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Mercredi 7 octobre 2020

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STANDING COMMITTEE ON ESTIMATES

Wednesday 7 October 2020

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mercredi 7 octobre 2020

The committee met at 1546 in room 151 and by video conference.

MINISTRY OF LONG-TERM CARE

The Chair (Mr. Peter Tabuns): Our committee comes to order. 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 six hours and 31 minutes remaining for the review of these estimates.

When the committee last adjourned, the government had just finished their rotation. We will begin with the official opposition. Ms. Armstrong, the floor is yours.

Ms. Teresa J. Armstrong: Thank you, Chair. We covered the COVID-19 responses yesterday a little bit, but I'd like to go into this a little further. When did the minister receive her first briefing on COVID-19? And can the deputy minister provide details on the calculation it has created to determine how much funding the long-term-care homes would need to prevent and respond to COVID-19 this fiscal year? If I could just get those two questions out first.

Hon. Merrilee Fullerton: Thank you. As you've heard me say many times, the COVID response was a coordinated effort, with the Ministry of Health as the lead and the command table, with the expert tables and the various tables. So that was started, and our deputy feeds into that command table. That was the process by which the response was to be created.

Speaking in terms of our own ministry efforts to look after our long-term-care homes, that started well back at the end of January, early February, where we worked in conjunction with the Chief Medical Officer of Health to provide guidance to the sector. But work had already been started at the command table structure.

I'll pass it to the deputy.

Ms. Teresa J. Armstrong: Sorry. Minister, you don't have a timeline when you met?

Hon. Merrilee Fullerton: There were many meetings over that span of time. In the early days, the Ministry of Health and the command table were the leads. At the Ministry of Long-Term Care, Deputy Steele was there and—you started new at that time too, didn't you?

Mr. Richard Steele: Yes, I started in March.

Hon. Merrilee Fullerton: Yes, so it would have been the previous deputy who would have been in those briefings. Certainly, I was kept apprised of events on an ongoing basis, but that is the way it was structured.

The Chair (Mr. Peter Tabuns): Minister, I apologize. You're a soft-spoken person and—

Hon. Merrilee Fullerton: Do you want me to sit closer?

The Chair (Mr. Peter Tabuns): I think I do.

Hon. Merrilee Fullerton: Okay. We've moved this forward. We had the technician's help with that earlier. There we go. Is that better?

The Chair (Mr. Peter Tabuns): I think it is, yes.

Mr. Richard Steele: In terms of the second question around how we calculated the funding requirements for long-term-care homes to deal with COVID, starting in March, and through the spring, in fact, our priority was to try to get—we knew the sector would have a need. To be honest, I don't think any of us knew at the time exactly what that need would be, because none of us knew exactly how the pandemic would unfold. The objective was to get some funding out to the sector quickly so that they would have that supplementary funding to deal with some of the items we talked about yesterday: staffing, PPE, infection prevention and control and so on.

The immediate funding that was made available in March, I think I mentioned yesterday, was $25 million, and then a subsequent $25 million for April. We then ramped up to approximately $45 million a month for the subsequent months. As I mentioned, we're just completing a process now with the sector to get them to tell us what they have actually spent and reconcile that against what we've provided, to try to understand whether the allocation formula we used in the spring is appropriate or whether, in fact, certain homes and certain situations need more. Maybe some need less as well. That process is ongoing and will then inform how we would be allocating the $405 million that was announced last week.

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So we'll be looking at that data from the sector in terms of what the experience has been to date. Even going forward, realistically, it will still be an estimate of course, because we don't know what's going to happen in the next six months. We'll need to keep looking at it and keep reconciling with the data and understanding what the actual spending is and whether we need to continue to adjust.

Ms. Teresa J. Armstrong: The plans that the government asked for from the long-term-care homes—you've reviewed them, I'm assuming. Based on those plans, is the $405 million projected correct funding, or is it underfunded? Are you looking at what the homes have put in

their plans, compared to what's allotted, what's allocated? Does that meet their needs?

Mr. Richard Steele: I think it's actually impossible to say at this point. Clearly, $405 million is a significant investment in the sector. We think it will go a long way to whatever those needs may be. But it will depend, obviously, on what we see through the course of the fall in terms of what the COVID experience is and what the level of outbreak is.

We do know, for example, that homes that go into outbreak do spend significantly more money than a home that isn't in outbreak. Obviously, the amount that will be spent between now and next March, for example, will depend to some degree on how many homes go into outbreak. As they go into outbreak, they do need more staffing. If staff, unfortunately, are COVID-positive and off work sick, homes may need to bring in temporary staff, which costs more money. They frequently do need supplementary staffing to ensure that resident care is provided and, obviously, significantly more money is being spent on PPE and on cleaning, for example, in an outbreak situation.

So it's not possible to be definitive on what is the exact amount that would be needed between now and next March. The amount we've put out there is our best sense of the baseline, but we will have to continue to review that.

Ms. Teresa J. Armstrong: I know you don't have the actual figure, but could you provide us with an estimate of what you think that figure would be?

Mr. Richard Steele: You mean supplementary to $405 million? I really can't. It could be that the $405 million is bang on. I just don't know at this point. It will require ongoing dialogue with the sector and an ongoing review of the sector as to what their actual spending is.

Ms. Teresa J. Armstrong: Okay. A study last week showed that the NDP government in BC acted quite quickly in addressing the COVID-19 in their long-term-care homes, unlike, unfortunately, the Conservative government here in Ontario. BC did it a little differently. Can the minister please explain whether Ontario's delay to respond quickly is due to the lack of funding? Was that part of it? And can the minister estimate how much funding is needed to move residents into a single room?

Hon. Merrilee Fullerton: If we look at North America or Canada from coast to coast, you have to understand the travel hubs, how the cases were coming into the country and the differences between the east coast and the west coast. If you look at the number of cases in North America, you can see a high concentration of cases on the east coast travel hubs, and just the sheer population of Montreal, Ottawa, Toronto because that is a corridor. That had a significant impact on the number of cases coming in because of the number of flights in the early days.

What I'm getting at here is that BC had far fewer cases coming in, compared to Ontario—and Ontario adjacent to its neighbours either south of the border or to its east. So if you look at the comparisons between BC and Ontario, in terms of how they managed it, even things like the March break played a role in terms of spread or introducing cases back into the provinces.

You have to really look at the macro piece and the micro piece, and the micro piece is looking at the measures we took. Very early, we started—at the end of January, early February—to provide guidance through the Chief Medical Officer of Health to our homes. That was, I think, fully out by about February 3. By March 13, early March—yes, March 12, March 13—we had issued active screening in our homes. That was an early measure, as well. And then we restricted homes to essential visitors only. We were one of the very early adopters of that process and, fundamentally, we did not do it as a full mandate, knowing that some of our homes were in staffing crises for many years and that that might be an intervention that would cause some of the homes to have staffing issues to a greater degree, even though it was being called for by many, many groups. It was something that we took very seriously. So we were actually putting out measures ahead of BC, or at least as early as.

But I think we have to understand that the differences between the COVID cases in the areas that were affected—and certainly that Montreal-Ottawa-Toronto corridor, with its travel hubs, exceedingly concentrated cases coming in. So if we look at the other measures that BC took along the same lines—closing to essential visitors—the measures were taken in similar timing. But to say that Ontario took them late would be misconstrued, in my opinion. The reason why BC would have done better—all you have to do is look at a map of North America and the cases. You can see it's very, all of sudden, in the middle of the continent. You see much fewer cases on the western side, and that is because of travel hubs and the concentration of cities.

So BC has Vancouver. The population is substantially different from Toronto and Ottawa, being substantial in their populations. You have to look at the population. You have to compare that, understand the travel at the macro level and the micro level. You have to understand that the measures we took were very similar in nature. In fact, the measures that we took, through the Chief Medical Officer of Health, were early. This is something that I think is misunderstood.

I'll pass the monetary aspect to the deputy. Thank you.

Mr. Richard Steele: I think I've responded to that part.

Ms. Teresa J. Armstrong: So the question was if there was the funding that was needed to move residents into a single room. We touched on that—

Mr. Richard Steele: Oh, sorry.

Ms. Teresa J. Armstrong: That's okay. We touched on that yesterday, that there are still some homes with wards, with three or four people sharing those wards. I'm just wondering if you had an idea of the estimate that we would need in order to move people into either single or double rooms to get them out of those wards.

Mr. Richard Steele: I don't have a number as to what the financial cost would be to achieve that. I think the issue for us, practically speaking, would be less the financial cost and actually just the fundamental availability of the

capacity. So it isn't so much a financial constraint on moving to no more than two people in a ward room; it is the physical constraint of capacity in the system. Obviously, we started the year with 99% occupancy in long-term care, and while that is reduced now, as those ward rooms do empty out, there is not a lot of spare capacity in the system to move people to. So it is more a question of time and capacity than a constraint around money.

Ms. Teresa J. Armstrong: My colleague has a question.

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

Mr. Wayne Gates: I just want to do a follow-up on the minister's response to the question. I understand your point where you try to deflect around travel hubs, mentioning March break, but we also have to remember—and I don't know if this had been covered yesterday afternoon; I wasn't here yesterday afternoon. We also have to cover the fact that the Premier told people to go away on March break, even though he had had a number of meetings letting him know that we had COVID-19 in our province and it was spreading.

But the one thing that you didn't touch on in your response, which I think is important to agree with, is that the reason why we had the long-term-care problems we did have—including in my riding of Niagara, which I've talked to you about—whether it be long-term-care or retirement homes, is the severe understaffing of the homes. As we went into March break, prior to that, these homes were told that COVID-19 was going to be in their homes. They didn't have proper PPE, which you haven't talked about.

A lot of these places were privatized compared to those that were publicly owned by regions and stuff. The for-profit, not-for-profit: I don't know if you talked about that yesterday, but certainly that is a big issue on how we go forward. We're not addressing what I believe is the single most important thing on fixing long-term care—after the staffing—which is the fact that we have to make sure that we can't put profits before care. You didn't touch on any of those.

