sector and moving, ultimately, into regulated health professional roles. So it's a really important source, for sure.

**Ms. Teresa J. Armstrong:** I chose to use this 30 minutes because the topics that the minister addressed are ones I want to get into a little more.

We all know that the PSW shortage has been here prior, it's here and it reflects a crisis in the sector, and so PSWs need the permanent wage increase. I have two questions on that announcement: Why is the increase only temporary? And has the government determined the impact of the PSWs who decide that the temporary increase is not good enough to stay in the sector?

**Hon. Merrilee Fullerton:** Well, clearly there are two parts to this issue, the recruitment being one and the retention being the other. The pandemic pay that we put out earlier to help support what is the backbone of our long-term-care sector, our personal support workers—I want to make sure that they understand how much they are valued, not just during COVID-19, but every day that they are serving our residents in long-term care—because we are taking a resident-centred focus, and our staff are really the critical piece to providing that care and the quality care that we need in our long-term-care homes.

Looking at the fees that were increased by $3 an hour for PSWs in long-term care: That really is until March 31, the end of the fiscal year. That was a time frame that is suitable to addressing what needs to come next—and I want to make sure that our personal support workers across Ontario know that they are valued, recognizing that this whole sector has been largely neglected for decades.

**0950**

I want to comment a little bit on the high wage transition fund. As soon as we became a new ministry, we recognized that this fund, which goes back to the 1990s, had always been meant to be temporary. When we became a ministry, we identified that the deadline was coming up for this, and we acted quickly to extend it. We've done that in order to make sure that we have a proper transition. So I want to be clear on that—that this was extended and it was not cut.

I'll ask the deputy if he would like to comment too.

**Mr. Richard Steele:** I'll just add, in terms of attraction and retention of PSWs and, for that matter, other workers into the sector, there is a range of issues I think we need to address. Compensation is certainly important. In the context of the pandemic, one of the things that clearly is critically important is ensuring that employees feel that they are working in a healthy and safe work environment. That has been a critical part of our fall plan as well, in terms of ensuring homes have access to adequate levels of PPE, and also a major focus on ensuring that the infection prevention and control measures and resources are in place in homes, both by increasing the capacity of homes themselves and by working closely with the Ministry of Health on the creation of IPAC hubs across the province that can provide additional support into homes. In an immediate pandemic context—I acknowledge that that's not the long-term solution, but in terms of ensuring that people feel safe to come into work now, that has been a key part of the strategy too.

The staffing study that the ministry released in the spring based on the input from a range of experts on staffing in long-term care highlights a range of the issues that do need to be tackled in terms of, ultimately, retention and attraction, including, fundamentally, the culture of the sector.

So, as the minister has noted, there's lots of work to do, but we are taking steps in that direction.

**Ms. Teresa J. Armstrong:** We've been talking about the conditions of long-term care being in dire need prior to the pandemic, and so I just wanted to ask if the minister could explain why the Conservative government reduced the level-of-care funding this year, even as the homes faced a pandemic. Why did the government cut the level-of-care funding, especially as the needs are going up?

**Hon. Merrilee Fullerton:** Thanks for the question.

In terms of the level-of-care per diem funding, it is in four envelopes: nursing and personal care, program and support services, raw food, and other accommodations. We have increased, overall, the amounts by 1.5%, and we've increased the funding to long-term care over and above the previous year by $72 million more. We invested an additional $80 million to improve and maintain the quality of care and overall resident experience in long-term-care homes in the economic statement in the spring. We've really made sure that we have continued to supply the dollars for the level-of-care.

I think the deputy might have more to add on this.

**Mr. Richard Steele:** Yes, that's absolutely correct. The level-of-care funding increased by 1.5%, or approximately $60 million, year over year from 2019-20 to 2020-21. There were a number of other additional investments into the sector, including, as I think the minister has already mentioned, the creation of the minor capital program and the extension of the high wage transition fund. So in total, in the operating funding for the sector, there was an increase of approximately $80 million. In addition to that, of course, there was an additional investment into the capital development program. So you'll see, year over year, both of those increases, both in the level-of-care and operating funding and also into the capital development program. So both saw an increase, year over year.

**Ms. Teresa J. Armstrong:** Minister, the average of level-of-care funding is 2%. Can you explain why it went down?

**Hon. Merrilee Fullerton:** Well, we're saying we've increased it by 1.5%. This is a situation where we're addressing not only the staffing but also the capacity issues, the level of care, maintaining the quality of care in our long-term-care homes.

I'll ask the deputy to comment further.

**Mr. Richard Steele:** I apologize. I missed the question.

**Ms. Teresa J. Armstrong:** The level of care is 2%, and the minister mentioned it was 1.5%.

**Hon. Merrilee Fullerton:** Increased by 1.5%.

**Ms. Teresa J. Armstrong:** So 2% plus 1.5%—so it went up 3.5%?

**Hon. Merrilee Fullerton:** It has increased by 1.5%. I'll ask the deputy to clarify.

**Mr. Richard Steele:** That's correct, yes. Year over year, it was a 1.5% increase.

**Ms. Teresa J. Armstrong:** But is the level-of-care funding supposed to be 2%?

**Mr. Richard Steele:** Sorry; I'm not quite sure what the 2% references. Where are you—

**Ms. Teresa J. Armstrong:** That's the amount that we understand is supposed to be for level of care: 2%. The average level-of-care funding is not 2%?

**Mr. Richard Steele:** No, I'm not sure what that 2% number represents.

**Ms. Teresa J. Armstrong:** Okay. So what was it last year?

**Hon. Merrilee Fullerton:** Do you mean the increase? Are you referring to the rate of increase?

**Ms. Teresa J. Armstrong:** Yes.

**Hon. Merrilee Fullerton:** It's an increase of 1.5%—if the question that you're asking is, "What was the increase last year?" Is that what you're asking?

**Ms. Teresa J. Armstrong:** Yes.

**Hon. Merrilee Fullerton:** Okay.

**Mr. Richard Steele:** In terms of the prior year, so the increase from 2018-19 to 2019-20, I could see if our CAO, Peter Kaftarian, is on the Zoom call and can respond to that question. If not, we can certainly get back to you with what that prior year percentage increase specifically in the level-of-care funding was. I can you tell you from the estimates what the overall funding increase was year over year, but in terms of pulling out specifically the level-of-care funding, I would need to follow up on that.

**Ms. Teresa J. Armstrong:** Thank you. Nearly every single organization has stated that long-term-care homes are underfunded—they've been talking about that for years—and that this has gotten worse since the pandemic started. Does the minister believe that the funding provided so far is going to keep up with the pace of need?

**Hon. Merrilee Fullerton:** First of all, I think it's important to acknowledge the level of complexity of the residents in long-term care, even over the last 10 years. So if you look at the people who are coming to long-term care, many of them had been waiting—as we mentioned in the opening remarks and you have reiterated, the average is 145 days. That is, clearly, only an average. That means there are people who are waiting longer than that, and so we acknowledge that. Really, that is a buildup of the neglect of this sector, and our government is committed to addressing that issue.

But if we look at the amount of funding going to providing for our long-term-care residents, that level of complexity is an issue, and that's why we've just invested over half a billion dollars into long-term care—to help with staffing, to help with operations, and the minor capital improvement of $61.4 million to enable homes to address physical infrastructure that might be of help to them—also looking at the certainty for our staff that they get the PPE that they need. We have rolling out this week six to eight weeks of PPE for each home in long-term care across Ontario—making sure that we get them the resources that they need.

So all of these things are entwined with the quality of care that we provide the residents. It's the physical capacity, it's the staffing, it's the maintenance, the minor capital funding—all of these measures.

I'll ask if the deputy would like to add anything further.

*Interjection.*

**Hon. Merrilee Fullerton:** Nothing? Okay.

**Ms. Teresa J. Armstrong:** I just want to go back to level-of-care for a minute. Historically, it's been an average of 2% for funding for level-of-care. Someone just gave me a note saying that last year it was 1.7% for level-of-care and this year it's 1.5%. Historically, it has been 2%. Why the lower amount during the pandemic?

**1000**

**Hon. Merrilee Fullerton:** There are many aspects—

**The Vice-Chair (Mr. Wayne Gates):** Excuse me.

Official opposition, you have one minute left.

**Ms. Teresa J. Armstrong:** Okay. I will let the minister answer that.

**Hon. Merrilee Fullerton:** There are many aspects to how we provide funding to our homes' multiple envelopes of care, plus the additional dollars that our government has put out to provide support for staffing. All these measures are taken in coordination. There's not one particular area where you can say, "This is going to cause a decrease in care." It's all of these pieces together that provide the quality of care. It's the staffing. It's the physical space. It's the changes to infection control. All of these things contribute to the care and enable our staff in long-term care to provide the care that our residents need. You're zeroing in on level-of-care, and that's one aspect, but the whole sector has been neglected for decades.

Our government is investing in this sector. It is committed to addressing the staffing issues, the capacity issues and the COVID-19 cracks that have been exposed.

**The Vice-Chair (Mr. Wayne Gates):** Thank you very much. Your 30 minutes are up.

We'll now go back to the minister for a 30-minute reply, please.

**Hon. Merrilee Fullerton:** Thank you again for the opportunity to appear before you today.

The COVID-19 pandemic has had a significant impact on Ontario's long-term-care sector, disproportionately affecting residents and staff, and what occurred in long-term-care homes across the province is a tragedy. We offer our deepest condolences to the loved ones of everyone we have lost—residents who have lost friends; families who have lost a husband or a wife, a parent, a grandparent, an aunt or uncle, or siblings; and staff who lost someone they saw every day and had a strong, caring relationship with. Our hearts go out to you.

Our government's focus has been and continues to be on fighting the virus to keep residents and staff in every long-term-care home safe. Since the outset of the COVID-19 outbreak, we have worked extensively with ministry officials and across government—with the command tables, with the Chief Medical Officer of Health, with the outbreak response coordinator and with Public Health Ontario and local public health units—to assist homes during this crisis, fortifying the protection of our most vulnerable and the province's front-line heroes.

Before I move forward, I want to acknowledge and commend the staff working at long-term-care homes, who have been heroic in their efforts and in these incredibly challenging conditions. Their efforts and dedication are helping to improve the lives of those in long-term-care homes now and into the future, and, along with all Ontarians, our government is continuously grateful.

As I mentioned in my opening remarks, every option is on the table to protect the health and well-being of Ontarians from COVID-19, including that of long-term-care residents and staff. This is the biggest public health emergency that any of us have ever seen in our lifetimes or, indeed, for generations. The situation in this global pandemic has evolved constantly, changing day to day, even hour to hour. We are still learning more about COVID-19, and we know more each day.

We were determined to meet these evolving circumstances with firm action, and we did, adapting to each change that the virus posed with enhanced action that comes from deeper knowledge and lessons learned.

In the spring, we implemented a robust action plan to better protect our most vulnerable population and stop the spread of COVID-19 in our long-term-care homes. To support home operators and staff in their efforts to prevent and contain the spread and impact of COVID-19, we introduced aggressive measures to ensure that all long-term-care homes have the flexibility and funds to rapidly hire and retain nurses, personal support workers and other front-line staff as needed. We invested $243 million in emergency funding to cover the incremental costs of new staff and to support the offer of full-time hours to part-time staff who are restricted to one workplace. This also includes the cost of supplies and building much-needed capacity.

We introduced screening and testing of both residents and staff, and we partnered with hospitals to support long-term-care homes with further medical expertise in infection prevention and control.

We enabled hospitals, public health and the home care sector to deploy health professionals to homes experiencing critical staffing shortages, and we called on the Canadian Armed Forces to provide temporary support to seven homes across the province, which faced unprecedented challenges due to COVID-19.

We are grateful for the partnership of the Canadian Armed Forces. They stepped in to help with infection control and prevention and to help maintain staffing levels at Orchard Villa in Pickering, Altamont Care Community in Scarborough, Eatonville Care Centre in Etobicoke, Hawthorne Place Care Centre in North York, Holland Christian Homes' Grace Manor in Brampton, as well as Downsview long-term-care centre and Woodbridge Vista Care Community. The teams of medics, nurses and other personnel covered general duties like cleaning and food preparation to help protect residents and support the heroic staff working at these high-priority homes.

We increased and stabilized Ontario's supply of protective personal equipment, including same-day delivery to homes in urgent need. This happened in the face of global competition with jurisdictions across North America competing for a finite supply.

We introduced directives focused on keeping residents safe, which meant quickly and decisively limiting the flow of people in and out of homes.

And lastly, we limited the admission of residents to ward rooms in which more than two residents share a room and where an outbreak is more difficult to contain.

The ministry is focused on the deployment of resources and protection of vulnerable residents and staff. As the situation evolves, we continue to work directly alongside our sector partners in long-term care and across the health sector to monitor each individual situation closely while

relying on the scientific evidence of Dr. Williams, Dr. Yaffe, Dr. Huyer and many other public health and medical experts to guide decision-making—more than I can list.

Our government is investing over half a billion dollars in fall preparedness funding for the long-term-care sector as part of a broader strategy to address COVID-19 in long-term-care homes, which includes invoking emergency response measures and longer-term modernization initiatives that support building a 21st-century long-term-care sector. These measures will help ensure we continue to build stronger long-term-care homes across our province to protect the health, safety and well-being of vulnerable seniors in long-term-care homes.

We are committed to taking every step to protect long-term-care residents, staff and essential caregivers and visitors. Nothing is more important than protecting the health and well-being of Ontarians in long-term-care homes, including their rights, their safety and their security.

Long-term-care homes enforce rigorous provincial standards for all public health concerns, including outbreak management systems for detecting, managing and controlling infectious disease outbreaks. All long-term-care homes are required to have an infection prevention and control program to be compliant with the Long-Term Care Homes Act and the regulations.

Compliance is assessed through the ministry's rigorous inspections program, and every single long-term-care home in Ontario is inspected at least once a year with an aim to reduce risk of harm to residents, maintain quality of life and keep current and prospective families and residents informed about inspections and non-compliance. The ministry continuously works to improve transparency for families and promote safe environments for long-term-care residents.

**1010**

For example, long-term-care inspection reports are posted and available to the public on the ministry's website. That's only right, in a democratic society with a transparent government. The ministry's 140 inspectors actively work to conduct unannounced inspections so that homes respond to problems and ensure a safe and secure environment for residents and staff. Ministry inspectors also conduct inquiries so that these issues do not cause actual harm, or risk of serious harm, to residents.

Following a recommendation by Ontario's Auditor General in the fall of 2018, and validated by Justice Gillese in her recommendations in her public inquiry's report back, the ministry shifted towards a risk-based framework—how are we doing for time, Chair?

**The Vice-Chair (Mr. Wayne Gates):** We have about four minutes.

**Hon. Merrilee Fullerton:** Okay—in which reports issued to the ministry are assessed and prioritized according to risk to residents. This has allowed us to respond to urgent concerns and to clear a backlog of inspections that had been accumulating for years. It has allowed us to focus on the homes that need the most help and pose the most risk.

Additionally, and beyond formal inspections, inspectors have been essential in monitoring and tracking conditions at homes during the COVID-19 crisis. They have been in regular contact with our 626 long-term-care homes to ensure that any critical concerns, such as outbreak status, a decrease in staffing capacity or the supply of personal protective equipment, are escalated so that homes are getting the resources they need when they need them in order to combat the virus, help our staff do their jobs and help protect our residents and staff, and deliver the quality care that is so needed by our residents.

The ministry also constantly seeks to develop strategies to improve safety and security and how allegations of abuse are managed within long-term-care homes. There are numerous provisions in the Long-Term Care Homes Act that are designed to ensure residents are protected from abuse, neglect or harm—these include mandatory reporting of abuse, neglect or improper care of a resident—as well as for incidents that result in serious injury or death of a resident or a risk of serious harm. All homes are required to have measures in place to protect residents from serious harm or a risk of harm.

Furthermore, our government understands the importance of supporting long-term-care residents with responsive behaviours. As a result, the ministry has enhanced the quality of care and services provided to residents through investments in programs and services, including Behavioural Supports Ontario and behavioural specialized units, known as BCUs. Currently, the ministry invests up to $74 million in base funding for services provided by Behavioural Supports Ontario, an initiative that crosses various sectors, designed to improve health care services for older adults, including long-term-care residents with responsive behaviours associated with dementia, complex mental health, substance abuse and/or other neurological conditions.

Behavioural support units also support the care of residents with responsive behaviours, providing enhanced specialized support and access to care, helping to reduce potential hospital admissions and increasing residents' safety. There are 11 of these units in our province, including three new units designated by the ministry in 2019 as part of a pilot project.

Long-term care is a huge priority for our government, and we are committed to making it better, to repairing it, rebuilding it and modernizing it, which is why our government made Ontario the first jurisdiction in North America to voluntarily and proactively launch an independent review into COVID-19 for our long-term-care sector. Ontarians deserve a timely, transparent and full investigation, and so we launched an independent commission to analyze and learn from what happened in long-term-care homes during the pandemic.

**The Vice-Chair (Mr. Wayne Gates):** Minister, it is now 10:15. We'll have a recess. We'll reconvene at 3:45 this afternoon. Thank you.

*The committee recessed from 1015 to 1545.*

**The Chair (Mr. Peter Tabuns):** Good afternoon, everyone. We're going to resume consideration of vote 4501 of the estimates of the Ministry of Long-Term Care.

There's now a total of eight hours and 45 minutes remaining for the review of these estimates. When the committee recessed this morning, the ministry had 16 minutes and 40 seconds remaining.

Minister, to you.

**Hon. Merrilee Fullerton:** Long-term care is a huge priority for our government, and we are committed to making it better, which is why our government made Ontario the first jurisdiction in North America to voluntarily and proactively launch an independent review into COVID-19 for our long-term-care sector. Ontarians deserve a timely, transparent and fully public investigation, so we launched an independent commission to analyze and learn from what happened in long-term-care homes during the pandemic.

Beyond investigating how COVID-19 spreads within long-term-care homes, three commissioners, Associate Chief Justice Frank N. Marrocco, Angela Coke and Dr. Jack Kitts, have been appointed for the expertise they bring, to address the commission's mandate. The commissioners have a duty to act in the interest of Ontario while demonstrating impartiality. They have the power to conduct hearings, deputations and summon any person to give evidence and produce documents as they conduct their investigation under section 33 of the Public Inquiries Act.

As well as the ability to call for stakeholder input, ensuring a public-facing process is necessary. Already, the commission has received briefings from government officials on a number of aspects of long-term care, professional groups representing those who work in long-term-care homes, such as the Ontario Personal Support Workers Association, and groups representing seniors broadly and residents specifically. This commission is about the way forward.

The commission's findings will be delivered to the public in April 2021 so that our government is equipped to act quickly. We look forward to this report and its recommendations.

In tandem with the commission, our government is continuing our pre-pandemic work to modernize long-term care in our province. Our government knows that staff in long-term-care homes are the backbone of the sector, and we understand that staffing is an integral part of ensuring safe and quality care for long-term-care-home residents.

To bolster our staffing supply that was already a serious issue and that was further amplified by COVID-19, we have taken significant action to increase flexibility and funding, including issuing emergency orders and introducing amended regulations, which include meeting urgent staff needs through our Health Workforce Matching Portal, a tool that matches pools of available workers with open positions at long-term-care homes and hospitals across the province. In addition, the government has invested $320 million to implement temporary pandemic pay for staff in long-term-care homes, and we recently introduced a temporary wage increase of $3 per hour for personal support workers in long-term-care homes. Hospitals across Ontario have deployed teams to long-term-care homes to support them in infection prevention and control and to help maintain staffing levels.

As outlined in the province's COVID-19 fall preparedness plan announced last week, we have made significant investments to support long-term-care staff so that they can continue to help improve the lives of those in long-term-care homes now and into the future. We are on the right path.

We recognize the balance that is needed between the emotional and psychological needs of residents and their safety, and we know that seeing their family and loved ones is a critical component of well-being. That is why we updated our visitor policy to long-term-care homes in stages since June, as the pandemic evolved. These were anticipated steps from families and caregivers, and they were welcomed across Ontario communities.

**1550**

After announcing the gradual resumption of visits to long-term-care homes, retirement homes and other residential care settings in June, we changed the essential caregiver and visitor policies to allow us to ensure operators implement consistent visiting practices across the sector and across the province last month. The updated visitor policy, released in September, helped to clarify that essential caregivers are allowed to visit homes and provide essential care, including during an outbreak, subject to direction from the local public health unit.

We know that caregivers are essential visitors and important partners in care, who provide direct care to residents, such as helping with feeding, mobility, hygiene or cognitive stimulation. As I mentioned, that emotional, psychological, psychosocial component of health is absolutely critical. It is imperative that we took the actions that we have and that we continue to understand the need for residents and families to have this element. We recognize the important roles these family members or friends, privately hired caregivers, paid companions or translators play in the continuum of care. Under the updated visitor policy, each resident and/or their substitute decision-maker may designate a maximum of two caregivers.

Directive 3 was also updated by the Chief Medical Officer of Health to allow residents to leave their homes for a short stay and temporary absences, including day trips or short overnight absences—of course, while following public health measures, including physical distancing while away. These expanded directives and policies must be considered in combination with prevention and containment measures, as well as continued staff testing in long-term-care homes, to ensure that we continue to do everything we can to protect residents, staff and their families.

Testing is key to defeating COVID-19, and the sooner we can identify cases, the better positioned we are to contain them and save lives. There are currently—I've got today's numbers here—51 homes in outbreak; 38 of those 51 have no resident cases, and 13 out of the 626 homes have resident cases. Four homes have five or more resident

cases, and the other nine have less than three resident cases. I mention this because that was the reality we were seeing—staff members contracting COVID-19, often without symptoms, through the community and bringing it to the home, through no fault of their own; this is an invisible intruder. It comes in undetected without the surveillance that we're doing and continue to do.

Surveillance testing works, and that's why we're seeing the number of 51 homes in outbreak—because we are picking up staff who are coming in, testing them before they come in, testing them as positive and then allowing them to self-isolate at home. It enables us to make sure that individual cases are stopped and to take measures to prevent wider spread, to focus on those homes and ensure they have what they need to contain the virus. Twice-monthly surveillance—that means every 14 days—for all long-term-care-home staff continues until further notice. These steps all help to support consistency across this sector and to ensure that residents get the level of care they need.

We were able to introduce this new measure thanks to the hard work of our front-line workers and the collective efforts of everyone involved in helping to contain the spread of COVID-19. My deepest appreciation goes out to everyone who is making the testing work, providing that ability to test, whether it's in the field or at assessment centres. It's absolutely critical that everyone has their role and contributes, and so that also means the people of Ontario. As the Premier often says, we're all in this together.

But we recognize that there are continued challenges when it comes to recruiting and retaining front-line staff. As outlined in the long-term-care staffing study released in late July of this year, it's why the ministry is working to develop a comprehensive staffing strategy for the sector by the end of the year. We understand there is an emergency need, a stabilization process and future staffing requirements as we build capacity in long-term care, so I don't want to give the impression that we're thinking this can wait for months and months. We're taking measures now, and many of the efforts that we've put forward are being acted on immediately.

Currently, long-term-care homes are required to have an organized program for nursing services and personal support services, which includes a staffing mix that is consistent with residents' assessed care and safety needs. We are very grateful to the experts and sector partners who contributed to the staffing study, providing our government with advice on staffing in the long-term-care sector, including recommendations that will help us move forward to support resident care and improve working conditions, retention and recruitment of staff, so that our long-term-care homes are sustainable for years to come and so that our residents can get the care that they need, when and where they need it. Our government is committed to building a sector that works in the best interests of residents and for the people who work so hard to keep them safe and cared for.

We are moving forward with improvements and acting on essential learnings from the COVID-19 pandemic. There have been lessons learned, and science, in some ways, has managed to catch up to the speed of COVID-19. We need to include building a long-term-care sector that addresses the long-neglected challenges that grew over a long period of time and that lead to infrastructure that supports a safe and high quality of life for residents in long-term care that they can call home.

I thank you for the opportunity to highlight the ministry's continuous efforts—I would also like to point out the member who is my PA, from Oakville North–Burlington—to modernize the long-term-care sector and provide access to high-quality, resident-centred care to Ontario's most vulnerable.

**The Chair (Mr. Peter Tabuns):** Thank you, Minister. With that, then, we will start the rotation of questions. We'll go the opposition for 20 minutes. When their turn is finished, we will go back to the government, and we'll alternate 20 minutes at a time.

I'll go to Ms. Armstrong.

**Ms. Teresa J. Armstrong:** Good afternoon, everyone. I wanted to talk about the state of preparedness.

Specifically to Deputy Minister Steele: Can you please confirm whether there was an actual risk assessment done and completed on how much funding the long-term-care sector needs to stabilize the PSW workforce? Has that needs assessment been done?

**Mr. Richard Steele:** Sorry; one second.

**Hon. Merrilee Fullerton:** I can start by addressing some of that while the deputy gets organized.

We're looking at the retention and the recruitment of PSWs, understanding what happened with COVID-19 and the imperative to stabilize the long-term-care sector with its staffing. We're looking across the different sectors, whether it's PSWs in home care, PSWs in hospitals or PSWs in long-term care, because whatever we do in one area, it can affect another. We always have to be aware of that coordination. So a great deal of work was put into that.

I'll pass that to the deputy.