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I know—not just your government, but the Liberal government before you—there has been a bill for a Time to Care Act that would give four hours of care for our seniors. Would your government support that? Are you willing to admit here that some of the problems that we had were the fact that they are understaffed? You've had 10 months to correct that; it hasn't been corrected. Just so you know, I have outbreaks now in my own riding again. The privatization is an issue that you're going to have to address. Will you admit that those are some of the problems why we are where we are today? And we haven't addressed them in the 10 months since we found out COVID was on our shores. Thank you.

Hon. Merrilee Fullerton: I will, first of all, suggest and just state really clearly—no attempt to deflect here, just really looking at the facts. At first, in terms of the staffing, our PSWs are the backbone of our long-term-care homes, and my heart goes out to everyone who has worked so hard—

Mr. Wayne Gates: I can't hear you.

Hon. Merrilee Fullerton: Can you not hear me? Can you still not hear me? Is that better? Do you want me to—I can talk louder, but I really—

Mr. Wayne Gates: There you go. Whatever you did there, do it again.

Hon. Merrilee Fullerton: It's just not the way I talk and it's hard for me to talk that way. If there's any way you can turn up the volume perhaps—yes.

In any case, talking about the staffing, our PSWs are absolutely critical to our homes, and my heart goes out to them. They are our heroes, our champions, and that's the first thing.

But everyone knew, as we became a new ministry, that staffing was in a crisis. That's why we put together the expert panel to provide input into a comprehensive staffing strategy. It's why we took Justice Gillese's recommendations to heart right away, as soon as we became a ministry, to understand what needed to be done.

The staffing study: I'd like to give thanks to our expert panel, who contributed so much to that. Clearly, if you look at the dollars that we've spent improving that, hundreds of millions of dollars going to support our staff, who are so appreciated, in long-term care—whether it's our recent announcement with the $540 million, almost half a billion dollars, going to support our homes, whether it's the $461 million to address the $3 increase to our PSWs in long-term care, whether it's the pandemic pay that we put out to support our staff—it's very clear that recruitment and retention are critical. That's why we've been working, ever since we became the new Ministry of Long-Term Care, to address this. It's extremely important. Really, the staff are the backbone.

We've taken measures. I'll maybe let the deputy go into the details on the dollars, but I just want to address your second part, which is about the ownership.

We look at the ownership—and a number of studies have come out, one of them through the CMHA as well, talking about the prevalence or the number of cases in the public health unit regions where our long-term-care homes are. That is the biggest predictor of an outbreak. I want to remind everyone that an outbreak, as it is currently defined, and it does lead to some confusion, is one resident or one staff in the home who tests positive for COVID. Right now, the bulk of our numbers of outbreaks are related to staff coming in, or being stopped from coming in, actually, who have tested positive. That means our surveillance system of testing is actually working. So we have a very small number of homes that are experiencing resident cases. I think that that's an important differentiation.

But overall, looking at the dollars and the commitment that our government has shown to addressing the staffing issue—you don't just produce PSWs with a snap of your fingers; it does take time. We know we're dealing with somewhat of a neglect of this sector for many years. But whether we're looking at a return of service from the PSWs or fast-tracking or providing our long-term-care homes with flexible options so that they could make sure

they had the proper staffing needed during the outbreaks, all of these were measures taken. We take it very, very seriously and have been acting on this ever since we became a new ministry. Our government, overall, has been very supportive on this, both cabinet and Treasury Board.

I'll pass it to the deputy.

Mr. Richard Steele: I'm just wondering if it would be helpful, to supplement Minister Fullerton's comments, if I could turn it over to ADM Janet Hope, who has been leading our work on the staffing strategy, to speak a bit more about the work of the advisory group.

Ms. Teresa J. Armstrong: I am very interested to hear the presentation, but if I could either ask the minister or the ADM or the DM while giving that presentation to keep these in mind:

Could the minister estimate how much funding is needed per year to make the temporary wage boost permanent? If you've forecasted that, that would be helpful.

As well, can the minister estimate the percentage of long-term-care staff who are full-time and the percentage who work part-time? That would be good information.

And then, lastly, on the staffing piece, can the minister estimate the percentage of long-term-care staff that is hired by temp agencies? I think knowing that information would be a good start.

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

We go to the government. I understand MPP Parsa will be taking things from here. MPP Parsa, the floor is yours. You seem to be muted at this end.

Mr. Michael Parsa: I think I was just unmuted. Can you hear me, Chair?

The Chair (Mr. Peter Tabuns): I can, indeed. Thank you, sir. You're good to go.

Mr. Michael Parsa: Wonderful. Thank you very much, Mr. Chair. I appreciate it.

I want to start off by thanking the minister for all her work. Honestly, your care and your compassion is evident in not only your actions, Minister, but is clearly noticeable in your voice here today, as well as yesterday. We all know that this has been a very difficult period for everyone. Individuals, families and businesses have all been impacted by this pandemic, including our seniors and those in long-term-care homes.

Minister, you touched on this in your remarks yesterday—and I've heard you on other occasions talk about your vision of what long-term-care homes could look like going forward. Of course, there's no doubt you have considerable experience of this sector, both as a former family doctor as well as your own personal experience, which you alluded to, again, in your remarks yesterday. You talked about what institutional long-term-care homes were like when you started practising: for example, residents wearing hospital gowns rather than their own clothes, and so on. Now, I realize there has been some evolution away from that, but I think a lot of homes still get stuck in that institutional mindset.

You talked about the need for resident-centred care and the need to think of these being people's homes as opposed to institutions. Would you be able to elaborate on this for us and let us know what is being done to improve the experience of residents in long-term-care homes, please?

Hon. Merrilee Fullerton: Thank you. That's a very good outline. That's exactly what we've been doing since we became the Ministry of Long-Term Care, a stand-alone ministry, back in the summer of 2019, with a vision for a compassionate way of dealing with our most vulnerable populations and making sure that they are treated with the respect and dignity that they deserve in a place that they can call home. And it truly needs to be a home. We have a complexity of residents that's really increasing over time, and so we understand their increasing complex needs. It makes it even more important that our long-term-care homes really be homes, where people can live out their lives with the support that they need in a caring and compassionate way.

I mentioned this the other day, I think: We need to have our long-term-care homes be places where our residents can live, and really live, the rest of their lives, not places where they go to stay. Over the decades of being a family doctor and in and out of long-term-care homes and dealing with families, I've seen how challenging it is to change the nature of what it used to be 30 years ago. But our homes have made progress in this.

We still need to keep moving in the direction to provide the right culture and the right environment so staff want to work in our long-term-care homes, that they see themselves as valued members of a health care team. Whether we're looking at creating more roles for our staff so that they can be part of teams, they can be part of research, they can really be part of innovative programs that are being done in some of our long-term-care homes across Ontario—and really bring another level of interest to encourage people to want to work in long-term care so that they also bring their best selves when they're supporting our residents and their families, because it really is a ripple. The staff bring their best interests and their desire to provide compassionate care, our residents get the care, families feel supported and communication is part of that. We see when that's done well. We can all learn from that, and homes across Ontario can learn from that. It really is a whole-person approach.

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I really strongly believe that as our population ages, we have to find a resident-centred long-term-care system that is modernized so that our most vulnerable people will get the care they need, our staff in long-term care are supported and the families can have the communication they need, and integrate this with the complexities and the support of those complexities that medical expertise and health care expertise can provide. Again, that integration with our hospital expertise is not to create our long-term-care homes as institutions or hospitals, because they're not intended to be that; they're intended to be homes.

But how do we integrate the medical expertise that is in our hospitals and other areas of health care and not leave to the last the importance of emotional, psychological and psychosocial well-being? These things are all connected:

safety, health and well-being. They're all vitally important to individuals and, also, the culture of the home and the leadership of the home. It's all combined.

We've seen the toll that our lockdowns have taken with our residents in long-term care. Initially, very significant measures were taken by the Chief Medical Officer of Health in conjunction with our ministry, the command table and the Ministry of Health to ensure the safety of residents. It's very clear that the essential caregivers have an important role to play in our long-term-care homes to support our residents and, in many ways, to provide a better functioning of our homes.

These are all pieces that I really look forward to being part of: that innovation, that movement forward, repairing and rebuilding long-term care and advancing long-term care. We're all touched by it, each and every one of us, in some way. It's absolutely critical, and I know that our government is behind this. I am supportive in this process. It must be done, and we will continue to advance long-term care.

Mr. Richard Steele: I think ADM Sheila Bristo had a couple of comments to add to the minister's comments.

The Chair (Mr. Peter Tabuns): MPP Parsa, have you completed your questions?

Mr. Michael Parsa: Yes. If the deputy minister would also like to add anything from his standpoint, I'd really appreciate it.

Mr. Richard Steele: I think ADM Sheila Bristo was going to add a couple of comments on this particular point.

The Chair (Mr. Peter Tabuns): Okay.

Mr. Michael Parsa: I'd appreciate it. Thank you.

The Chair (Mr. Peter Tabuns): Ms. Bristo? I think we're sorting out the muting. We can see you're trying—

Ms. Sheila Bristo: Yes. Thank you. I needed to be unmuted.

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

The Ministry of Long-Term Care is committed to the safety, dignity and well-being of residents in long-term-care homes. The Long-Term Care Homes Act is designed to help ensure that residents receive safe, consistent, high-quality care that centres on the resident. Every resident has a plan of care that evolves with their care needs. This includes care for medical, nursing, personal support, dietary, recreational, social, religious and spiritual needs. We understand the importance of high-quality nursing and personal care. For 2020-21, the government has announced an investment increase of $102 million to maintain the overall quality of care of residents. This new investment will help support nursing and personal support care and programs and services for residents and their families.

We also know the crucial importance of protecting the rights of residents. The Long-Term Care Act establishes a bill of rights for every resident in a long-term-care home. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. Residents have the right to be protected against abuse and the right not to be neglected by the licensee or staff. Residents have the right to live in a safe and clean environment and exercise the rights of a citizen. Residents have the right to be afforded privacy in treatment and the care of their personal needs, and they have the right to have their participation in decision-making respected. The act also specifies that every resident has the right to participate in a residents' council.