**Mr. Richard Steele:** Thank you, Minister.

There are a number of components to the work that has been done in terms of assessing what the gap is in terms of, specifically, PSWs in the sector. We have a shared service department between the Ministry of Long-Term Care and the Ministry of Health that is responsible for our health human resources planning across both the health and long-term-care sectors. One of their roles is to actually do the longer-range and shorter-range planning in terms of what will be the demand for various forms of health human resources—so not just PSWs, but also various nursing staff, doctors and so on.

**1600**

A part of that work has looked at what the current demand is for PSWs in long-term care, home and community care, and acute-care settings, and identified what the current level of gap is and, particularly, what the expected gap is in the future as well. It's that analysis, certainly, that has informed many of the efforts that we do have under way in terms of trying to stabilize the PSW workforce.

As the minister noted, we have a number of efforts under way to really try to augment supply of PSWs. Most recently, the PSW return of service program was announced, which aims to, in its first iteration, attract 2,000 PSWs back into the health care sector who may otherwise have been choosing to work in other sectors outside of the health care sector. That was launched a couple of weeks ago and is already gaining a great deal of interest from employers. So we're very encouraged by that program and by the potential, ultimately, to extend that program further and attract and retain additional PSWs back into the sector.

**Ms. Teresa J. Armstrong:** But with the numbers that you've talked about—has there been an actual needs assessment to establish those figures, that demand for PSWs? When you're throwing the number "2,000" out—has there been a needs assessment specifically on PSWs? We know that there's an extreme shortage of PSW front-line workers.

**Mr. Richard Steele:** Through conversations with the sector and analysis of what the staffing needs of the sector are, there is that level of understanding of what the current demand for PSWs is within the context of the current level-of-care funding. There's obviously a separate discussion, which was certainly raised in the staffing study that the ministry released earlier in the year—there's a separate line of conversation, if you like, around what is an appropriate level of care. That, obviously, in turn, would have its own implications for what the number of PSWs and nursing staff would be in the future as the government considers what the direction should be on that front.

**The Chair (Mr. Peter Tabuns):** Ms. Gélinas.

**M^me^ France Gélinas:** Would you share that number with us?

**Mr. Richard Steele:** Sorry, which number?

**M^me^ France Gélinas:** You just referred that when you look at the risk assessment and the need for PSWs, you look at two levels: You look at what funding—but you also look at what the field was telling you was needed. I'm just curious to see what those numbers are.

**Mr. Richard Steele:** Yes, I believe we can share that information, in terms of what the current demand assessment is for PSWs across all health sectors and what the current assessment of that gap is. I don't have the number right with me. It is a combination number across multiple sectors, but I believe we can provide that to you, yes.

**M^me^ France Gélinas:** Okay, and that's specific to long-term care?

**Mr. Richard Steele:** Again, there's an assessment across the whole health sector, and, within that, there is a segment that we believe would be at least an approximate number for long-term care, yes.

**M^me^ France Gélinas:** Okay, thank you.

Sorry, Teresa.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong?

**Ms. Teresa J. Armstrong:** Yes, just to clarify: There was a risk assessment completed, and that's how you determined how much funding we would need to stabilize the workforce for PSWs?

**Mr. Richard Steele:** I wouldn't describe it as a risk assessment; I would describe it as demand forecasting for the sector. I think in terms of our stabilization planning, we've been focused, to some degree, on the art of the possible: What do we think is a realistic number that can be hired at a given point in time, and then what do we think are realistic numbers that can be trained up?

As the minister has noted, staffing is not a challenge that has suddenly arrived with COVID-19. It has been a challenge for the sector for some time, so there are both short-term things we need to do and longer-term things we need to do.

In the context of fall preparedness planning, we've been focused on what the steps are that we believe we can take quickly to augment the supply of PSWs and other staff in the sector. I'd say that, again, that has been driven more by what we think can be accomplished within particular timelines to at least go some way to address that gap. I wouldn't suggest that what we're doing through our COVID-19 fall stabilization plan in any way solves the longer-term staffing problem for long-term care.

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

**M^me^ France Gélinas:** To continue on what you're talking about, our neighbours to the east, Quebec, went with paying everybody who wanted to take the course $21 an hour for the duration of the course to become a PSW, guaranteed a full-time job at $25 an hour, and they got 10,000 new PSWs who are in their long-term-care homes right now, ready for the second wave. Have you ever considered an option like this to deal with the shortage of PSWs?

**Mr. Richard Steele:** Obviously, we've considered a range of options in terms of what the appropriate approach would be to addressing the near-term staffing. PSW training, at least in the Ontario model, does take a bit longer. It's typically a three-month-plus college program, so the option of quickly running full PSWs through that kind of a program at scale—that's definitely part of our plan, is to scale up and increase the supply of fully qualified PSWs.

The other element we have done that in many ways, perhaps, is a bit more similar to what's happening in Quebec is the emergency funding that we have continued to provide to the sector. It has allowed the sector to hire what they call resident aides, which are people who are providing support in the homes—less than a fully qualified PSW—and can provide some assistance with resident care, but also assistance with things like screening and managing visitors and so on. That is something that the sector has certainly taken very full advantage of and has indicated to us it's been enormously helpful for them in complementing the PSWs who are available.

**M^me^ France Gélinas:** And those resident aides won't be getting the $3 an hour pay increase.

**Mr. Richard Steele:** They would not be PSWs so they would not be receiving the PSW pay increase. That's correct.

**M^me^ France Gélinas:** Okay.

Go ahead, Teresa.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong.

**Ms. Teresa J. Armstrong:** So you created the new programs in order to try to get the second wave under control there with PSWs. But what measures have you taken to keep and retain a stable workforce going forward?

**Hon. Merrilee Fullerton:** That's an important question.

When we look at the personal support worker workforce, even when they're in training—we lose about half of them during their training. Then, of that half who do graduate, we lose half of them within two years. So there is a pipeline that is reasonably robust, but even that we need to improve. That's why we can start with college programs, return of service programs, where some of the students will agree to work in a long-term-care home for at least six months after they graduate. In return, they would receive funding for their education of about $5,000. There is a rapid training process that we have to help get our personal support workers up and out into the communities where they can also gain experience at the same time as going to school. So there are mechanisms to do that.

But ultimately, to retain our personal support workers and people who want to work in long-term care, we must make sure the culture in long-term care is one that values the resident and values the staff. We can talk about the dollars, but we also have to talk about the culture and how important it is to integrate long-term care into other aspects of our health care system—because I can tell you, it used to be a place where people went, and it needs to be a place where people go to live. This is something that needs cultural change. That integration is key.

It has to be about more than numbers. I know that's what we're here to talk about today. The numbers are part of that, but it's about, how do we create a long-term-care sector that people want to work in and want to stay in? That's a critical piece.

Deputy, would you like to add anything to that?

**Mr. Richard Steele:** No.

**Ms. Teresa J. Armstrong:** I want to touch on the fall preparedness plan that we talked about earlier. As you mentioned, the Conservative government is spending $541 million on its plan, and now there's $40 million for homes that have changes in occupancy numbers. Could you clarify the government's policy? Are there homes with residents still living in four-bed ward rooms? Does the $40 million cover the proactively moving of all residents out of wards into one- or two-bed rooms? And if the $40 million doesn't cover that cost—proactively moving residents from a four-bed ward room—then why hasn't the minister increased those funds so that they could cover that transition?

**1610**

**Hon. Merrilee Fullerton:** To be clear, the $40 million is to allow our homes to be stabilized during a process—with experiencing the impact of COVID-19. In homes where there are ward rooms—not all of them have them; they're typically the homes that were built back in the 1970s. They are the ones that typically have them. The information available to us, the data, is something that we have been working on to make sure that we have an accurate picture of all of the homes and what their arrangements are in terms of four-bed rooms. Most of the homes that have been rebuilt after the 1970s do not have ward rooms, but this is something that we're actively monitoring—and that is part of a risk assessment for a home, as well, how many ward rooms they might have.

Currently, we are not increasing the number above two people per ward room. Typically, they're four-person ward rooms.

But this $40 million is a way to stabilize the homes that have had impact. We want to make sure that those numbers stay in a way that protects our residents in long-term care. It's absolutely critical, the whole ward room and redevelopment piece. We have to move forward in parallel with the new builds and the redevelopment.

I'll ask the deputy if he'd like to comment.

**The Chair (Mr. Peter Tabuns):** Before we go further, Madame Gélinas, you have a follow-up?

**M^me^ France Gélinas:** Just to clarify: We're talking about the older homes with the four-bed ward rooms. They now would only have two people in what used to have four—now two? Am I getting that the $40 million is to pay them for the other two empty beds so that you stabilize them?

**Hon. Merrilee Fullerton:** It's to stabilize them, but it also ties into cohorting. When there's an outbreak, you need to have space in the home, and we were at 99% capacity in our long-term-care homes across Ontario. By being able to support and stabilize homes to enable them to have space, to do proper cohorting—COVID-19-positive versus someone who is not infected—these are critical pieces to maintaining the well-being and safety of—

**M^me^ France Gélinas:** So what can the home use that $40 million for?

**Hon. Merrilee Fullerton:** I'll let the deputy give you the details on that.

**Mr. Richard Steele:** Thank you, Minister.

Just to clarify on a couple of points: The public health direction around three- and four-bed rooms was essentially that for new admissions to long-term-care homes—there should be no new admissions to ward rooms where that would essentially result in three or four individuals being resident in a three- or four-bed ward room. Of course, the challenge with quickly emptying those rooms, outside of admissions, is, where would those individuals go? That's the challenge.

What's been happening since the spring is, there have been no new admissions into those rooms, so we have been seeing a significant reduction in the number of individuals who are residents in three- and four-bed rooms, as the minister noted. Pre-pandemic, the system was running at about 99% occupancy. As of the end of July, which is the latest comprehensive data we have, it's running at about 93.5%. So there's been a significant drop in occupancy,

largely—although not entirely—related to that emptying of those three- or four-bed rooms.

There are still homes that do have more than two individuals in a room, because it will take a bit of time for that admissions policy to take full effect and for all of those rooms to be emptied, but that's definitely the direction things are heading in.

**M^me^ France Gélinas:** I'm interested in the money. Does the $40 million go to make those homes whole, or does it go to rent hotel rooms someplace to house people who would have been in a long-term-care home—but now we do the right thing and don't put them in a four-bed ward?

**Mr. Richard Steele:** The $40 million goes, as you say, towards stabilizing the funding for the homes so that essentially there isn't an immediate and large impact on their cash flow, which would obviously be, in this context, quite problematic in terms of their ability to maintain their staffing levels in the home, for example, and everything else that they're trying to do in terms of COVID-19. So yes, it is essentially about revenue stabilization for the homes that are seeing lower occupancy.

**M^me^ France Gélinas:** How do you do those calculations? If a home used to be 128 beds—they had four four-ward beds—and they're now at 100 beds, you give them the equivalent of 20 times $2,000 or whatever?

**Mr. Richard Steele:** Instead of me trying to make up that answer in terms of the mechanics of how that funding works, it probably would be best to see if we can loop in our ADM of operations, Sheila Bristo, and see if she is able to respond to the specifics as to exactly how the mechanisms of that funding works, if that's helpful. Otherwise, we can get back to you with the mechanics.

**M^me^ France Gélinas:** Yes, please.

**The Chair (Mr. Peter Tabuns):** Do we have that person available to answer questions?

**Ms. Sheila Bristo:** Hello, can you hear me?

**The Chair (Mr. Peter Tabuns):** I can. Please state your name for Hansard.

**Ms. Sheila Bristo:** My name is Sheila Bristo. I'm the assistant deputy minister of operations division in the Ministry of Long-Term Care.

**The Chair (Mr. Peter Tabuns):** Thank you. Please proceed.

**Ms. Sheila Bristo:** In answer to the question around how we apply that funding: What was established early on in COVID-19 to stabilize the homes was to confirm with the homes that they would continue to receive their occupancy funding at 97% so that, going forward, they wouldn't have to worry about cash flow, as the deputy mentioned earlier, recognizing that some of the beds would be reduced because of the ward beds as a result of cohorting, as the minister mentioned—as well as being able to provide beds for isolation if somebody in the home is required to isolate due to a COVID-19 diagnosis or suspected diagnosis.

So because it's very fluid, the decision was made at the time that the homes would be guaranteed their funding level at 97% so that they would be able to continue their work. Their funding level would not be reduced because of bed occupancy, thereby providing stabilization as well as the necessary resources to ensure that you have money to pay for your staff and all the other things that you need to pay for when running a long-term-care home.

**M^me^ France Gélinas:** Do you think that there are still lots of long-term-care residents in four-bed wards, or have we moved them all to accommodate no more than two?

**Ms. Sheila Bristo:** As the deputy mentioned, that has been something that has been ongoing. As occupancies arise, people are moved around. I will have to take that back and look into it.

**M^me^ France Gélinas:** Thank you.

**The Chair (Mr. Peter Tabuns):** With that, I'm sorry to say we're out of time.

It's now the government. Ms. Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** Thank you, Minister and Deputy Steele, for being here this afternoon.

It goes without saying, that COVID-19 has been, and still is, an unprecedented global crisis. We've seen jurisdictions across North America and the world struggle in the face of it, and we've seen long-term-care homes across Canada and the United States, but also in other jurisdictions, become the front lines in this battle. It is an invisible enemy, as you said earlier, and the challenges we've faced and are facing are new ones, and it has been clear for some time that there has been the risk for subsequent waves. It seems that, often, the experience with pandemics is, in fact, that reality. We saw that the pandemic subsided somewhat over the summer and the curve had been flattened, and now there has been a considerable resurgence. As the Premier said, we're now in wave 2.

Minister, can you outline for us, step by step, how Ontario responded to the first wave, and what work has gone in to prepare for the second wave, to fight the pandemic in our province, and what specific protections we have put in place for vulnerable residents and staff in long-term-care homes?

**1620**

**Hon. Merrilee Fullerton:** That's a very good question.

Our government was aware of the challenges facing Ontario's long-term-care system, really, after many years of neglect—and I will call it that, neglect—and it was taking action to fix it before the pandemic hit. Our Ministry of Long-Term Care had been addressing the issues—the staffing, the capacity and the shortcomings.

When the pandemic hit, we used every resource available, every tool available, to support the province's long-term-care homes as we worked to stop the spread of COVID-19. I will remind us all that at the beginning of this pandemic, there wasn't a lot known about this virus. The scientific evidence and knowledge was lacking. We've taken significant action since the onset of this pandemic to protect long-term-care homes from the unprecedented challenges faced with this virus.

Many actions have taken place on the ground to keep our most vulnerable seniors and front-line heroes safe. To name a few: Temporary management has been appointed

at homes which, despite supports, could not get their outbreaks under control, allowing hospitals to manage the outbreaks. We implemented our aggressive, intense COVID-19 action plan for protecting long-term-care homes, issued four emergency orders, introduced three packages of amended regulations, and announced $243 million in emergency funding to support the needs of the homes. And that was just to start.

This global pandemic continues to evolve. We know more and more about this virus every day. Our government has made adaptability the cornerstone of our approach—not only adaptability, but also attempting to keep up with the speed of COVID-19, which is why, as part of our fall preparedness plan, we are investing over half a billion dollars to protect residents, caregivers and staff in long-term-care homes from a second wave of COVID-19.

These investments include:

—$405 million to support operational pressures created by COVID-19;

—$61.4 million in minor capital to support homes to improve IPAC measures and other mechanisms that would support the homes in ways that would allow them to be able to keep their infection prevention—whether it's changing carpeting or surfaces that might need to be updated;

—$40 million to support homes impacted by shifts in occupancy numbers, which we just talked about;

—$30 million for long-term-care-home staff to hire and train more IPAC workers. We anticipate that we might be able to get about 150 with that amount of money—so it's not only to hire, but also the training that's the key; and

—$2.8 million to extend the high wage transition fund. I will repeat that this was a fund that was never cut. It was designed back in 1998, I believe, around that time, and was always intended to be temporary. As soon as we became a new ministry, we understood the need to continue that fund. It was never cut.

We're also providing an additional $461 million to increase PSW wages. As a minister, I am extremely proud of that effort. This will provide 50,000 PSWs with a $3-per-hour wage increase through to March 2021.

We are also investing $26.3 million to support PSWs and supportive care workers.

It is vital that we do whatever we can to protect our seniors and staff against this very deadly virus.

We are also prioritizing our distribution of the flu vaccine and making an early distribution to long-term-care residents and vulnerable populations.

Work is ongoing, but we really have just begun.

Our government inherited a long-term-care system that was "neglected"—and that is the word; there is no doubt. I watched it for 30 years and longer—because I retired a number of years ago, so add that time in, too. You recognize how severely this sector was largely ignored.

We are looking forward to doing the good work that the independent commission into long-term care will produce and looking to their guidance. We're happy to see that the commission is posting transcripts on its website for full transparency. That transparency is absolutely important to our repair, rebuilding and modernization of long-term care, and our government values that transparency.

We are also pursuing an aggressive modernization agenda to support residents and staff in long-term care. We have to be forward-thinking. Not only do we need to deal with the emergency before us now, but we must take intermediate steps to stabilize and to also look long-term, and this is all being done in parallel.

Further detail can be provided by Olha Dobush, the executive lead from my ministry. Is Olha online at all? Maybe she's not here today. Do you know if Olha's online?

**Ms. Olha Dobush:** I am. Can you hear me?

**Hon. Merrilee Fullerton:** We can hear you now. Thank you so much, Olha.

**Ms. Olha Dobush:** Wonderful. Thank you very much, Minister.

Good afternoon, Madame Chair and committee members. As the minister has mentioned, the COVID-19 pandemic has created unprecedented challenges in health and particularly in the long-term care sector. Some of those [*inaudible*] systemic issues that the minister has mentioned facing long-term-care homes have been brought sharply into focus by COVID-19.

The approach that we have taken in terms of stabilization and preparedness for the future waves was very much in appreciation that COVID-19 demands a culture of continuous learning. We have done exactly that. We have listened and we have been applying what we have learned in the emergency response to the first wave, and we'll continue doing so. Specifically, what we have learned through pre-pandemic evidence is that high occupancy rates, staffing shortages, ancient infrastructure and the increasing complexity of resident care presented challenges for long-term-care homes to prevent and contain outbreaks.

To learn more about what happened on the ground during the first wave, we held a number of targeted discussions with long-term-care sector partners and experts, including long-term-care-home operators and administrators, health care professionals, incident management response decision-makers and Ontario Health's regional partners who supported homes during this unprecedented emergency. What we have learned from these sessions was:

—there is a correlation between the community infection rate and outbreaks in homes;

—the critical nature of infection prevention and control for both outbreak prevention, containment and staff retention;

—imperative proactive rigorous risk assessment of homes and just-in-time surveillance for rapid response has been critical; and

—the heavy reliance on health systems and other partnerships for additional staffing capacity, infection prevention and control expertise, and emergency response was evident, as well as the need for reliable clinical care and leadership quality in each home.

With all these learnings, we have developed strategic priorities and goals to focus on prevention and building

capacity in the sector to be able to respond to the pandemic, while ensuring the health, safety and well-being of long-term-care residents and staff. We know that there are many systemic issues that cannot be solved in the short term. Many of those actions are under way through the modernization activities that the minister has already mentioned. The reality is also that outbreaks unfortunately continue, and we are seeing an increase in the past weeks. That requires continued and rapid emergency response and action.

These are the three different streams of work that are currently active and ongoing, hence the focus of the stabilization and fall preparedness actions is very much to support the long-term-care sector to be ready to respond to continued waves of the pandemic. Our strategic priorities were on strengthening the workforce, enhancing infection prevention and control, improving partnerships and robust surveillance and risk assessment.

To better understand the homes' readiness for a future wave and to help prioritize where supports are most needed, we asked long-term-care homes to conduct preparedness assessments and planning exercises during the month of August. Together with their partners at the community level and facilitators throughout the Ontario Health regions, long-term-care homes conducted preparedness assessment exercises over the course of the summer. The preparedness assessments focused on the areas of human resources, infection prevention and control, and partnerships and sustained operations.

Results indicated that planning exercises helped strengthen regional and local partnerships across the homes and health system partners. They also highlighted the systemic staffing challenges and availability of health care professionals, as well as the IPAC capacity and training, requiring ongoing focus and action.

**1630**

In direct response to these results, the government has prioritized communication with the licensees as well as the rollout of an infection prevention and control training program through Public Health Ontario. This is in partnership with the Ministry of Health and Public Health Ontario. As well, in partnership with the Ministry of Health, there are a number of incentives for new personal support workers and nurses to return to and enter long-term-care sector work, and these started to be rolled out in September. This is not all that has occurred over the summer months while we were preparing the preparedness plan as well as stabilizing the sector.

The long-term-care sector involves a number of stakeholders at the provincial, regional and community levels, such as public health units, hospitals, health care providers, residents, families, caregivers and other ministry partners in the province. And we heard that partnerships are critical to a home's preparedness and ability to prevent and deploy critical supports quickly to manage the outbreak. As such, the Ministry of Long-Term Care established new partnership tables to provide oversight, to drive support and stabilization as well as second-wave and future-wave preparedness efforts and to support ongoing long-term-care system operations.

The updated visiting policies the minister has already mentioned have also recognized the important role that essential caregivers play in the care and well-being of our residents, and provided guidance to long-term-care homes to connect caregivers with the training, education and resources on personal protective equipment and infection prevention and control. Furthermore, the ministry has developed a robust surveillance-and-risk-based approach to regularly monitor and act, as an early warning process to prioritize action and maximize impact of available interventions amongst scarce resources across the health system.

A continued testing strategy for residents is critical for early detection of cases and appropriate response, and that continues.

This approach also incorporates a home's preparedness results and other factors that demonstrated evidence of success or risk in preventing and managing this infection. While not all outbreaks are predictable, this surveillance-and-risk-based approach provides us with more information than we had in the first wave, to redirect and direct actions and investments where most needed.

Over the past number of weeks, we have been seeing a surge in community infection rates and outbreaks in the long-term-care homes, and we were able to reinstate the incident management process. We're looking at the long-term-care homes and monitoring the data to contain, manage and resolve the outbreak, as well as the action by health system partners to provide appropriate supports to the home.

As the minister has mentioned, on September 29, the government announced the province's COVID-19 fall preparedness plan, Keeping Ontarians Safe: Preparing for Future Waves of COVID-19. With this substantial investment, the minister has already alluded to a number of various programs, such as $405 million for prevention and containment measures and $61.4 million for minor capital repairs and renovations to help homes improve infection prevention and control. These repairs and renovations may include minor upgrades to support physical distancing, plumbing or water supply cleaning; updating HVAC systems; or repairing and replacing furniture and equipment that cannot be fully cleaned.

We have also provided $30 million to allow long-term-care homes to hire more infection prevention and control staff, as the minister has mentioned. Part of the funding is for new personnel and also for training new and existing staff.

In terms of these investments and others that the minister has alluded to, they will help the province quickly identify, prevent and respond to any scenario in order to ensure the continued health, safety and well-being of long-term-care residents, visitors and staff.

Other measures that are being implemented include the temporary wage increase of $3 per hour for approximately 50,000 eligible staff working on-site in licensed long-term-care homes, and partnering with the Ministry of Health to expand the pool of available personal support workers and registered clinical staff through targeted programs being implemented immediately.

In short, building HR capacity and ensuring safety through IPAC capacity and knowledge to support the long-term-care homes have been key stabilization activities, and the Ministry of Long-Term Care and our health partners continue to work around the clock to ensure necessary supports for the long-term-care residents and staff in preventing and responding to future waves of this pandemic. Thank you.

**The Acting Chair (Mme France Gélinas):** You have two minutes left.

**Ms. Effie J. Triantafilopoulos:** Can you elaborate and give us some examples of specific things you've learned along the way, such as asymptomatic spread being a driver?

**The Acting Chair (Mme France Gélinas):** Is your question for the minister or for Olha?

**Ms. Effie J. Triantafilopoulos:** For the minister or whoever you designate.

**Hon. Merrilee Fullerton:** Asymptomatic spread?

**Ms. Effie J. Triantafilopoulos:** Yes.

**Hon. Merrilee Fullerton:** Well, if we look at the science behind COVID-19, now that we know it—in the early days, it was not clear to the experts, even. There was a lot of information coming out and it had to be deciphered, and our experts have done that very well. There now does appear to be an asymptomatic component.

In long-term care, we know that the staff were the vector bringing COVID-19 into the long-term-care homes. Our residents were simply not going out that often. With the surveillance that we started in April, it was very clear through the testing and the repeat testing that the vector was the staff members—and no fault of their own. I'm not blaming anyone here. It really just is the reality.

The asymptomatic spread, that invisible intrusion of COVID-19 into our long-term-care homes, had a significant role in the first wave of spreading COVID-19 in our homes and the impact on our residents and staff in long-term care.

**The Chair (Mr. Peter Tabuns):** Thank you very much. Now we go to the opposition.

**Ms. Teresa J. Armstrong:** The government explains that there is $405 million going to help homes with operational pressures due to COVID-19. Can you please explain to us the breakdown on where that $405 million is going so it adds up to the $405 million? It's not available in the fall preparedness plan—the actual breakdown that adds up to that figure. I would ask if the deputy minister could provide that—Deputy Minister Steele?