Under the Long-Term Care Homes Act, all homes are required to establish a residents' council, which provides residents with a safe peer-to-peer environment. Residents' councils can advise on residents' rights and obligations, as well as resolve disputes between care homes and residents. Residents' councils also advise homes on ways to improve the quality of life for the residents. The Ontario Association of Residents' Councils supports the sustainability of these councils through the ministry's annual-based investment of approximately $500,000 a year.

Every long-term-care home may also have a family council that can provide assistance, information and advice to residents and their family members. Family Councils Ontario supports the sustainability of family councils through the ministry's annual-based investment of approximately $400,000 per year.

We also understand the need to protect residents through a risk-based compliance framework. The ministry's continual system of inspection into complaints and critical incidents works to ensure that all long-term-care homes and staff understand, respect and follow the intent of the legislation. During the COVID-19 pandemic, inspectors continued to inspect issues that represent a high risk of potential harm to residents and continued to respond to concerns from residents and families. Many inspectors have continued to do this throughout the COVID-19 pandemic.

Every single long-term-care home in Ontario gets inspected at least once a year. These inspections must be unannounced. In 2019, the ministry conducted 2,882 inspections across 626 homes. The ministry's risk-based inspection framework allows us to ensure that we can prioritize homes based on risk, so that homes with complaints, critical incidents or a history of non-compliance and other risk factors are subject to extended inspections. If someone has urgent concerns about a home or a resident, we ask that they call the ministry's family support and action line, a 1-800 number, 1-866-434-0144, which operates seven days a week.

We remained committed to the safety of residents in long-term-care homes. We are continuously working to improve transparency for families and to provide safe environments for residents and staff in long-term care.

I would like to take a moment to acknowledge that the ministry recognizes the unique difficulties that residents, staff and families have faced this year. The COVID-19 pandemic has created unprecedented challenges for residents and staff in long-term-care homes and their families. Together with the Ministry of Health and Public

Health Ontario, the Ministry of Long-Term Care has provided guidance, amended regulations and issued directives and emergency orders to deliver critical services that continue to protect long-term-care residents during the COVID-19 pandemic.

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To support all long-term-care homes, staff and residents during these difficult times, the government has provided an initial investment of $243 million in emergency funding to homes. The government has also approved subsequent investments, including $135 million for ongoing prevention and containment efforts and an additional $114 million to implement several initiatives to support the stabilization of the long-term-care sector, as well as close to $540 million in preparedness funding for the sector.

To improve the residents' experience in long-term-care homes and proceed towards resuming normal operations, the government has implemented a number of important measures. Actively screening both residents and staff of homes is now required. The ministry has also implemented surveillance testing to staff to help identify and contain cases of COVID-19. In addition, we have partnered with hospitals to support homes with medical expertise in infection prevention and control and deployed health professionals to homes experiencing critical staffing shortages.

We have increased and stabilized Ontario's supply of personal protective equipment, including same-day deliveries to homes in urgent need. We have also appointed temporary management at some individual homes. Through rigorous management structures, local hospital partners work with homes to return them to normal operations.

We are thankful for the work of the long-term-care operators and staff across the province, working hard each day to take steps needed to manage and contain COVID-19 outbreaks.

The ministry continues to explore additional measures to help stop the spread of COVID-19 and keep those most vulnerable safe. We know that safety is the number one priority for residents, staff and families.

The COVID-19 pandemic has also had significant economic impacts which, in turn, have led to financial challenges for families seeking care for a loved one. In recognition of these financial challenges, we have taken action to limit cost increases for residents and families. The annual resident accommodation copayment rate increase has been deferred for a period of six months. The new rates that were scheduled to be applied on July 1, 2020, have now been deferred to January 1, 2021, to provide relief to families experiencing challenges due to COVID-19.

During this unprecedented time, the ministry continues to have systems in place to support the well-being of residents and families. We understand that Ontarians with complex health needs continue to wait for spaces in long-term-care homes. We are, therefore, moving forward with improvements, acting on essential learnings from COVID-19 and supporting the accelerated development of new, modern long-term-care beds. Over the next five years, we are investing $1.75 billion in long-term-care homes.

We also recognize the importance of fairness and consistency in access for those who need it. Wait times are posted regionally by home to help families and prospective residents understand availability near them and make informed decisions. Those waiting for placement can access personal support and nursing services provided through the local health integration networks.

In response to COVID-19, the government modified and streamlined requirements for long-term-care home admissions, readmissions and discharge to make this challenging time as simple as possible for residents and their families. This included changes to make sure long-term-care applicants in the community who decline an open space at a long-term-care home are not removed from the waiting list or moved down. New admissions to a long-term-care home or a retirement home can occur if the receiving home is not in a COVID-19 outbreak. This includes applicants from the community or from the hospital, including alternate-level-of-care patients.

It is important that we continue to ensure those who are on the waiting lists for long-term care will receive the care they need as soon as possible. I would like to note that there are also admissions and discharge measures in place to protect residents from the spread of COVID-19. Residents who are newly admitted to homes or readmitted from hospitals are no longer placed in three- or four-bed ward rooms. In addition, residents of homes in outbreak may leave the home if they wish. They are discharged, but when they need to go back, their readmission will be expedited.

Prior to the COVID-19 pandemic, the ministry had been aware of the challenges the applicants to long-term-care homes often experienced. The ministry supports spouses and partners who want to live together in long-term-care homes. In recognition of this, every long-term-care home with regular long-term-care—

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

We go now to the opposition. Ms. Armstrong.

Ms. Teresa J. Armstrong: I just want to go back to the staffing that we left off of. When they're talking about staffing, can the minister, the DM or the ADM estimate how much funding is needed per year to make the temporary wage boost permanent? Can the minister estimate the percentage of long-term-care staff who are full-time and the percentage who work part-time, as well as estimate the percentage of long-term-care staff that are hired by temporary agencies?

If the minister could give us those numbers, that would be great.

Hon. Merrilee Fullerton: The answer to the last question is a very small number, and I will defer to the deputy. I believe it's about 10% or possibly less, but I'm going to ask him to confirm that.

In terms of the full-time equivalent situation, our numbers are in flux right now. I can't give you an exact number. If the deputy has that, I would appreciate him sharing that with you.

And in terms of the dollar amount, I do know it is substantial. However, that is something that we have to carefully consider. It certainly would be a longer-term understanding of the dollars that are required to do this and it is tied, also, to looking at the number of hours per resident, so these have to be taken in coordination.

I'll ask the deputy to comment as well.

Mr. Richard Steele: Thank you, Minister. I'm going to turn it over to ADM Janet Hope, who has been leading our work on staffing. Before I do, I'll just note that, as the minister notes, while the questions of part-time versus full-time and casual staff versus regular staff are definitely questions that our staffing advisory group did some work and data-gathering on, it is important to note that the COVID situation has put some of that into flux. We've certainly seen, in the last number of months, a significant switch from part-time to full-time, with the single-site order that the minister put in place. I heard from one operator last week that their full-time percentage has increased from 45% to 65%, just as one example.

ADM Hope can certainly speak further on the subject.

Ms. Janet Hope: Hi. Thank you very much for the opportunity to address those questions. My name is Janet Hope. I'm the assistant deputy minister of the policy division at the Ministry of Long-Term Care.

A significant source of data for us on the staffing situation in long-term-care homes is a staffing survey that each home is asked to complete annually. The latest year for which we have complete data is 2018. Normally, at this time of year, we might have information on the 2019 data, but given the situation that homes have been facing over the last number of months, we don't currently have that information. So I'm pleased to give you data that reflects the situation in 2018, as reported by our long-term-care homes.

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In terms of the proportion of staff who are working full-time and part-time, I have that broken down by the different categories of direct-care staff. For our personal support workers, in 2018, 41% of those were working on a full-time basis, 48% were working on a part-time basis and 11% worked on a casual basis. For nurse practitioners, 35% worked on a part-time basis; for registered nurses, 41% on a part-time basis; and for registered practical nurses, 45% on a part-time basis.

As the deputy noted, we did have significant discussion with our staffing study advisory group about opportunities to increase full-time work opportunities for care staff—it's an area that the sector has talked about—opportunities to share best practices, some of the challenges in providing full-time employment when it is a 24-hours-a-day, seven-days-a-week operation. There are challenges with scheduling across day, evening and night shifts and weekday and weekend shifts. It's certainly an area where there's a lot of dialogue within the sector. As the deputy noted, we anticipate that at the current time, there is a higher percentage of full-time staff, given the additional emergency funding and the impact of the one-site requirement.

The last question you asked was about the percentage of agency staff. Again, from that staffing study, it was a very small percentage: less than 2% of staff from agencies. We would anticipate that number is probably higher at the current time, given the use of agencies to help when staff are off ill or self-isolating. Thank you.

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

Interjections.

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

Mr. Wayne Gates: I've got to put my glasses on so I can see what I wrote, which isn't a surprise, I don't think.

First, I'd like to say that it's a nice presentation—nicely bundled—but what I want to talk about is what's really going on in long-term care. We knew that the military was called in. They went in; they did an incredible job. We should all thank our military. It's very brave to go into a situation like they did. There's not a lot of training in those types of situations. But when they had to do the report, they blew the whistle on long-term care.

Quite frankly, I think that most people in the province of Ontario and I would think that most MPPs or even my colleagues were probably shocked at what was really going on in long-term care: with rotten food, they had rats or rodents, patients were dead in their beds and they were there for a day. I can give you some examples of that, if you like. They had no PPE. There was not enough staff. Profits were always before care. This is what was going on. I'm not making this up; it's in the military report.

You talked about one outbreak says it's an outbreak. The reality is—and why I think this is so important to discuss—that approximately 2,000 of our loved ones—our moms, our dads, our grandparents—died, most of them in private homes. I had asked the question around private homes, and you didn't really address it. Most—and I'd say not all, but most—were preventable. That's the sad part of this whole thing that has gone on since January.

We've had MRSA in our long-term-care facilities. We were able to get MRSA under control. We've had C. diff in our long-term-care facilities. We did have some deaths from C. diff in Niagara as well. But this was something that we can control and something that we could have done better.

I really believe that your wage increase to PSWs—oh, I'm sure it's certainly welcome. I think everybody who works in long-term-care facilities, quite frankly, should be getting some form of pandemic pay.