**Mr. Richard Steele:** Just as a bit of background: Starting towards the end of March and then through the spring and the summer, the ministry provided prevention and containment funding—$25 million in March, $25 million in April; and then in May, June, July, August and September, we provided approximately $45 million a month to the sector for prevention and containment efforts. The $405 million that you mentioned is in addition to that funding that was provided up to the period to the end of September.

For the period to the end of September, we developed an allocation formula for the funding between the 626 homes in the province that aimed to—it provided all homes with some funding and it aimed to provide, obviously, those homes with the highest need with additional funding—so all the homes with more ward beds, where you had more challenges in managing COVID-19 prevention, and particularly homes that were dealing with outbreak and all of the extra costs associated with outbreak. They received additional funding.

Through the course of September, we've asked the sector to provide us with information on what their COVID-19-related spending has been to date, because again, that allocation formula that we've used to date was based on discussions with the sector and some approximation of what we thought made sense.

**1640**

We just, in fact, have completed a survey of the sector to understand what the actual spending has been, and we will use that information to, if necessary, adjust that funding allocation that we've used to date to reflect what we've learned through the last six months in terms of applying an allocation formula for that $405 million for the balance of the fiscal year, and also to address whether there are expenses that haven't been covered yet that need to be addressed from that $405 million as well.

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

**Mme France Gélinas:** Deputy, so it was $25 million a month for March and April; it went up to $45 million a month; we're now at $405 million for the next six months. Give me examples of what could be part of those extra costs and what could not. Were they allowed to increase the amount of money they paid their staff? Were they allowed to pay for their PPE? What were they allowed to use that money for?

**Mr. Richard Steele:** I'll give you the broad answer, and if you want to get into more detail I'll turn it over to ADM Sheila Bristo.

Yes, the parameters for the COVID-19 funding we deliberately kept fairly broad, because we did want to provide homes with some flexibility. To be very clear, the money has to be spent on COVID-19 prevention activities; it's not something that could be funnelled to some other purpose. Ultimately, at the end of the year, we will reconcile all of that and we will need to see that that's where the money was spent—but it could absolutely be used for staffing.

I would say that the most significant areas of expenditure that we've seen are, absolutely, staffing, PPE and environmental services, so additional and enhanced cleaning services. Those would probably be the top three areas of spending that we've heard from the sector, but there could be some others as well. Again, in some cases, homes may have undertaken some kind of minor capital improvements to enhance their ability to manage COVID-19, as well. So extra staffing to support staff testing in the home—a range of expenses, but staffing, PPE and additional IPAC and environmental services would be the top ones.

**Mme France Gélinas:** When we look at staffing, would paying somebody to stay home because they tested positive or stay home because they have one of the symptoms and they had to isolate—could they use that money

to pay for sick days or to pay the staff who cannot come because of COVID-19?

**Mr. Richard Steele:** Well, I think in terms of the specific scenario, I don't want to misspeak so I probably want to take that back and confirm. I will say that many of the employees—not all; there are some casual employees in the sector—do have health benefits, which would certainly cover sick pay, so they would be receiving benefits in the normal course. I'm happy to take some specific scenarios and confirm (a) whether they would be eligible and (b) whether we have actually seen any of those types of payments being made.

**M^me^ France Gélinas:** Thank you.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong.

**Ms. Teresa J. Armstrong:** I'd like to take Deputy Minister Steele up on his offer and ask if you could, for the next meeting, give us a breakdown of where the $405 million is actually going and how it adds up, simply because it's not in the fall preparedness document plan. So it would be good to have that breakdown as to where it's going and how it adds up. Is that possible to get for next meeting?

**Mr. Richard Steele:** We can absolutely provide it when we have it. To my previous response: We're basing that allocation formula on the information we're just getting from the sector now on what they spent to date. We have to do a little bit of work to analyze those responses in order to develop the allocation formula that we'll use for the balance of the year. So, absolutely, once we have that information we'd be happy to share it.

**Ms. Teresa J. Armstrong:** And do you know when you'll have that information?

**Mr. Richard Steele:** The survey closed at the end of September for the sector. I think we had a reasonable response rate, but not everybody, so we need to do a bit of chasing to get some of those surveys back in, and then it will take us likely a few weeks to complete that analysis. I would say, approximately speaking, around the end of October I would anticipate us having that.

**Ms. Teresa J. Armstrong:** On September 24, the Conservative government announced more than a billion dollars into COVID-19, of which I think the majority was federal dollars. At least $30 million was allocated for outbreak management in long-term care, schools and other congregate settings.

Can the minister confirm that the government is spending just an additional $30 million for outbreak management across all long-term-care homes, all schools and congregate settings?

**Hon. Merrilee Fullerton:** While I won't speak to the education sector, I'll speak to the Ministry of Long-Term Care. Certainly, the needs of our long-term-care homes and the expenses incurred with COVID-19 are significant.

I'll let the deputy respond to the details of the ministry on the $30 million.

**Mr. Richard Steele:** I think the numbers you're quoting there were from the Ministry of Health's fall preparedness plan, so that might be a question better posed to the Minister of Health, who I believe will be here.

**Ms. Teresa J. Armstrong:** Is there any additional funding for the Ministry of Long-Term Care itself in order to manage the outbreaks?

**Mr. Richard Steele:** Yes, absolutely. As the minister and ADM Dobush have run through, essentially all of the funding we're providing through the long-term-care fall preparedness and stabilization plan is aimed at enhancing the capacity of the sector to manage outbreaks, whether that's the $405 million that we just spoke to, again, very much focused on having the staffing and PPE and IPAC in place to manage outbreaks; the $30 million for IPAC resources in training, again, all about outbreak management in long-term care—similarly, the IPAC capital program. So, yes, the whole funding package that was rolled out for long-term care last week is very much all aimed at ensuring that homes can prevent an outbreak and, in the unfortunate circumstance that they do have an outbreak, can contain that outbreak quickly. That was the purpose of that funding.

In addition, there were elements of the Ministry of Health's fall preparedness plan that included, if you like, shared capacity across multiple sectors. One example would be the infection prevention and containment hubs that were created or are being created by Ontario Health. I believe there are 25 IPAC hubs across the province aimed at supporting long-term care, but also other congregate settings as well.

The investment we're making is going to the homes to increase their capacity. They would be working closely with the hubs that the Ministry of Health is funding to provide your higher level of expertise for them to plug into.

**Ms. Teresa J. Armstrong:** I missed it. What is the actual figure in additional funding that is dedicated to long-term-care homes for outbreak management?

**Mr. Richard Steele:** I don't think we've broken our numbers down quite that way—because we've indicated funding for prevention and containment and for IPAC and for staffing and so on. There's no line in our plan that says "outbreak management," but all the elements of the plan are very much focused on precisely that goal of preventing and then managing outbreaks if they happen.

I'm happy to run through the numbers again in terms of what the elements of that plan are.

**Hon. Merrilee Fullerton:** If I can give some context to this: I think what we're missing in the discussion is that every home has a unique situation in terms of its staff, in terms of its physical set-up, in terms of the community that it's in. In order to understand what outbreak management entails, it requires having the PPE, the staffing, the physical set-up, the ability to cohort and the funding for supplies.

All of the different numbers that we've mentioned today, whether it's the total amount of $540 million that we announced last week, which includes the $405 million, the $61.4 million for minor capital to support homes to improve IPAC measures, the $30 million to help train staff in IPAC or the $26.3 million to support PSWs and maintain the staff—it's all part of the ability of the home

to manage during a very difficult time. It really is every day what these homes are doing where there's community spread and we're getting staff coming in. All of these pieces have to be taken into consideration.

I want to also emphasize the importance of the perspective that we've taken as a ministry, to look at flexibility and adaptability to allow our homes to respond quickly, to have the resources that they need. This is something that we heard from the sector loud and clear, and we've been doing our very best to make sure that our homes not only have the resources they need but that they have the flexibility and adaptability to respond. Really, that context is so important, so I appreciate your question.

**1650**

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

**M^me^ France Gélinas:** Deputy, you mentioned that all of the homes had to submit their state of preparedness in August. Have you reviewed them? Were most of them prepared? How did it look?

**Mr. Richard Steele:** Yes. The preparedness plans were developed. Each individual home was required to complete a preparedness assessment, which they worked with their local Ontario Health region on. The Ontario Health region assessed those and did a roll-up for us of where some of the key areas of focus should be as we moved into full planning.

In many ways, there were no huge surprises for us in terms of the areas that we needed to focus on, and we've talked about many of them already this afternoon. The continued requirement to focus on availability of health human resources and continued need to focus on IPAC readiness and training are perhaps the two biggest priorities. The assessment process also served as an opportunity to really ensure that each home was clearly connected with local partners in the event that they needed that support. So every home has been paired up with a local acute-care hospital that they'll connect with. They're working together with Ontario Health and the ministry. Should they be in an outbreak situation, particularly a more severe outbreak situation—that preparedness assessment process really helped foster and build those relationships between homes and their local partners.

It gave us, yes, a good sense of the areas that we needed to continue to focus on from a stabilization plan and also helped to actually build capacity through doing the assessments themselves.

**M^me^ France Gélinas:** Minister, did you have an opportunity to look at those assessment plans? Do you feel that the funding that you've put forward and what you've shared with us will mean that they're all prepared?

**Hon. Merrilee Fullerton:** It depends on our starting point. So there are plans, but we know COVID-19 can impact homes differently in different regions, depending on the prevalence of COVID-19, depending on the testing that's available, depending on many, many factors—the level of staffing in the home, the PPE, all of these things.

If you look back on the first wave, it was a very different time in the first wave. Like I said, the testing, the global competition for the testing, the PPE—we are in a very different place now, going into the second wave. Clearly, it is incredibly important that we keep up with the testing of the residents and the staff, so we can be vigilant and provide that level of surveillance, but that in the first—

**M^me^ France Gélinas:** But was this something that came up through the plans in the state of preparedness—that the homes wanted more testing? The deputy focused more on HR and IPAC and—

**Hon. Merrilee Fullerton:** There's no doubt that those were foundational—the staffing, the PPE, the IPAC, the integration with the hospitals—but one of the tools that we do use for surveillance for our long-term care to detect COVID-19 coming in is the testing. That has changed throughout the last number of months, the availability of reagent in a worldwide competition for the reagent, and sometimes a shortage of the items that are required—much beyond anyone's ability to fill out a preparedness survey.

These are things that are external to us and the homes, but there are many factors. And my point there really is that we need to be adaptable, we need to provide flexibility. The preparedness is important, but when changes occur with COVID-19 or some variable changes, we have to be able to adapt quickly, and our homes need that flexibility. That's really—

**M^me^ France Gélinas:** Were any of those preparedness plans a surprise to you?

**Hon. Merrilee Fullerton:** No. In fact, even early in March, when I was speaking to many of the homes as—

**M^me^ France Gélinas:** No, I mean the plan that they did in August, remember? You asked for the state of preparedness plan in August.

**Hon. Merrilee Fullerton:** Yes, certainly.

**M^me^ France Gélinas:** Were any of those plans a surprise to you when you read them?

**Hon. Merrilee Fullerton:** Well, no, because we knew staffing was already in a crisis. We knew that already existed. We knew the capacity in our homes was congested. We were doing everything to make sure that we could integrate our homes and provide the support to these homes. I think it was a critical piece—having the hospitals to be integrated, so that we could get the expertise from the hospitals and assistance with the staffing. But we are in a much different situation now. I'm grateful to everyone on the front lines and at our hospitals, and everyone who has really contributed in a very positive way in supporting our homes. So I was not surprised with—

**M^me^ France Gélinas:** And you're confident that with all of the money—the $405 million in operation, the $61 million in capital and all of this—your government has done what's needed to answer those plans and to be ready?

**Hon. Merrilee Fullerton:** Well, I think as much as we can at this point in time. There are many variables—the cost of PPE, what other demands are being made on the worldwide supply. But we have our own sources now, so there is more confidence. I have more confidence that we are able to identify cases before they get into the home, and that's exactly what we're seeing. So I am confident that we are doing everything possible to be prepared and

our homes are doing everything possible to be prepared, but we must be adaptable and we must be flexible.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong, you have one minute left.

**Ms. Teresa J. Armstrong:** I just want to ask the minister if she has personally reviewed the plans. You did ask for them from the long-term-care sector. Can you attest that the funding levels that you received—the plans that you've got, the funding levels you've committed to—are actually enough to prepare homes for the second wave? Have you seen them and reviewed them personally, and can you attest that your estimates are adequate for the second wave?

**Hon. Merrilee Fullerton:** I'll go back to that point in time.

When we look at the competition for staff, when we look at the competition for other aspects of IPAC or supplies, these things are all changing. These are variables that are not static. So we have to be in constant contact and communication with our sector and our homes—the IMS table, the command table, to understand where the risks are, whether it's in contact with our medical officers of health, or our hospitals that have the mandatory management orders or voluntary management contracts, to understand what's going on in our homes.

This is not a one-moment-in-time effort. It's not a static process. It's a very dynamic process. That's why we are continuing to communicate so much and consult with our sector—because we have to understand what their pressures are. But this is changing and it's a hard thing to explain—

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

We will go to the government. Ms. Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** MPP Pettapiece has a question.

**The Chair (Mr. Peter Tabuns):** Please, MPP, proceed.

**Mr. Randy Pettapiece:** Thank you, Chair. It's good to be here. It's good to see you in the chair, because you handle things so, so greatly. You're one of the better ones, I understand—from any criticisms I've heard.

Minister, you have spoken about what it's like when homes reach that crisis point of not being able to cope with an outbreak, that situation where you have half or more of your staff off work for a variety of reasons, and the struggle these homes experience to maintain the level of care needed to keep up with IPAC measures. We saw hospitals coming in to homes and helping out with IPAC and then, in more formal ways, mandatory management orders being imposed under one of the emergency orders and voluntary management contracts.

I wonder if you can explain in broad terms the development of these hospital partnerships and the mechanics of how they work.

**Hon. Merrilee Fullerton:** It's an excellent question.

We could see from the very beginning, as we began to make arrangements for these, that there is an aspect to this about relationships. Some of the long-term-care homes had very good relationships with their hospitals because of either proximity or because of multiple variables. Others might have been more remote from the local hospital. These all had to be taken into consideration.

Really, since the pandemic hit, we were using every available option to support our province's long-term-care homes. The mandatory management orders were one mechanism, and the voluntary management contract is its sibling but on a voluntary basis.

**1700**

As well, I want to point out the importance of the medical officers of health in the public health units and the tools and levers that they have—also very important. When we talk about "COVID-19 speed," we have to understand that sometimes it really is the medical officers of health at the public health units who will be able to move more quickly with their measures, depending on the situation with the home.

The four emergency orders that we enacted allowed homes that flexibility that I mentioned earlier in staffing and operating processes, so that there were enough staff that they could spend the maximum amount of time caring for residents. That's a really key piece. As the staff starts to dwindle, you could see homes really get into difficulties, and it was taking—really, we looked upon the hospitals as the cavalry coming to assist. Again, the first wave was very different from our second wave.

The emergency orders also restrict staff to only working at one home to prevent the spread of COVID-19 and allow the placement of temporary management at homes struggling to contain outbreaks. I just want to comment here, too, to say that the existing staffing crises, which some of our homes had more than others, really made us think very, very thoughtfully about when we issued that restriction to one location only, because the potential for some of the homes to have a crisis in staffing was very real. And so this was done in a very, very thoughtful way, knowing the risk that that might pose to some homes and taking that into consideration.

The fourth order allows the appointment of temporary management at homes which, despite numerous supports, in some cases could not get outbreaks under control, unfortunately.

The situation continues to change day to day, and we're learning more about how to fight the virus. Our government remains committed to adapting as this pandemic evolves. We have seen that, and we have also heard the diversity of opinions on what needs to be done now, what can be done later and what needed to be done earlier. There is a diversity of voices and opinions. Ultimately, we acted in the best interests of our residents and staff in our long-term-care homes, making sure that we used every tool possible, every measure possible. And as the science evolved and our technical expertise in testing evolved, we were able to do more.

The management orders that our government has issued enable local hospitals to temporarily manage long-term-care homes which, despite receiving hospital or other supports for weeks, were unable to contain the spread of

COVID-19. In the early days, we looked at the spread in the communities. Some medical officers of health were saying that it was significantly widespread; other areas were not determining or putting themselves in a position to indicate whether it was or not. We heard a number of different public health units with different perspectives, and I think it speaks to the differences across Ontario in terms of the cases.

We looked at how we could intensify the management structure, and we're still modifying this as we speak to the hospitals that are involved in the management of the homes, finding new ways to make sure that the staff are supported and efficiencies to make sure that the residents are receiving the care that they need, even in challenging times, and making sure that we're expediting testing, to make sure that we can get the test results back. All of these things are absolutely critical for us to work in—it's more than tandem; it really is a network, whether it's our medical officers of health, our public health units, the Ministry of Health or the Ministry of Labour, working with the whole sector to understand what is required to bring homes under control in terms of their spread. The mandatory management orders are one way to do that, or the voluntary management contracts, but it is an ongoing process to refine our efforts.

IPAC played a big role—I keep using it as though everyone listening will understand, but it's the infection prevention and control teams—going into the homes and really spreading that knowledge and training, and making sure that that's updated. These are all part of what we really managed to do with some of the orders. Again, that flexibility and adaptability are key for homes in different regions to be able to respond in a timely way to the crises that they might be facing with an outbreak.

It is unnerving for staff. We need to create that certainty for staff, that they feel confident that the supports are in place. We understand the importance of that.

The emergency orders were temporary measures to make sure that our homes had the support they need and needed, and I believe about 13 homes have that and had that. Over time, the homes have recovered and done much better. I think that this is really an important message—that we have learned lessons in this process of how we can do things in COVID-19 time and how we can support our staff and residents. Of the 13 homes that had temporary management, eight have had the hospital move out of managing the home, because the hospital believed and told our government that those homes were ready. If they weren't ready, then we had the hospital stay, and the hospital was willing to stay. I'm very, very grateful for the hospitals to step up.

This is a very different situation now with wave two, but we will not hesitate to have a mandatory management order or a voluntary management contract if needed. I've also spoken to medical officers of health to encourage them to use the tools that they have as well, so that we can respond in a timely way.

I'll turn this over to Sheila Bristo.

**Ms. Sheila Bristo:** Thank you, Minister.

**The Chair (Mr. Peter Tabuns):** And welcome back. If you could again identify yourself for Hansard.

**Ms. Sheila Bristo:** My name is Sheila Bristo. I'm the assistant deputy minister of the long-term-care operations division in the Ministry of Long-Term Care. Good afternoon, Chair and committee members.

The long-term-care operations division is responsible for implementing the regulatory compliance inspection program for the provincial long-term-care sector, which serves over 100,000 Ontarians annually. Long-term-care homes account for $6 billion in government spending that helps to ensure that long-term-care residents have access to the high-quality, specialized care that they need. Working with our partners across Ontario, the division is leading the modern risk-based inspection approach to ensure long-term-care-home licensee accountability and implementation of legislation, regulation and policy that is related to long-term care.

We recognize the ongoing dedication of health care workers in long-term-care homes and other sectors across our province, which has been critically important during these unprecedented times. We also recognize the dedication of our inspectors, who are also health care professionals, for their contributions in response to COVID-19.

The challenges posed by the COVID-19 pandemic have required a collaborative approach with leaders in our health care system across Ontario, including the province's hospital and long-term-care-home sector. This collaborative approach took many different forms, but the partnership between long-term-care homes and hospitals played a significant role in managing outbreaks and ensuring the safety of residents and the sustained operation of the homes.

Given that it is a highly contagious acute respiratory illness which causes higher mortality in peopled aged 60 years and older, COVID-19 posed a significant risk to residents of long-term-care homes. Residents of long-term-care homes are particularly vulnerable and at a higher risk of an adverse outcome and becoming infected, since they live in close proximity to others. Elderly adults experience a decline in the effectiveness of their immune systems, which makes it more difficult for their body to fight off viruses, infection and disease. This is one of the reasons that COVID-19 and many viruses like the flu can have such a detrimental impact on older adults.

**1710**

Additionally, 74% of older adults aged 65 years and older live with at least one chronic condition, and one in four Canadians over the age of 65 is living with frailty. These underlying health conditions further impede the body's ability to fight off and recover from illness, making viruses such as COVID-19 more dangerous to elderly residents. Addressing this risk to elderly residents meant rapidly implementing solutions across a sector that comprises over 620 homes across the province with more than 78,600 beds.

The long-term-care sector employs over 52,000 dedicated staff who provide interdisciplinary care. These dedicated staff include on-call doctors, nurses, personal

support workers and allied health professionals, such as physiotherapists, dietitians and programming staff. They provide high-quality, resident-centred care to some of our province's most vulnerable and increasingly medically complex individuals.

During the early stages of the pandemic, LTC homes experienced critical staffing shortages that were of great concern. With staff off sick, in self-isolation after COVID-19 exposure or staying home with their school-aged children, most homes struggled to maintain their workforce. Additionally, many part-time staff in long-term-care homes worked in multiple homes or in other parts of the system. To control the spread of the virus, the government implemented an emergency order that limited staff to working in a single long-term-care home.

Partnerships between long-term-care homes and hospitals were instrumental in providing the additional staffing support needed to control outbreaks and help prevent them in the future. On April 24, 2020, amendments to emergency order O. Reg. 74/20 were made to allow defined health service providers, including public hospitals, to redeploy staff to provide assistance in long-term-care homes. These partnerships between hospitals and long-term-care homes are similar to the mandatory management orders that are sometimes issued when there are significant and persistent compliance concerns in a home that need to be addressed with external assistance.

In many urgent cases, voluntary management contracts were entered into between long-term-care homes and hospitals, and the result was a positive relationship that greatly benefited the homes' residents and staff. Once the contracts were approved, the hospital managers, in conjunction with the respective home's administrator and licensee, identified goals and associated timelines in a detailed management plan. The ministry was closely involved with the finalization and approval of these plans.

While a separate emergency order was in place limiting long-term-care-home staff to working in a single home, an exception was made to allow hospital workers to complete shifts in long-term-care homes as well as the hospitals. Furthermore, hospital workers who deployed to a long-term-care home in outbreak were allowed to return to their home facility and self-monitor for symptoms if they were asymptomatic and, if appropriate, infection prevention and control precautions were followed with no breach in personal protective equipment use. In the event that there were breaches in personal protective equipment use, the staff was symptomatic or the staff was being tested for COVID-19, they were made to self-isolate for 14 days from the last exposure or until symptomatic cases went 24 hours without symptoms.

Hospital managers were given the ability to set staff schedules and assign duties for their staff within long-term-care homes, while assuring staff that they remain employees of the hospital, with all the rights guaranteed to them under their collective agreements.

Hospital staff provided vital assistance in the form of infection prevention and control program assessments; clinical supervision; medication administration and nursing; and personal support services, including assistance with feeding residents of the long-term-care home.

Another important element of this partnership was knowledge-sharing between hospital staff and long-term-care home staff. This took the form of new education and training policies, procedures and practices to ensure a high-quality of care and services to the residents and families of the home.

The collaborative approach and development of continuous quality improvement programs helped this partnership have a lasting impact on the home. Hospitals would also assist with the financial management of the home, including the maintenance of general ledgers, payroll, accounting, accounts receivable and collection services.

There were frequent opportunities for long-term-care home staff and hospital staff to work together to operate the home and meet the needs of residents while making the many changes needed to control infection outbreaks.

These contracts were vital to assist homes that were experiencing unresolved outbreaks with a high spread of COVID-19 among residents and staff, and a high number of deaths. They also alleviated the persistent staffing concerns that were common, despite the best efforts of the homes to obtain staffing supports.

Before contracts between hospitals and long-term-care homes can come to a close, there is a thorough transition plan developed by all parties to ensure that the home is stable and ready once again to operate independently.

The detailed transition plans take into consideration all aspects of operating the home, with residents' safety in mind as well as operational sustainability. These plans outline strategies for ongoing infection prevention and control, adequate staffing, effective home leadership, the acquisition and proper use of personal protective equipment, and the provision of care to residents.

The ministry, once again, played a role in the finalization and approval of these plans—

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

We'll be going to the opposition. Madame Gélinas.

**M^me^ France Gélinas:** My first question about what you were talking to us about, the voluntary management contract with the hospital, is, who paid the hospital staff to go into long-term care?

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

**Mr. Richard Steele:** In the case of either a mandatory management order resulting in a management contract or a voluntary management contract, the practice we've been using throughout the pandemic period is that the long-term-care licensee would pay the hospital costs in that context.

I'll just add that in other contexts where hospitals were assisting without a management contract—so they were just providing support; maybe they were providing some IPAC expertise, for example, to the home—generally speaking, that was not charged to the home, that was a cost

the hospital incurred and ultimately charged back to the Ministry of Health.

**M^me^ France Gélinas:** Through their regular yearly budget, or it could be—

**Mr. Richard Steele:** It could be supplemental. Hospitals were asked to track any additional costs associated with that, and that process of reconciling and flowing funds is still under way. But, yes.

**M^me^ France Gélinas:** Has any money flowed to the hospitals for this?

**Mr. Richard Steele:** I can't actually comment on whether the Ministry of Health has as yet flowed any funding directly. Certainly, it was clearly indicated to hospitals that the funding would be available, so that funding should not be an issue in slowing down their response. I think that was very clear. But whether the cash has actually flowed yet, I don't know. That would be a question we'd have to take back to the Ministry of health.