My question to you is: With what the military has said, when are we going to put the full-time employees in there, like PSWs, give them the pay they deserve, give them full-time jobs and make sure they have benefits? Retention of PSWs is extremely hard. It's an extremely tough, tough job. Our hearts go out to what they go into every day.

We come to work in this beautiful place, Chair, and we go to work. They know they're going in to work and they're going to have 10, 12, 14 or16 hours of working. All around them it's people who are sick, and yet they give every ounce of energy to that particular person. We've got to provide more care. We've got to provide more full-time jobs and more benefits. You haven't really addressed that.

You've said it before in question period too, and every time you say it, I'll be honest with you, I hate you saying it when you say, "Well, one is only"—we've lost 2,000 loved ones. I'll just finish by saying that in my riding—it wasn't our long-term care facilities; it was a retirement home—21 people died in Lundy Manor on Lundy's Lane. Two parent groups of a husband and a wife died. It was preventable, very preventable, and I think the inspections have shown that. If you've lost your mom or your dad, you know how hard it is. We've lost grandparents. I lost my parents. It's hard with one. Can you imagine losing both your mom and your dad within 24 hours with COVID-19 that was preventable?

It's a bit of a speech, but the reality is that you've got to do better and you've got to make sure that you're taking care of long-term-care facilities. You've got to find a way to make sure that profit doesn't come before care of our loved ones. Thanks.

Hon. Merrilee Fullerton: Thank you. I can definitely feel your passion for this area, and I share the same passion and compassion. My heart goes out to everyone who has been impacted by this. It is a terrible virus, unseen by the world before. It has ravaged countries across the world.

I do really want to thank the military for being there in our time of need. The pre-existing staffing crises, the measures that were taken to protect our residents and staff—and in a small number of homes, it was not sufficient.

Again, I speak to the CMAJ study that was very clear about the prevalence or the number of cases in the public health unit regions really being predictive of the outbreaks. We're very fortunate that many of our homes have managed to overcome the outbreaks, and even as we speak, I believe that of the homes that are now in outbreak, the majority have no resident cases. These cases are staff who are self-isolating at home.

But in the first wave, it was very different, dealing with a situation where there was global competition for the PPE. We were not independent as a province in making our own, as other provinces were not either and many other countries were not. So it was a real global competition for PPE. I want to thank the public servants and everyone—the Premier—for playing such an important role in addressing this issue. Now we are in a much more stable situation with PPE. We're able to produce our own masks, gowns and even N95s. So we really have learned lessons. But again, my heart goes out to everyone who was affected by this.

The toll of influenza—you also mentioned a few enteric outbreaks or MRSA. These are things that do hurt the vulnerable, especially people in long-term care who have, often, complex medical needs, multiple what we call comorbidities: lung disease, heart disease and other issues, diabetes. It's very tragic. They are vulnerable to these germs.

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As we move forward we're adding more and more layers. As I said, the integration with our hospitals has been an absolute key part, and I want to thank our hospitals and staff for helping our long-term-care homes in Ontario. I think this is a very important model to move forward with: how we can integrate the expertise. We need to make sure that long-term-care homes are supported with IPAC. That's exactly what we did in the most recent announcement, is to add more dollars so we can have our homes hire more infection prevention and control and also make changes to their homes to prevent spread or outbreak, with $61.4 million and also the $405 million as part of our $540-million expenditure, recently announced, to make sure that our homes have operational support, whether it's staffing or other measures.

Our government is absolutely committed to long-term care as a priority. I'm very grateful for everyone who has worked through the uncertainties of the first wave. As we head into wave 2, we are much better prepared, with our lessons learned. Clearly, items like rapid tests would be a very major change; you've heard it called a game-changer. They definitely would be.

As we move forward, learning the science from the evolving nature of COVID, working with the health experts, our command table experts, our medical officers of health expertise, Public Health Ontario, Ontario Health, the Chief Medical Officer of Health—these all have to be done in collaboration. How incredibly important it is for all of these people to have been part of this process, providing their expertise.

I understand your passion for this, and I share your compassion. We need to modernize long-term care. That's what our ministry has been doing ever since we started, whether it was addressing the capacity issues, which played a part in the outbreaks, the ward rooms—we've been very transparent about that. Once again, I thank the military for coming in, as was needed. Whether it's the staffing, whether it's the capacity, whether it's the science that we know about, I'm just so grateful for the military, for everyone who is contributing to the solutions. It's absolutely imperative that we keep rebuilding long-term care, repairing long-term care, advancing long-term care, absolutely.

Ms. Teresa J. Armstrong: I'll interject for another question. How much time do I have left, Chair?

The Chair (Mr. Peter Tabuns): Ms. Armstrong, you've got about three minutes.

Ms. Teresa J. Armstrong: Oh, gosh. Okay.

I want to go back to the staffing piece we talked about yesterday. I'd like to inquire about the Justice Gillese staffing report as it relates to long-term-care funding. The Conservative government recently released a staffing report at the end of July. One of the key recommendations in the report was to improve staffing and funding. Has the ministry calculated how much funding is needed to provide four hours of direct care per resident? Has the ministry calculated how much money it costs the province every year because of long-term-care staffing shortages, so things like how much does it cost the province because we don't have enough staff to prevent someone from falling in long-term care? Could you focus on those two pieces?

Hon. Merrilee Fullerton: Certainly. One of our priorities is the staffing study and the comprehensive strategy

that will be out by the end of the year. But we've really been working in three different areas: our emergency response to COVID; the stabilization of our homes, including staffing; and the longer-term aspect of it. All of this is going on in parallel during a trying time, as you can imagine, with dealing with the outbreaks and keeping COVID-19 out of our homes.

As we look, and as I mentioned, it's important to understand the correlation between the hours of care and the number of staff and also the increase in the dollars that we've recently provided—all of these have to be taken at the same time—the $461 million to our long-term-care PSWs, that increase of $3 that we announced last week, really, in hopes to retain.

Some of your question really revolves around how we create the interest in long-term care and make it a place where people want to work, because, as I said, we can't just snap our fingers and have people appear. It does take a very serious, integrated effort, with many measures, not just the dollars. But we have put the dollars behind our plan and are continuing to work with the Ministry of Health in an overall plan, because what we do in one area affects another.

The Ministry of Health, in its fall preparedness plan, indicated the importance of addressing home care PSWs as well as personal support workers in long-term care and in the hospitals—really, those three because what we do in one area can affect another.

Your question is hard to answer because we don't actually know where we will end up in terms of the numbers. We're hoping we'll have substantially more PSWs in long-term care with the measures that we're taking. Obviously, it would make it much easier to be able to provide those four hours of care per resident, but all of this has to be created because of the sheer neglect over the last 20 years of this entire sector.

We, as a ministry, are working very diligently to address these issues. I know the ballpark numbers it would take, but it largely depends on whether we can attract the staff we need with the measures that we're taking—

Ms. Teresa J. Armstrong: Sorry, Minister. If you know the ballpark numbers, would you be prepared to commit to a permanent funding boost to achieve the four hours of hands-on care in the fall budget? Are you looking for that commitment?

Hon. Merrilee Fullerton: Again, it's tied to the number of staff. You have to understand that in order to provide four hours of care per resident, you need the staff to provide that.

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

We go back to the government, and I have MPP McKenna. I gather you will be speaking?

Ms. Jane McKenna: Hello?

The Chair (Mr. Peter Tabuns): Hello. I can hear you now.

Ms. Jane McKenna: Okay. Thanks so much, Chair. I just want to, first of all, thank you for all your hard work. You do a phenomenal job as Chair.

I want to bring up a couple of points first to the minister. My daughter is a nurse and my uncle was a chief of staff at SickKids. I told my daughter I was on this committee, and she wanted me to pass through to you that she has a lot of friends who are PSWs and they are thrilled to be at the table with this government because they haven't been in so long. A lot of doctors are saying—because she works at Windsor Regional Hospital—that they're thrilled to be at the table as well.

I want to just reiterate what MPP Gates was saying—a great, valid point about how the military was called in. Obviously, the Premier asked them to come in, but I want to thank you, Minister, for continuing to enhance supports to all places that have the spread, because you stabilized those long-term-care homes to get them back to normal.

There have been lots of situations that have happened in long-term care. When this started and it was separated from the Ministry of Health, I want to commend you because before the pandemic came out, you were doing leaps and bounds, recognizing the problems that we have with PSWs.

I just want to point that out because obviously the pandemic came around, and people talk all the time about how we've had SARS—we've heard that comment a couple of times in this committee, but SARS was a targeted area. People talk about the Spanish flu, but we didn't have international travel at that time. So different pandemics are very different in how we tried to deal with them.

I say all the time that when you work alone, you make progress, and when you work together, you make history. I want to thank you very much, Minister, because you're such a positive force and you've done a phenomenal job trying to do all the things that need to be done. Like you say all the time, we can't make changes as fast as we possibly can. We have had the military in, which MPP Gates brought up, because the Premier realized, along with yourself, that we needed help to do the best that we possibly could for the people who are in long-term care, so my sincere gratitude for that.

I do recognize too, just talking to my daughter about the staffing issues from PSWs—can you elaborate on what progress we have made in addressing long-standing staffing issues in the long-term-care sector, please, Minister?

Hon. Merrilee Fullerton: Thank you for your kind words. It's much appreciated.

To address the staffing issue, it has really been multiple ministries—the Ministry of Health, the Ministry of Long-Term Care, the Ministry of Labour and the Ministry of Colleges and Universities. It really is a multi-ministry effort across government, and also multiple layers of government. We also need to work with the federal government to understand whether there's a possibility of foreign credentialing. These are all areas that are being—we're tapping every possible route.

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I want to put out a big thank you to our expert panel for that staffing study that was done to inform a comprehensive staffing strategy—an amazing group of people who really had their hearts in this. It's been very helpful to understand. They have also recommended the four hours

of resident care, and I think that's an important acknowledgement. They also pointed out the importance of understanding how one area of PSWs affecting that could affect other areas that have PSWs as providers as well. So they were very insightful. We've really taken their recommendations to heart, as well as Justice Gillese's recommendations.