**1720**

**M^me^ France Gélinas:** When you talk to us about the $25 million in March and April, $45 million and now the $405 million, would you say that some of that money that the homes received could have been used to pay for hospital staff?

**Mr. Richard Steele:** Well, again, in most contexts where hospitals were assisting, it wasn't in the context of a management contract, so there would have been no need to do that. In the limited number of cases where there was a formal management contract between a home and a hospital and ultimately the licensee would have been required to pay, I guess that's theoretically possible, although again I would actually need to go back and check as to whether we were considering that to be an eligible expense for our prevention and containment funding. Let me get back to you on whether that would be considered an eligible expense.

I would note that, in general, where a home was in a situation that required that kind of hospital intervention, they would already have been experiencing very significant costs to manage the outbreak. So I'm guessing that the funding we're providing would have been dedicated to those costs they would already have incurred and the hospital costs may have been over and above that.

**M^me^ France Gélinas:** I'm going to switch over to PPE. So now we have hubs from Ontario Health, the regional distribution and all of this—you have committed to every home getting eight weeks of PPE. I take it those eight weeks are eight weeks of inventory on-site. Am I right in thinking that way?

**Hon. Merrilee Fullerton:** That would be my understanding, yes.

**Mr. Richard Steele:** That's correct.

**M^me^ France Gélinas:** Would that also include N95s?

**Mr. Richard Steele:** Yes, it does.

**M^me^ France Gélinas:** Has the sector looked at all at P100s, and are they useful? They're the respirators.

**Mr. Richard Steele:** I'm probably not the best person to speak to N95 alternatives. Certainly, through the spring, there were a lot of conversations around what your potential alternatives to N95 respirators could be—were they sufficient and adequate, and under what context they could be used. At this point, because the supply situation is quite different, as the minister has mentioned, than it was in the spring, we believe there's adequate supply of N95 masks and that's what would be used, so there's less focus right now on potential alternatives.

**M^me^ France Gélinas:** Right now, every home can have up to eight weeks of PPE in their own inventory. Are they all buying through Ontario Health, or are some of them just using their usual suppliers that they've always used?

**Mr. Richard Steele:** To clarify, the eight weeks we're providing, we're providing at no charge, again as part of ensuring that that particular aspect of prevention is fully taken care of and that the funding that we're providing can be used for other things, particularly staffing. So that particular piece of supply the province is providing at no charge. For example, if a home is in an outbreak situation and running their supply and they need emergency supply, that again the province will supply at no charge through the provincial pandemic stockpile. Homes, though, should be continuing to maintain their own supply chains. That is part of what we're indicating to them. As we provide those eight weeks of supply as inventory just to ensure they have that on hand, they should be continuing to maintain their own supply chains, which they have been and will continue to do so. At this point, our commitment is that it's a time-limited commitment, to make sure every home, as we head into the fall, has adequate supply of PPE. They would continue to maintain their own supply beyond that.

**M^me^ France Gélinas:** So the eight weeks is not a rolling eight weeks, as in they have eight weeks of inventory on-site. That's what you're giving them so that everybody's ready, but if they use them, they're on their own to make sure that more supplies restock the inventory?

**Mr. Richard Steele:** At least at this point in time, yes, they should be continuing to restock through their regular supply chains. This is something we can continue to look at, obviously. But at this point, our commitment is a limited, one-time commitment, plus the emergency supplies, should they get into difficulties.

**M^me^ France Gélinas:** How did you come up with eight weeks? Why not six? Why not 10?

**Mr. Richard Steele:** I think it was just a level of inventory that we felt would be appropriate for people to be holding as we head into the fall. It is an inventory that we would like to see the sector maintaining in parallel with a commitment that we felt could be made safely from the provincial stockpile at this point.

**M^me^ France Gélinas:** If we look at when the minister did her first speech, she talked to us about how there are 50 homes; 13 of them—I think you said five; I forget the exact number—had more than three residents.

For the homes that are in outbreak—have they come to you with requests for more PPE or requests for more supplies or any of that?

**Hon. Merrilee Fullerton:** There are a number of ways that homes can access supply, either through their own,

through the provincial stockpile or on an emergency basis through the regional table. If the deputy can expand on that?

**Mr. Richard Steele:** Yes. Firstly, the PPE situation is one of the things we monitor very, very closely with any home in outbreak and ask them to report on daily.

In general, homes have entered the fall with a good inventory of PPE, and so far, that has not been a major issue. We have had a couple of homes in outbreak indicating particular items that they are low on, which have been shipped out to them.

We'll continue, absolutely, to respond on an urgent basis. If there is a home in outbreak that is short of a particular item of PPE, then we will make sure they have it.

**M^me^ France Gélinas:** Of the homes that are in outbreak right now, are you able to tell us if any of them still have four people to a room?

**Hon. Merrilee Fullerton:** As far as I know, there are four homes that have significant numbers above five. It's my understanding that those homes do not have ward rooms, but I would have to check back on that. It is something that we're monitoring—because as I said, the data did not exist. We're creating that data so that we have that information to draw upon. We are in contact with the homes to identify their risk based on ward rooms.

Would that be accurate?

**Mr. Richard Steele:** Yes. Certainly, the first two significant outbreaks we saw in the fall—two homes in Ottawa—neither of them had any residents in ward rooms. For the ones that we've been seeing over the last week or so here in Toronto, I would need to confirm that. I don't believe so, but I would want to confirm that for sure.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong.

**Ms. Teresa J. Armstrong:** I wanted to ask the deputy minister: When did the government start providing this provincial PPE supply to long-term-care homes? When did it begin?

**Mr. Richard Steele:** The kind of formal and, if you like, unconditional offer of PPE from provincial pandemic stock on an emergency basis was made to homes in April. Prior to that, as homes were reporting issues, certainly efforts were made through the Ontario Health regional tables and then back into the pandemic stockpile to try to respond to those. But in April, a process was very clearly communicated through which homes could access emergency supplies from the provincial pandemic warehouse, so that's been in place since then.

**M^me^ France Gélinas:** Was it free back then? Did you give it or did they have to buy it from the government?

**Mr. Richard Steele:** Any emergency supplies that have been provided have been provided at no charge. There hasn't been a process for reimbursement. Yes, the PPE has been provided at no charge on that emergency basis.

**The Chair (Mr. Peter Tabuns):** Ms. Armstrong.

**Ms. Teresa J. Armstrong:** I wanted to go into the topic of home outbreaks. There are 50 long-term-care homes in outbreak right now. Most of these homes are new outbreaks. Can the minister explain why these homes are back in outbreak? Did any of the 50 long-term-care homes in outbreak request funding or resources that they didn't receive? And can the minister confirm if the homes in outbreak still have four people in a room?

**1730**

**Hon. Merrilee Fullerton:** The outbreaks are considered outbreaks in long-term care when there is one staff who may be self-isolating at home because of a positive COVID-19 test or as soon as there is a resident case. There are as many outbreaks—51 homes in outbreak—largely because they are of the staff coming in from the community. We know that there is a correlation between the community prevalence, or the number of cases of COVID-19 in the community, and the likelihood of an outbreak in a long-term-care home. That is well established. When the staff test positive, even though there may be no resident case in that home whatsoever, that is considered an outbreak, because it allows us to have public health engaged immediately and provide the resources and the scrutiny that's needed quickly and on the ground.

But looking at the definition, it's odd and I think hard for people to understand in the public that there are this many outbreaks, and 38 of them with no resident cases—not a single case in the home. I think that that is something that really needs to be clarified with people. As I said, we have 13 homes with resident cases right now, and only four homes have five or more resident cases. All the other cases of outbreaks are one, two or three resident cases. So they're holding quite well. But again, this is something that we have a lot of scrutiny on, on a regular basis, to understanding the staffing and the PPE and how we support these homes.

In terms of the costs associated with this, this is an ongoing effort to make sure that our homes are getting the support they need, to understand what their needs are. You can imagine that during the process of a COVID-19 outbreak, if there are multiple residents, that these homes are very busy and their focus is on residents. We are patiently waiting to make sure that we can have a good understanding of what the dollar numbers are and what resources they might need in that capacity.

I'll ask the deputy if he'd like to comment on any further details.

**Ms. Teresa J. Armstrong:** Sorry; if the deputy is going to comment, could I get a clarification on: Did any of the 51 homes that the minister just identified in outbreak request funding or resources that they didn't receive? Can the deputy minister confirm if any of the homes that are still in outbreak have four people to a room?

**Mr. Richard Steele:** In terms of the last question, in terms of the ward rooms and which homes still have more than two people in a room, we're currently looking at an approach to getting regular updates from the sector on exactly what the status of that is. As we mentioned in response to an earlier question, we have been seeing since the spring the number of rooms with more than two residents gradually declining. That is changing on a weekly basis, and changing for the better on a weekly basis. That's a piece of work we have under way with the

sector that will give us a regular, very granular picture of exactly which homes still have more than two residents in any rooms.

In terms of the specific homes in outbreak right now, I would have to get back to you on whether any of those homes have ward rooms with more than two individuals. I think, again, it will require that more detailed data-gathering from the sector for us to respond to that question.

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

**M^me^ France Gélinas:** To continue with what you just said: You're monitoring; it's going down. We're trending in the right direction. We're now at 93% occupancy. Most of the difference is because the four-bed wards are not being used anymore. I like all of this.

Do you have a time frame as to when we will get to a point where nobody is with three other people or two other people, that there's no more than two? Do you set yourself an end date for this?

**Mr. Richard Steele:** We haven't, is the short answer, in large part because it depends on the individual dynamics within the home. Unfortunately, part of that, of course, is residents who may pass away, which is generally how space is created in a home. So it does depend a little bit on how that plays out in the months ahead. We haven't set a specific target as to when we think that will be accomplished.

I think what we can do, now that we've got a number of months behind us, is to take a look at the trending and what's the monthly change we're seeing. I think from there we probably could actually establish, if not a target, then at least a sense of when we think we would reach the point of no more than two residents in a room.

**M^me^ France Gélinas:** Is this an actual directive from your ministry—that the homes cannot have more than two residents to a room?

**Mr. Richard Steele:** Well, again, it isn't a directive from the ministry that they can't have more than two right now. It's a directive, actually, from the Chief Medical Officer of Health that admissions should not occur that would result in occupancy above two in a room. So it is, really, part of Dr. Williams's direction in directive 3 around admissions into long-term care that is driving that decrease over time.

**M^me^ France Gélinas:** Am I right in thinking—so homes have single rooms, double rooms, wards—as a room becomes available, let's say in a double room, that they would move someone from the ward to the double to empty their wards? Or could they still admit to a single room, admit to a double room, although they still have wards?

**Mr. Richard Steele:** Maybe I can ask ADM Sheila Bristo to just clarify the policy there.

There have been various policy clarification questions around how that admission policy should be interpreted. I think the policy intent would be yes, to your question, where—

**M^me^ France Gélinas:** Good answer.

**Mr. Richard Steele:** —a space outside of a three- or four-bed room opens up, we would be moving versus continuing to fill up and leave people in the ward room.

But let me ask Sheila if she's able to clarify any further on that point.

**Ms. Sheila Bristo:** Hi.

**Mr. Peter Tabuns:** Welcome back.

**Ms. Sheila Bristo:** Thank you.

**The Chair (Mr. Peter Tabuns):** Please introduce yourself again.

**Ms. Sheila Bristo:** I'm Sheila Bristo. I'm the assistant deputy minister of the operations division in the Ministry of Long-Term Care.

One of the things that we know about admissions in homes is that it is more complex than what people would think. For one thing, we do take into consideration the resident's choice in terms of their desire to move rooms. As I mentioned earlier, we reserve certain rooms for cohorting. We also reserve rooms for isolation. So some of those single rooms are held for purposes like that, so that we can move people around if we have to if there is a home in outbreak.

With regard to whether ward rooms are still being filled up or are still full, and if a vacancy occurs in a semi-private or a private room, if those rooms—

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

*Interruption*.

**The Chair (Mr. Peter Tabuns):** You really are.

To the government: Ms. Triantafilopoulos.

**Ms. Effie J. Triantafilopoulos:** Chair, I'd like us to call on MPP Lorne Coe, who has some questions.

**The Chair (Mr. Peter Tabuns):** Mr. Coe.

**Mr. Lorne Coe:** Good afternoon. My question is for Minister Fullerton.

Minister, I want to turn to capacity in the long-term-care sector if we could, please. It's been clear since our government took office in 2018 that capacity is a major issue that has built over years. In my riding, for example, it has built for the better part of 15 years. I'm in the region of Durham, as you well know—you've been out here often—where we had 611 net new beds come online when the population over the age of 75 grew by over 170,000 people.

I know that there are a lot of challenges to development, so it was heartening to see the accelerated-build announcement last summer, where 2,800 new beds to modern design standards will be built rapidly at three sites, one of which is at Lakeridge Health, Ajax Pickering, where we were pleased to have you come out.