These are all pieces of information—and we worked very hard with our sector as well, our representative organizations, talking with municipalities for the municipal homes, the not-for-profit sector and the for-profit sector to come up with a really deep understanding, as soon as we became a ministry, of what it entails. The most recent one was the $461 million. We also put out, at the very beginning of COVID-19, the $243 million towards supporting staffing measures, but there are many measures going out, as I said, including for IPAC staff: the $30 million I believe was for that, $20 million for hiring and another $10 million for the training, and a $10-million annual training fund for front-line staff to create more flexibility.

We have done many, many regulatory levers to try to provide the flexibility to our homes during the crisis. As I've said, part of our effort was emergency, part of it was stabilization and now, in parallel to all of that, is the overall strategy of how we move forward, because our commitment is $1.75 billion for capacity and to create more homes, thousands of new homes. We acknowledge that we will need thousands of staff. So all of these have to happen in parallel at the same time.

It's a challenge, it's daunting, but it really is about the residents and their families. I have lived this personally. I know what it's like.

I'll pass it to the deputy.

Mr. Richard Steele: Thank you, Minister. I think ADM Janet Hope was going to comment a bit further on the question around staffing.

Ms. Janet Hope: Hi. Are you able to hear me?

Mr. Richard Steele: We can now.

Ms. Janet Hope: My name is Janet Hope. I'm the assistant deputy minister for the policy division with the Ministry of Long-Term Care. I'm pleased to have the opportunity to talk with you about what we're doing in the important area of staffing, building on the minister's remarks.

Long-term-care homes employ over 100,000 people across Ontario to care for approximately 78,000 residents. Most of the staff in long-term-care homes are those who provide direct care to residents. They're personal support workers, registered practical nurses and registered nurses, and some homes, in addition, hire nurse practitioners. In addition, a range of other types of staff are employed, including allied health professionals, such as occupational therapists and physiotherapists, recreational therapists and social workers, dietary staff, housekeeping staff and administrative staff. They all play a role in ensuring that residents experience quality of life.

As has been referenced, Justice Eileen Gillese released her report in 2019, the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System. That inquiry, as you know, was established to understand the events and circumstances which led to the offences of a registered nurse in long-term care. That inquiry included a recommendation directed to the Ministry of Long-Term Care to complete a staffing study that would determine the adequate levels of registered staff to support Ontario's long-term-care homes.

In response to this recommendation, the Ministry of Long-Term Care launched a staffing study in February 2020. That study was launched to provide strategic advice on staffing in the long-term-care sector across the province. The scope of the study was expanded beyond that, as recommended by Justice Gillese, to include the full range of staff and to consider key factors in workforce recruitment and retention.

The study was overseen by the advisory group that the minister referenced. We had 10 individuals who reflected varied perspectives on staffing needs. They included academics, thought leaders from the sector and the family voice. The advisory group engaged with a broad range of long-term-care sector partners, including staff and associations, operators and labour unions, to better understand the range of perspectives on staffing issues facing the sector.

Some of the groups the advisory group engaged with included the Ontario Association of Residents' Councils; Family Councils Ontario; and care providers, such as the Ontario Personal Support Workers Association, the Ontario Society of Occupational Therapists, and Therapeutic Recreation Ontario; as well as nursing organizations, such as the Registered Nurses' Association of Ontario, and the Registered Practical Nurses Association of Ontario. The advisory group engaged with seven different labour unions representing long-term-care staff and spoke with two main operator associations, AdvantAge Ontario and the Ontario Long Term Care Association. There were also a number of individual long-term-care home operators who represent unique aspects of our linguistic and cultural diversity in Ontario and the linguistic and cultural diversity of residents, so there were operators representing the francophone cultural groups and Indigenous operators.

I'm pleased to provide a brief overview of the findings of the staffing study. The study was positioned in the current context of long-term-care staffing and the residents they serve. Those 78,000 residents in long-term care all have unique backgrounds, cultures, health care and personal needs and aspirations. The long-term-care sector, of course, exists to support these Ontarians with round-the-clock care needs. These residents require frequent assistance with activities of daily living and on-site care and medical supervision that can no longer be provided in their homes.

On average, residents in long-term-care homes are 84 years of age. Eighty-one per cent of residents have some type of cognitive impairment, and often they have advanced and ongoing medical conditions and rely on multiple drug therapies. As long-term-care homes have become the homes of increasingly ill people often in the end-stage of their lives, we see higher acuity and care needs than in other care settings.

The study found that as long-term-care homes and staff have responded to residents' evolving needs, staff workloads have increased. Staff reported that they do not always have enough time to provide high-quality and holistic care to residents. Challenging working conditions and a negative public image of the sector have contributed to increased difficulty in recruiting and retaining staff for some homes. While long-term-care homes have been facing staffing challenges for some time, many of these staffing issues were intensified by the COVID-19 pandemic, as members of the committee have been reflecting.

In making their recommendations, the advisory group noted some overarching considerations. They noted that these issues of staffing in long-term care are complex, systemic in nature and long-standing. The solutions are not easy, and a multi-pronged approach that addresses a range of underlying issues will be most successful.

The long-term-care staffing issues also need to be considered within the context of the mobility of the labour market across the health care system. The advisory group asked that governments take care to ensure that measures intended to improve staffing in the long-term-care sector do not have unintended consequences on other sectors such as home and community care.

The advisory group noted that not all long-term-care homes have a staffing crisis, but all are experiencing challenges and some are experiencing quite critical challenges. So the advisory group called on the government to proceed with a comprehensive staffing strategy to urgently address the crisis in long-term-care staffing.

1700

The advisory group called on the province and the sector to work together to make long-term care a better place to live and a better place to work. They reflected that, "Most homes are warm, caring communities," supporting residents and staff, "and most staff are highly skilled and motivated, experiencing rewarding and fulfilling careers.

"There are also incredible volunteers and family members who make up an important part of the long-term-care community....

"But it is also clear" to the advisory group "that resident experiences are not consistent across the sector, and that many dedicated and skilled staff struggle with their conditions of work," and many homes are challenged to recruit and retain the employees they need.

Further, the advisory group reminded us that it is critical that staffing approaches in long-term care "reflect and respond to the diversity of the sector and the diversity of the residents who live in long-term care."

Our homes are in very diverse communities across the province and reflect the different situations of those communities. Given this diversity, a one-size-fits-all approach will not work. "We need to balance between setting the baselines or standards required to promote desired outcomes and providing the flexibility needed to respond to legitimate and appropriate variations in needs and support ongoing innovation."

Within the context of these overall findings, the advisory group provided recommendations within five priority areas that I would be pleased to summarize.

First, the advisory group recommended that the number of staff working in long-term care be increased, as the minister referenced. There was a broad consensus that the number of direct care hours per resident per day needs to increase to alleviate staffing pressures and increase resident quality of life. Specifically, the advisory group recommended moving towards a minimum daily average of four hours of care per day per resident.

There were differences of opinion about optimum staffing ratios and skill mix. However, the advisory group recommended that the ministry could improve staffing ratios and skill mix to reflect the specific circumstances of each home and the makeup of their resident population, increasing the levels of both personal support workers and registered staff.

The second area of recommendations from the advisory group was a recommendation that the culture of the long-term-care sector needs to change at both the sector level and at the individual home level. Some people have described the existing culture of the long-term-care sector as oriented towards regulatory compliance, and this was an observation that Justice Gillese made in her report. While of course oversight and compliance are necessary to ensure that appropriate levels of care are provided to residents, during the study, long-term-care partners reported that staff become overly focused on compliance with regulated tasks, sometimes at the expense of positive resident outcomes.

"A continuous quality improvement approach that places residents at the centre of care should be adopted," was the view of the advisory committee. The feeling was this "would encourage the" kind of "culture change that would support staff to feel respected and experience more job satisfaction," improving retention of staff.

The third area of recommendation was actions to improve workload and working conditions to improve staff retention and to improve the conditions of care. Poor working conditions are a key contributing factor to staff dissatisfaction, high staff turnover and the overall poor perception of long-term care as a career choice.

The advisory group recommended that the ministry take an evidence-based and systemic approach to compensation across health care settings and across occupations, recognizing that compensation parity across settings needs to be considered to reduce compensation-related labour shortages. The report observed: "Many staff and long-term-care partners call for more full-time positions to allow for more stable working conditions...."

It also observed the scheduling challenges of operating 24 hours a day, seven days a week. The advisory group recommended "that the sector work to share experiences and leading practices in maximizing opportunities for full-time hours."

The fourth area of recommendation related to effective leadership and access to specialized expertise: "Effective medical, clinical and administrative leadership is integral to making long-term care a better place to live and work. Leaders set the tone for the workplace, providing direction and oversight on how work is to be performed and are critical drivers of organizational culture."

The advisory group recommended that "the ministry clarify the role ... of the medical director position to bring greater consistency in medical leadership to the staff team." The advisory group also recognized that there's an opportunity to expand the use of nurse practitioners to support clinical leadership in long-term-care homes.

The final area of recommendation from the advisory group was with respect to attracting and preparing the right people for employment in long-term care and providing opportunities for ongoing learning and growth.

The previous recommendations I have referenced—for example, to increase the number of staff, to improve working conditions and to address a punitive sector culture—are expected to improve the perceptions of long-term care as a career destination of choice. However, the advisory group recommended attention be paid to issues of the curriculum and programs that prepare people for work in the health care sector, as well as to issues of how staff are on-boarded and opportunities for ongoing staff support and development.

Opportunities include building stronger relationships with secondary schools to attract new workers into the sector, ensuring there are stronger supports for new graduates to retain new staff, and providing ongoing education and training to more senior staff—

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

We now go to the opposition. Ms. Armstrong.

Ms. Teresa J. Armstrong: I want to just finish off on the staffing part, and it kind of ties into what the ADM was talking about. Recently, the media reported that there were only two PSWs for 60 residents at the West End Villa, which is a for-profit home that has the biggest outbreak right now. Can the minister explain whether she saw how much support this home requested when it submitted its assessment plan?

Hon. Merrilee Fullerton: Well, you're asking me to recollect a specific plan, but what I can tell you is Ottawa is one of the hot zones—Ottawa, Toronto, Peel, York—and so with the number of cases in the communities, it does come into the home with the staff unknowingly. That's really why it's so incredibly important that we have the surveillance testing that we're doing. It is picking up these cases, but COVID, as you know, can spread very rapidly.