Could you give us more detail on that program, Minister, and what else is being done to develop new beds and redevelop old ones up to modern standards?

**1740**

**Hon. Merrilee Fullerton:** Excellent question.

Obviously, a significant focus of our government is our commitment of the $1.75 billion to go towards the capacity in long-term care. But not only do we need to build capacity; we need the staffing to go along with that. That's understood. I know that has been raised many times, but we need that capacity.

With 38,000 people on the wait-list, we're looking at 15,000 new beds in five years and 30,000 new beds in 10 years, understanding that the redevelopment has to go along in many instances, in many projects—because there are newer beds being built, but the older homes can be redeveloped and those beds redeveloped so we don't lose that stock. That's critical—to be able to have an increasing supply instead of just replacing the old homes. Certainly, the homes built in the 1970s haven't been redeveloped or renewed, because the funding formula just didn't work—the construction costs, the development charges, issues that were quite regional. When we started out as a new ministry in the summer of 2019, we got to work immediately, understanding why that was lagging and why some of these projects were just not getting built. It was clear from speaking with the sector and the consultations that we did very diligently that the funding model was broken, so we got to work, consulting with the sector, understanding the regional differences between rural, mid-size, urban and large urban. That's where we landed on those four categories.

All across Ontario, you can see where the needs are. I don't think there's one region that doesn't believe it's got the largest seniors population in all of Ontario. It seems that way everywhere. Certainly, in the highly populated areas, the construction costs, the land costs, were a huge hurdle for homes to overcome. With the accelerated builds, or what we call the rapid builds, basically involving three campuses—four buildings, each one of 320 beds, for a total of 1,280 beds—the understanding is that these beds will help alleviate the pressures that really are going right back into the hospitals, with hallway health care.

I've looked in this area for probably the last 14 years to understand how our hospitals and our long-term-care homes function together. It really is the back door of the hospital that is the problem for hallway health care—so it's looking at how we address that in an expedient way, so that we can get our residents the care they need when they need it. Also, in parallel to that, we're looking at innovative programs—not just the building, but understanding how we can keep people in their own homes longer—community paramedicine, home care and working in partnership with the Ministry of Health on the home care aspect and the long-term-care wait lists, looking at how we improve and accelerate the capacity, streamlining our processes in the ministry to make sure that we have project managers who are speaking to the projects directly, so that there isn't an assembly line of waits for the processes.

We know we need to get these homes built, and we know we need to shorten that time frame. So we have 129 projects that are in the queue, some of them already going. The total would be about 9,000 new beds over the next few years, and redevelopment of about 12,000 older beds to modern design standards. That's not including the rapid or accelerated builds that we're in the process of expediting to make sure that the hardest areas to build are accommodated, which also tend to have high needs.

These are areas that we're working on right now. The modernization agenda, as I said, we started right away as a new ministry. This is in conjunction and happening in parallel to the emergency measures we were taking with COVID-19, the stabilization of the sector, because all of this has to move at the same time. Nothing can be left behind; it all has to keep moving. I just want to thank the sector, everyone who was involved in the consultation and, again, the parliamentary assistant for helping with that. She did a wonderful job.

I know that much of what we do is about relationships and communication, and that's what we have to keep working on in our sector to make sure that we can keep moving the ball forward and get these projects up and going.

I think I've covered everything that I wish to cover on this, at this point. If there's any—

**Mr. Richard Steele:** I think we should bring in Brian Pollard, who's leading our work in this area. He'll certainly add to that.

**Hon. Merrilee Fullerton:** Sure.

**Mr. Brian Pollard:** Good afternoon. I am Brian Pollard. I'm the assistant deputy minister for the long-term-care capital development division. I'm happy to give some remarks today in relation to the development program.

Let me start by just reiterating as strongly as possible that long-term care continues to be a top priority for the government. Developing new and redeveloping old long-term-care capacity, as the minister has just said, is critical, as Ontario's long-term-care system has become strained due to changing demographics and more diverse and complex needs of long-term-care residents. This has led to additional pressure on the province's health care system and is leaving people to wait too long for the care they need.

COVID-19 has further underscored the need for new and redeveloped long-term-care capacity that meets modern design standards—with an emphasis on "modern"—and provides safe environments that are better prepared to protect residents, caregivers and staff, and prevent any future outbreaks.

As part of a transformational strategy to end hallway health care, the government of Ontario is building a 21st-century long-term-care system that:

(1) is resident-centred;

(2) builds capacity and access for residents and caregivers to ensure Ontarians get the care they need when they need it;

(3) is responsive and flexible to residents and sector partners;

(4) reduces regulatory burdens and administrative barriers; and, last but not least,

(5) addresses gaps in the system.

The government has committed to the creation of 30,000 new long-term-care beds over the next decade to modern design standards, and over the next five years, the government is investing $1.75 billion to develop and redevelop long-term-care homes. By making smarter investments to modernize our long-term-care system, we can build long-term-care homes with a safe environment

and ensure our loved ones have access to the care and comfort they deserve, now and in the future.

To support the government's commitments, the Ministry of Long-Term Care has created a modernization strategy that commits to, number one, integrating long-term care within the broader care continuum—you've just heard about partnerships, and this speaks to the concept of a broader care continuum. By that, we mean we're defining long-term care's role within a transformed health care system and the broader care continuum that will focus on Ontario's most vulnerable seniors and ensuring seniors are properly supported in their homes.

Number two, quality of care: implementing innovative staffing and service models that meet the complex needs of residents to achieve a high quality of life.

Number three, oversight and accountability: improving quality assurance and fostering quality improvement through a range of oversight, accountability and performance measurement mechanisms that ensure safety and incent continual improvement of resident outcomes.

Number four, physical infrastructure: modernizing, accelerating and improving the development process of long-term-care beds, to create new beds and redevelop existing older beds to modern design standards.

It's in this last area that I want to spend some time. Within the area of bed development, the government supports long-term-care development projects across the province that will add more long-term-care bed capacity and redevelop existing older long-term-care beds to modern design standards.

Today, there are approximately 78,000 long-term-care beds in 626 homes across Ontario. Today, 129 projects are at various stages of readiness in Ontario, representing nearly 9,000 new long-term-care beds and 12,000 beds to be redeveloped, as the minister has just noted.

As of October 5, yesterday, there are 33 projects that have an executed development agreement, including projects that are under construction. These projects represent 1,643 new beds to be developed and 3,179 existing beds to be redeveloped.

**1750**

In terms of applications to the program, in October 2019, the ministry released the 2019 application for long-term-care-home development to support the implementation of its modernized long-term-care-home development program. As of September 25, 2020, the application is now closed. We are now evaluating applications to get long-term-care homes into areas where they are needed and to meet the needs of Ontarians.

Applications are being evaluated based on alignment with program objectives, alignment with policy priorities, project readiness, financial viability, ability to address local need and compliance history, as applicable. The priorities were developed in consultation with the sector. Policy priorities aim to improve outcomes and use additional long-term-care capacity effectively.

Some of the priorities include:

More flexible care structures—by this, we mean to address the needs of patients and residents who are medically complex, cognitively impaired and physically dependent and whose care needs cannot be met within existing programs. We're looking within the applications for evidence of homes being able to satisfy these needs. This includes individuals with multiple or chronic diseases, cognitive impairment, dementia or responsive behaviours or who are totally or extensively physically dependent for daily living support. We know by looking in our data that there is a significant cohort of these people who are either at home or getting stuck in hospital.

Number two, expanding care models—by this, we mean addressing specialized care needs. Applicants are encouraged and were encouraged to offer tailored program supports for models of care as part of their proposal. This can include programs supported by technology, care that's tailored to meet a community's linguistic and/or cultural needs or programming and services for the cultural and linguistic interests of persons of a specific religious, ethnic or linguistic group, such as francophone communities and/or Indigenous peoples.

Number three, increasing care capacity—increasing affordability and/or facilitating patient flow across care settings through partnerships. You heard a bit about that previously. The ministry evaluates an applicant for partnership within the Ontario health teams and other health and social institutions on expanding access to basic beds in our campus-of-care model.

When reviewing a long-term-care development application to develop new or existing beds, the ministry considers how a proposed long-term-care home would meet the needs of the community. This may include proposed programs and services to address the growing complexity and diversity of residents. All approved projects will now be eligible for a modernized funding model, as the minister just indicated, that will tailor government funding to each project's regional needs and will get projects under way faster.

A bit about the modernized funding model: On July 15, 2020, the government announced a redesigned modern funding model that will lead to the building of additional modern long-term-care homes to provide seniors access to quality care. This new funding approach will accelerate the construction of long-term-care projects and will ensure that beds are developed and redeveloped in places most in need. This new approach will help break down historic barriers in the construction of urgently needed long-term-care-home projects and new and redeveloped beds.

The new funding approach moves away from the previous one-size-fits-all funding model, which has not spurred development nor accounted for regional differences that deeply impact land, construction and other development costs.

The new funding model will help speed up construction by creating four new market segments based on geographic location, as the minister has just indicated, each of a targeted home size. These four geographic locations are categorized as large urban, urban, mid-sized and rural.

It will also provide an increase to the province's 25-year construction funding subsidy, and by that, we mean

there's a construction funding subsidy that we pay out over 25 years, which will be tailored to each of these four market segments, enabling the government to address the barriers and needs of different communities.

The funding model also provides development grants between 10% and 17%, depending on the market segment, to cover upfront costs of development charges, land and other construction expenses. We have repeatedly heard that equity availability was a significant concern for the sector, and these development grants are aimed at addressing that barrier.

It also helps small operators in rural communities navigate the high cost of development while also ensuring larger urban centres can secure real estate they need—and increasing funding to incentivize the offering of base accommodation and continuing top-ups for small and medium-sized homes.

Collectively, this is a key step towards repairing the cracks in our aging long-term-care system, addressing the growing wait-lists, building healthier and safer communities and ending hallway health care.

The Accelerated Build Pilot Program is an alternative approach to building more beds that the ministry is currently working on in partnership with Infrastructure Ontario. The government announced the Accelerated Build Pilot Program in July, which will speed up the construction of 1,280 new long-term-care beds in large urban centres that have traditionally experienced barriers to development for various reasons, as the minister just indicated.

To overcome the land availability challenge, the homes are being built on hospital-owned lands. Under conventional building approaches, it takes an average of 36 months to build a long-term-care home once the applicant has secured a site and financing. The pilot program is part of the government's plan to create new long-term-care beds across the province that meet modern design standards, including such features as air conditioning and private or semi-private rooms, beginning immediately.

Large urban centres are areas of high-service need and have a critical need for additional long-term care capacity, but they are difficult to build in due to issues like land availability and land cost. The Accelerated Building Pilot Program is using accelerated construction measures in order to build rapidly, while still achieving modern design standards that will provide a safe and secure home for residents.

The project aims to build four new long-term-care homes in approximately 14 months: two homes with up to 320 new long-term-care beds each will be developed and operated at Trillium Health Partners in Mississauga; one home with up to 320 new long-term-care beds to be developed and operated at Humber River Hospital's Finch site in Toronto; and one home with up to 320 new long-term-care beds to be developed and operated at Lakeridge Health's Ajax Pickering Hospital site in Ajax, as MPP Coe just mentioned.

Working together with our long-term-care and health system partners, the government is using innovative ideas and modern solutions to help end hallway health care and increase long-term-care capacity in communities across Ontario.

In 2018, the province announced a more efficient process for selling surplus government properties, along with acquiring surplus properties to be evaluated for their potential to achieve government social objectives, such as increasing long-term-care spaces. The ministry, with its government partners and Infrastructure Ontario, has identified six surplus properties for expedited delivery of long-term-care outcomes in regions that are in critical need of long-term care. The ministry and IO are currently preparing the sites for marketing the disposition, with the requirement to deliver and operate long-term-care beds on the sites. Part of the preparation activities includes the application of government levers, including the use of minister's zoning orders to zone for long-term care and for residential uses as required for a site; as well as other levers that will enable speedy development of long-term-care beds on the sites.

The six priority sites are: the Oakville Land Assembly; 7231 Martin Grove in Vaughan; 100 Bloomington Road in Aurora; the former Hamilton Psychiatric Hospital; the Thistletown Regional Centre in Toronto; and finally, Andy Bathgate in Mississauga. Three of the six sites in Oakville, Vaughan and Aurora—

**The Chair (Mr. Peter Tabuns):** I'm sorry to say that you are out of time, and we have less than a minute left.

With that, I'm going to adjourn the meeting.

**M^me^ France Gélinas:** We don't get to use our minute? I was joking.

**The Chair (Mr. Peter Tabuns):** Don't test me.

The committee is now adjourned until following routine proceedings tomorrow. Thank you, everyone.

*The committee adjourned at 1759.*

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