West End Villa did get hit hard. Looking at the staffing ratio, when a home is in distress, it can happen very quickly, and when you have a home that's starting to have outbreaks of significant numbers, you might start to see more and more staff having to self-isolate at home. In the case of West End Villa, I can tell you the community paramedics were there, there were agency staff helping, and the Ottawa Hospital is there as well and was there on-site fairly early in this process, as well as the medical officer of health and public health were involved. So all these measures, taken together, are supporting that home, and it is doing much better.

Another home in Ottawa that did have a serious outbreak previously was able to get back on its feet faster. I'm pleased to report that today it has zero resident cases.

We do see the measures that we're taking helping. The staffing in some situations, depending on the area that the home is in, has a contributing factor to the issues we're trying to deal with. There's no doubt about that.

I will let the deputy comment as well—

Ms. Teresa J. Armstrong: You can add to that, but if I could interject just for a moment. You asked for the submissions of assessment plans from long-term-care homes in order to do your fall planning. When were submissions received? Can the deputy minister recall how much support the home was requesting at that time?

Mr. Richard Steele: Thank you. A few comments: The request for homes to complete individual assessments, I think that went out—we can get back to you with the exact date, but towards the end of July or early August was our request to complete those self-assessments and conversations with our Ontario Health regions by the end of August.

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The intent of those assessments was not to receive back very detailed, specific requests from homes around exactly how many staff they need. Part of the assessment, part of what we were looking for the homes to do was to actually think through their own planning and preparedness for what the fall would look like.

In the case of West End Villa, as an example, one of the things that that particular operator, Extendicare, had been doing through the course of the summer as part of their fall preparedness was really to work on their staffing plan. As the minister noted, as a home goes into outbreak, typically it does have a significant impact on staffing, as staff are self-isolating at home or are indeed sick. That particular operator, through their planning, was able to draw on staff from other homes and also from their partner home care organization to supplement staff in the home, as well as bring in temporary agency staff.

Part of the objective of the assessment was to have the home think through their own planning. Certainly, it was also to identify for the ministry where there were still areas of gap that we need to be paying attention to, both at the level of the individual home and even more systemically across the province, what were the things that our fall preparedness plan really needed to focus on to ensure those gaps are being filled.

Ms. Teresa J. Armstrong: I want to talk about funding in long-term care. It's clear that all political parties agree that we need to improve the level of care and the dignity of care provided in long-term care to residents. I'm interested in seeing what the Conservatives will announce in the upcoming fall budget. That's something we're all waiting to see.

In the meantime, I'd like to go back to the conversation that we had yesterday morning, I think it was, when we talked about the level-of-care funding. First, I just want to ask the DM if he could explain to the average Ontarian what level-of-care funding means. I don't think we need to know the details about the four envelopes piece, but can you confirm that the level-of-care funding is the amount of funding that the province provides to a resident per day to get the care in long-term-care homes?

Mr. Richard Steele: Yes, that is correct. There are additional pockets of funding in addition to the level-of-care funding. We've talked about some of them through the course of yesterday and today. There is the minor capital funding. There are various pockets of money that are made available for staff training and so on—the high wage transition fund. So there are a number of elements of funding that are in addition to the level-of-care funding.

Of course, the other significant element of funding would be the capital funding subsidy for a newly developed home. That would be on top of the level-of-care funding—

Ms. Teresa J. Armstrong: Could you please go back and circle to level of care and what that means? How would you describe it to an average Ontarian if they were to say, "We get funding for level of care"? What does that mean to them?

Mr. Richard Steele: Level-of-care funding is intended to provide the per diem, per bed funding for a resident of the home. It covers all of the elements that go towards providing that care for that resident. Staffing is obviously a critical element. It includes other supplies required to care for the resident. It includes food and nutrition.

Again, it may actually be useful—I won't go into detail because I know you don't want me to go into a lot of detail, but—

Ms. Teresa J. Armstrong: For the average Ontarian, the detail—just an overview.

Mr. Richard Steele: I think they are fairly plain-language explanatories. For the average Ontarian, the biggest chunk is the nursing and personal care envelope. Again, that essentially covers the core staffing, nursing, PSW and other staffing to care for the resident; program and support services; raw food; and then other accommodations. Those are the four buckets.

Again, the intent of having the four elements of the funding is to ensure that minimum levels of funding do get provided for those specific elements, so for raw food, for personal care, for programming in support of residents. The fourth, other accommodation, is more of a general bucket that provides the operator with some flexibility as to how that funding gets used. The other buckets—

Ms. Teresa J. Armstrong: Thank you for that comprehensive answer. I think you're getting into other buckets, and I just want to go back to level of care, if I could.

Historically, we've seen in the past several years the percentage of increase for level of care has been 2%. That has historically been the level-of-care percentage. This year, it's at 1.5%. Could the deputy minister confirm that this is a decrease compared to previous years?

Mr. Richard Steele: In total, the level-of-care funding specifically?

Ms. Teresa J. Armstrong: Yes, please.

Mr. Richard Steele: You are correct. In a number of previous years, the percentage increase in the level-of-care funding specifically was 2%. This year, it is 1.5%.

I would note, though, further to your opening remarks, the level-of-care funding is just one element of the overall funding provided by the ministry to the sector. If you look at the total funding being provided to the long-term-care sector this year, it actually increases by 5.3%. So the level-of-care component increases by, as you note, 1.5%, but in addition to that, we do have the other funding elements—the minor capital, the capital development funding—that are being provided that sit on top of that.

Ms. Teresa J. Armstrong: And I do appreciate that.

Because I want to focus on the level-of-care piece, I want to ask you, has the Conservative government cut the level-of-care funding compared to previous years?

Mr. Richard Steele: No, the level-of-care funding has continued to increase year over year—so a 1.5% increase this year. I believe it was 1% the previous year. But the funding has not been cut; it has increased each year, by varying amounts.

Ms. Teresa J. Armstrong: But under the average of 2% historically—it doesn't quite catch up to the 2%.

Mr. Richard Steele: I'm sorry?

Ms. Teresa J. Armstrong: Historically, though, it has been about 2% over the years, so it is lower than the 2% average.

Hon. Merrilee Fullerton: May I just comment here? I think what we're talking about is a rate of increase, and I think that that is confusing. If we want to make sure that the public understands, I think we've got to clarify that point. Year over year, there are more dollars going into level of care. The rate of increase is at 1.5%, and it's the rate of increase that's different. The total amounts are going up every year.

Ms. Teresa J. Armstrong: Okay, fair.

Has the ministry analyzed whether the level-of-care funding is keeping up with the population needs? Does that rate tie into population growth?

Hon. Merrilee Fullerton: When you say "population growth," do you mean—

Ms. Teresa J. Armstrong: Population needs, statistically—as people are getting older, are you forecasting that level of care based on population needs?

Hon. Merrilee Fullerton: You've just struck a really important point, because if we look at the last 20 years and particularly the last 10, when we should have been building capacity and addressing these issues, it just wasn't being done in any substantial way. It really is—the word that comes to mind is "neglect." The neglect of this sector has really left the Conservative government in a situation where we recognized and put long-term care as a priority, not just for capacity but for innovative programs, creating a new stand-alone ministry, putting the dollars behind it—half a billion dollars just last week and hundreds of thousands of dollars before that and our $1.75-billion commitment to creating 15,000 new beds in five years and 30,000 in 10. It's very, very clear that it is our government that has taken this extremely seriously and is really wrestling with the neglect of the last 10 or 15 years.

And so level of care: Yes, if you look at the complexity of our residents in long-term care, that's something that we heard loud and clear with all the consultations that we did. We need to acknowledge that, and that is exactly why

we are modernizing this sector. There are many, many important efforts going on as we speak. It's the vision for long-term care. It's the dollars for long-term care. It's creating innovative ways of retaining staff. It really is a comprehensive effort.

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After decades of watching long-term care be ignored from a distance, as a physician and a family member who went through this with a number of my own relatives, I can tell you this is a breath of fresh air for everyone who has a loved one, or future, in long-term care. We should all be looking at this and saying, "Yes, the neglect, for too long." The commitment of our government, a priority of our government, to the vulnerable people in Ontario—and as someone who watched this neglect, it is heartwarming to see this change.

Ms. Teresa J. Armstrong: Thank you, Minister. Yesterday, the minister indicated that the Conservative government provided a funding increase of $72 million in 2019-20. So its first full year in government, it was $72 million. What is the percentage of that $72 million, as compared to the overall long-term-care budget? And what is the percentage of this year's operational increase, as compared to the overall long-term-care budget? If I could get that.

Mr. Richard Steele: Maybe I can take it backwards. For this year, the overall percentage increase was 5.3%. For the previous year—let me see if I have that. If I don't, I'm going to push this across to see if our CAO Peter Kaftarian is—

Ms. Teresa J. Armstrong: If I could just clarify: So the $72 million that was provided for 2019-20, what's the percentage of that $72 million compared to the overall budget? Are you saying that's 5.3% of the—

Mr. Richard Steele: No.

Ms. Teresa J. Armstrong: No.

Mr. Richard Steele: Sorry. What I'm saying is the actual total increase in spending for long-term care. The year-over-year increase, before COVID spending is factored in, based on our estimates going into the year, it was slated to increase by 5.3%. Again, it's a combination of the increase to level-of-care funding and the increase in funding for the capital development program and a number of other programs.

Ms. Teresa J. Armstrong: So the question I was looking for the answer to was: What is the percentage of the $72 million, as compared to the overall long-term-care budget? What percentage is that $72 million of that budget?

Mr. Richard Steele: I'd have to take a calculator out to do the math, but it would be the $72 million against the previous year's—

Ms. Teresa J. Armstrong: Do you want to do that and submit it later?

Mr. Richard Steele: Sure. We can bring that to you later.

Ms. Teresa J. Armstrong: Okay. And then the other one was—

Hon. Merrilee Fullerton: May I just add—

Ms. Teresa J. Armstrong: Yes.

Hon. Merrilee Fullerton: We do have to understand the context. It is a complex funding model. So I just would encourage the information to be thorough that we provide you in terms of all the other additional funding that has gone on to the ministry in the last year.

Ms. Teresa J. Armstrong: I can appreciate that, but sometimes when you're trying to get specific areas and analyze it, then those questions, I think, are where we're going.

The other one I wanted to ask, and again you can do the percentages and submit them later: What is the percentage of this year's operational increase, as compared to the overall long-term-care budget? Would that be something you could work out and provide?

Mr. Richard Steele: We definitely can. I just want to make sure I completely understand the question, so we can get the appropriate figure. So the percentage?

Ms. Teresa J. Armstrong: What is the percentage of the $72 million, as compared to the overall long-term-care budget?

Mr. Richard Steele: Yes.

Ms. Teresa J. Armstrong: And then what is the percentage of this year's operational increase, as compared to the overall long-term-care budget?

Mr. Richard Steele: Sure, we can provide that.

Ms. Teresa J. Armstrong: Then the other question I had on funding was, why is the long-term-care funding increase for the past two years still under the recommendation amount to meet the health inflation spending?

Hon. Merrilee Fullerton: I think what you're talking about is the funding that is the copayment. Is that what you're referring to, that it's indexed to inflation?

Ms. Teresa J. Armstrong: Yes.

Hon. Merrilee Fullerton: Okay. And that is the answer: It is tied to the inflation index, and so it is by nature of the increase.

Ms. Teresa J. Armstrong: So was the increase the inflationary rate this year?

Hon. Merrilee Fullerton: For the copayment?

Ms. Teresa J. Armstrong: Yes.

Hon. Merrilee Fullerton: It is. We actually held that during COVID, I believe, so that we did not increase the copayment at that time because of the COVID situation.

Mr. Richard Steele: That is correct, Minister. This year's increase for copay, which would have taken effect in July, was deferred to January 2021.

Ms. Teresa J. Armstrong: I remember the ADM saying that, yes.

Wayne, did you have any more questions? Okay.

It was Janet Hope who had mentioned that there are 100,000 staff in long-term care and 78,000 residents in long-term care. Is there a way to break down the 100,000? There's the dietary, cleaning staff, all that. Is there a way to identify how many PSWs are in that 100,000 in the long-term-care sector?

Hon. Merrilee Fullerton: In the long-term-care sector, I believe the number of PSWs is approximately 65,000 in

that zone. If you've got any more specific numbers—65,000 to 68,000.

Mr. Richard Steele: Thank you, Minister. I think, certainly for the purposes of calculating the pay increase for PSWs, we're working off a slightly smaller number of about 50,000, and that may be because, again, we've shifted a little bit from part-time to full-time. So while the hours are similar, the actual number of individuals may be somewhat less. Perhaps I could ask ADM Janet Hope to provide a more comprehensive answer to the various categories, because I do think we have some information on that.

Ms. Teresa J. Armstrong: Thank you.

The Chair (Mr. Peter Tabuns): You have about 40 seconds left.

Ms. Janet Hope: Oh, okay—enough time to say my name. It's Janet Hope, assistant deputy minister of the policy division, Ministry of Long-Term Care. There is detailed information on page 14 of the staffing study that breaks down, from the 2018 staffing survey, the different categories of employees.

The Chair (Mr. Peter Tabuns): With that, you're out of time.

We go to the government. I understand, MPP Cuzzetto, you're up.

Mr. Rudy Cuzzetto: Can you hear me?

The Chair (Mr. Peter Tabuns): I can now. Yes, sir.

Mr. Rudy Cuzzetto: Thank you, Chair. I would like to, first, thank the Minister of Long-Term Care, our first-ever Minister of Long-Term Care in the province of Ontario. That shows our commitment as a government. I know that long-term care has been neglected for many years in this province. That's why I would like to look at the development and the redevelopment piece for a bit.

It's clear that there are real challenges associated with building new homes or expanding existing ones or redeveloping old ones. It seems like projects can get bogged down pretty easily at any number of the steps in the process. The figure I've been hearing a lot is 36 months from the selection of a site to approval. Can you explain for us how your ministry will remove barriers to developing and redeveloping long-term care in the province of Ontario, and especially in my riding of Mississauga–Lakeshore?

Hon. Merrilee Fullerton: I can tell you, first of all, that there is an amazing group of MPPs. I've been very grateful to work with them and understand what their needs are in their ridings. We were able to make some announcements before we were really inundated with more efforts here. Looking at Durham and MPP Coe, the accelerated builds in that area, 320 beds—and MPP Cuzzetto and MPP Coe, you've been great. MPP Michael Parsa, thank you for all your good work. And to MPP Triantafilopoulos, thank you. It's much appreciated, all the work that you do.

What we really looked at is the commitment of this government to $1.75 billion for the 15,000 new beds in five years. We looked at what had happened over the previous years. Between a number of years leading up to 2018, only a few hundred beds had been built and the wait-list was growing. We were at 38,000 people, so clearly we needed to act quickly. The rapid builds were one piece, but also looking at the modernized funding model—because looking back in previous years, it was very clear that these homes just weren't getting built.

We took time to consult with the sector to understand what needed to be done and to add more dollars to address the differences in the regions, whether it's mid-size, rural, urban or large urban. These were really the four categories that we landed on to understand the needs in these different areas, these different categories. Whether it was land development that was the problem, construction costs, development charges or simply just the cost of the land, particularly in the Toronto area, looking at how we could help our homes get up and going with those construction projects and streamlining the process so that the homes that we're looking to redevelop—not only build new beds but also redevelop older beds so that we wouldn't lose that stock, how we could assist them by streamlining the process. And we've had good feedback about that.

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But once again, I thank MPPs Donna Skelly and Jane McKenna and MPP Pettapiece for all your work with your constituents and the homes in your areas, for letting us understand and allowing us to listen and hear your voices and, through you, the voices of the sector to understand what needed to be done.

The construction funding subsidy needed to be addressed, and that's why we announced that modernized funding model. We are really thrilled about that because we have 129 projects that are on the go. This is going to create almost 9,000 new beds and almost 12,000 redeveloped, so we're well on our way.

I know it can't come fast enough, but that's why we are also looking at other innovative programs to help residents be able to stay in their own homes longer. We know it's going to take many solutions and it's going to take all of us really working together to address the long-standing issues that have been so badly neglected for so long, but we're really taking every measure possible.

Thanks to everyone who has provided that feedback to us. Really, your voices in your constituencies are very valued. I can't say enough about the teamwork that will overcome the obstacles to getting this done. Thank you, everyone in the public service. You have been absolutely amazing, really working around the clock to get things done. It's going to take all of us.

Thank you for that question, and please keep the channels of communication open. Let us know what we can do to help our long-term-care homes redevelop and develop new capacity, because ultimately it is about serving residents, serving Ontarians. That's what we're all here for.

Mr. Richard Steele: Minister, I think ADM Brian Pollard has some additional comments in response to the question too.

The Chair (Mr. Peter Tabuns): Are you waving to be unmuted, sir?

Mr. Brian Pollard: Yes, that's right. Thank you.

The Chair (Mr. Peter Tabuns): You're welcome, and if you could introduce yourself for Hansard. Thank you.

Mr. Brian Pollard: Good afternoon. My name is Brian Pollard. I am the assistant deputy minister for the long-term care capital development division. I'm pleased to be here to supplement some of the comments that the minister has just made with regard to the development program.

Before I do that, though, let me just talk a bit about my division and say that the long-term care capital development division is responsible for implementing the government's direction for capital development across the long-term-care sector. Working with our partners across Ontario, the division is leading the design, development and implementation of policy related to long-term-care development. We provide program and sector oversight and administration and administer long-term-care home licences, in addition to our development responsibilities. So that's, in a nutshell, what we do.

For me, personally, for the past 18 years, I have been proud to work with leaders in our health care system across Ontario, including the province's hospitals and long-term-care home sector. Through working with people in the province's health care system, it has provided me with the opportunity to see first-hand the shifting challenges within the system, many—I would almost say all—of which the minister has articulated.

This experience has also provided me insight into the opportunities to improve access to long-term care while also ensuring it is a safe and comfortable environment for residents and staff. That whole issue of safety has been no more pronounced than during the COVID pandemic.

Countless times, we have heard about the issues surrounding our long-term-care system and the resulting pressures on the broader health care system. We recognize the ongoing dedication of health care workers across the province, who have told us that some things need to be done differently. Many individuals are occupying space in hospitals across Ontario because the appropriate care they need, such as care in the community or indeed in a long-term-care home, is not available to them in a timely manner.

Access to a long-term-care bed can vary across the province. As demographics shift, most of us are acutely aware that the number of people on the wait-list has increased, and has increased significantly. Most importantly, most urgently and most recently, the impact of COVID-19 on the long-term-care sector signalled that it was time to begin acting on these concerns, with an emphasis that we do not have time to waste.

As the minister just indicated, between 2011 and 2018, there were 611 long-term-care beds built across the province, out of step with the growing demand for access to care. At the same time, there has been a 24% increase in the number of individuals on the wait-list for long-term-care home placements since 2016 alone. That number is even larger if you look at it compared to 2011. As of June 2020, 38,553 applicants are on the wait-list to access long-term care in Ontario.

Formally, the main source of funding provided by the ministry for long-term-care development projects has been the 25-year construction funding subsidy program. The subsidy was provided to eligible long-term-care home projects that were approved to develop or upgrade long-term-care beds, also known as redevelopment.

The previous model allowed for funding to flow after occupancy if the applicant had met all eligibility requirements, successfully completed construction in accordance with their development agreement, and received ministry approval to admit the first resident. Under the previous model of funding, the upfront costs of construction of long-term-care homes were borne by operators at 100%, so operators had to find significant equity to get their projects moving.

The government has committed to ending hallway health care and to building a modern, sustainable and integrated health care system focused on patient-centred care. As part of this commitment, the government is taking action to create a 21st-century long-term-care system that focuses on residents, builds capacity for them and their caregivers, and provides a place for Ontario's most vulnerable people to call home.

Over the next five years, the government is investing $1.75 billion to develop and redevelop long-term-care homes and is committed to building 30,000 new long-term-care beds over the next decade. This funding will help kick-start necessary investments to increase access to new long-term-care beds while also addressing the long wait-list for long-term care by creating new and redeveloping older long-term-care beds in the coming years.

To end hallway health care, the government recognizes that people who need long-term care should not be waiting in a hospital. At the same time, recognizing the diverse and changing needs of people across Ontario, the ministry has worked with the long-term-care home sector to establish new approaches and opportunities to develop and redevelop long-term-care beds across the province.

One such initiative is the modernized funding model, as the minister has just indicated. On July 15, 2020, the government announced a redesigned 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 where they are needed most. This is an innovative, pragmatic solution which responds to regional realities and province-wide barriers experienced across this overburdened sector.

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:

(1) creating four market segments based on geographic location, each with a targeted home size, and those four market segments are large urban, urban, mid-size and rural;

(2) an increase to the province's historic 25-year construction funding subsidy that will be tailored to each of

these four market segments, enabling the government to address the barriers and needs of different communities within those market segments;

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(3) providing development grants between 10% and 17%, depending on the market segment, to cover upfront costs like development charges, land and other construction expenses;

(4) helping small operators in rural communities navigate the high cost of development while also ensuring large urban centres can secure the real estate they need; and finally

(5) increasing funding to incentivize the construction of basic accommodation and continuing top-ups for small and medium-sized homes.

The new funding model will address concerns about the structure and the sufficiency of funding raised during formal stakeholder consultations that the ministry held in January 2020. The new model of funding will help to get new beds built and redevelop older beds to modern design standards, which will positively impact access to long-term care, reduce wait-lists and support the government's commitment to end hallway health care. This is a key step towards repairing the cracks in the aging long-term-care system, addressing a growing wait-list and building healthier and safer communities.

Of course, closely related to the funding model is redeveloping older beds to modern design standards. By enabling operators to redevelop older homes in the province, the sector will be able to provide safer quality care to the people of Ontario. This means we will be one step closer to bringing aging homes with three- or four-person ward rooms up to modern design standards.

This will also enable long-term-care home operators to redevelop their existing homes, either by building a new home or renovating an existing home so that it complies with the province's current design standards and applicable legislation and regulations, such as the Long-Term Care Homes Act, the fire code, the building code and the Accessibility for Ontarians with Disabilities Act.

We have actively engaged with the long-term-care sector and the people of Ontario to support innovation in the delivery of long-term care and to develop a modernized approach to long-term-care development. By making smarter investments to modernize the long-term-care system, we can build strong homes and ensure our loved ones have access to the care and comfort they deserve, now and in the future. We are committed to building a modernized long-term-care system that better responds to the needs of residents, their families and front-line health care workers.

Our modernization efforts also go beyond the redesigned funding model as part of the ministry's broader long-term-care development modernization strategy. This year, the ministry has modernized the application process for long-term-care development to ensure new and redeveloped beds are where they're needed most as quickly as possible.

Additional efforts were made to modernize the long-term-care licensing process through changes to public consultations. This change provides the Ministry of Long-Term Care with greater flexibility on when and how public consultation is required as part of the licence transaction process. These changes have also expanded the reach of public consultation notices by posting all consultation notices on the long-term care public consultation registry located at ontario.ca to allow members of the public the opportunity to be engaged in the public consultation process. We continue our efforts to further streamline the licensing process and reduce administrative burden and red tape for licensees to develop long-term-care homes in a timely manner.

On July 21, we announced the Accelerated Build Pilot Program. This innovative program is also part of the ministry's broader plan to modernize the long-term care development program and supports the government's objective of creating 30,000 new long-term-care beds across the province that meet modern design standards.

Aimed for completion in 14 months, the program will leverage the expertise of Infrastructure Ontario to advance four accelerated pilot projects: two homes with up to 320 new beds each to be developed by Trillium Health Partners in Mississauga, one home with up to 320 beds to be developed by Humber River Hospital in Toronto and one home with up to 320 new long-term-care beds to be developed by Lakeridge Health in Ajax. These accelerated projects will be completed through a range of accelerating measures such as modular construction, rapid procurement and the use of hospital lands.

In keeping with the government's commitment of putting surplus lands into productive use, this past June, the ministry received approval to work with the Ministry of Government and Consumer Services and the Ministry of Municipal Affairs and Housing to dispose of six government-owned properties with the requirement for the purchasers to develop and sustain long-term-care beds on each site.

We are now also looking at the potential of using additional levers to dispose of the properties as efficiently as possible. These levers include the issuing of minister's zoning orders that allow for affordable housing and other services on the sites, in addition to the long-term-care home. This will help deliver the beds more quickly, raise the value of the sites, introduce other types of necessary development and reduce the fiscal impact to government. Other levers include site severance, removing barriers related to access constraints. Work has begun to expedite the marketing and bidding process and will be critical to getting the beds built sooner.

Although we are cognizant that more work needs to be done, these initial steps will begin addressing the barriers to development so that shovel-ready projects can begin. The work that is currently under way underscores the bold types of solutions that will be required for change. To ensure that we deliver on the government's commitment, we will continue to work with our partners in the long-term-care sector to ensure that Ontarians who need long-term care receive timely access to quality care best suited to their needs in environments that facilitate that care, at

the same time focusing on the capacity and care structures that better respond to the changing and diverse needs of the people of Ontario.

The Chair (Mr. Peter Tabuns): Thank you. With that, time is up for the government side.

We go to the opposition. Mr. Gates.

Mr. Wayne Gates: Just a couple of quick questions and then I'll turn it back over to my colleague. The administration cost for long-term care last year was $1,248,000. In your estimates this year, it's $5,692,000. I'm just wondering why.

Mr. Richard Steele: I'm happy to take that one, Minister. Essentially, it's simply a reflection of the fact that the ministry was only created partway through last year, so what you're seeing is the annualization of the costs. There isn't actually a per-day increase; it's just the annualization of the cost.

Prior to July of last year, the ministry was, as you know, a part of the Ministry of Health, so the administration costs would have been reflected within the Ministry of Health's estimates. It goes up because last year it covered only a number of months, and the ministry was still in the process of being created, so it took some time to staff up. So it's really just the annualization of splitting out the ministry.

Mr. Wayne Gates: All right. Thank you. How will the current estimates cover the redevelopment of long-term-care homes?

I'm going to use an example: Gilmore Lodge, which just happens to be in my riding, which is to be built. We obviously have a big shortage of long-term-care beds in Fort Erie—well, quite frankly, in all of Niagara. So how will that affect it?

Hon. Merrilee Fullerton: What is your question?

Mr. Wayne Gates: How will the current estimates cover the redevelopment of a long-term-care home like Gilmore Lodge?

Hon. Merrilee Fullerton: There's a process with the applications and a whole development continuum from the start that the application gets put in until the shovels are in the ground and the home is being built.

I'll let the deputy speak to the details on that.

Mr. Richard Steele: Thank you. I'm just trying to find the right line item in the estimates, and I can certainly do that. But within the long-term-care homes program, there is a line item for the long-term-care development program which covers this year's costs for the funding formula that ADM Pollard just lined out. Basically, the cost of development with the new funding formula is split between the upfront subsidy and then the capital funding subsidy that is paid out over 25 years. So for any individual home, the actual redevelopment costs will be reflected over, essentially, a 25-year period in the ministry's estimates. You won't see it all in one go.

For this year—again, I'm just trying to find the exact number, but I believe there's about $100 million—

Mr. Wayne Gates: Just for time, and I know that my colleague has got a number of questions, maybe you can get that back to me when you find out—

Mr. Richard Steele: Sure.

Mr. Wayne Gates: —because obviously it's important to get that Gilmore Lodge built as soon as possible. I appreciate it. Thank you.

I'll turn it over to my colleague.

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

Ms. Teresa J. Armstrong: I wanted to ask about the hospital decanting process, when it comes to hospital to long-term-care home. If you could speak to that, please.

Hon. Merrilee Fullerton: Early on, that was in wave 1 and that was something that we were trying to understand fully. We had discussions with the ethics table, which really drove the point home that this is a resident's home and that there are legal requirements around movement of any resident from the home. Obviously, they are not going to be moved if they cannot be moved physically or if they do not want to be moved. But if their medical condition requires them to be moved, they will absolutely be moved to hospital, and that is something that the medical expertise will determine.

But looking at how hospitals can support our long-term-care homes, there was a table or a task force looking at all the different considerations. It has to be a very thoughtful process to understand the rights of the resident, the medical implications, the safety of the resident and the well-being of the resident.

Some of you would know how frail some of our residents are in long-term care and simply a transfer could be threatening to their life. Many of them do have advance care plans. They are allowed to refuse medical care, and so this is something that is very much about their rights as residents and that the long-term care is their home. The decanting concept has to be taken very carefully.

I don't know if the deputy has anything he wants to add to that.

Mr. Richard Steele: Really, just to reinforce the point that that issue of decanting—and it is an area that both through the spring and more recently, as we head into the next wave, we've certainly given some thought to and sought the best clinical advice on. But it is really guided by those two things the minister mentioned: firstly, obviously resident choice and what does the resident want, and then clinical guidance from both a long-term-care clinician and an acute-care clinician perspective.

If a resident requires or could benefit from acute care and it is their wish to be transferred to acute care—as the minister says, in many cases it is not, but if it is, then absolutely that transfer should happen.

There have been circumstances as well, again with resident and family agreement, in wave 1 where a home was experiencing significant difficulties, where residents who did not necessarily require acute care were transferred to hospital just because it was felt that the residents could be best protected in a hospital environment while the home got the infection under control. Again, that is a very situational analysis and decision that is made between the clinicians supporting the long-term-care home and the clinicians in the hospital and residents and their families in terms of what's most appropriate for their care.

Ms. Teresa J. Armstrong: I wanted to use the Norwood long-term-care home as an example, because it's been taken over by management agreement. What criteria does the province use to place a home under a management agreement and who pays for this?

Hon. Merrilee Fullerton: The mandatory management agreement comes about when a home is in distress. What we do is we look at coordinating a hospital or partner to help support that home. Mandatory is exactly what it means. It's being required for the home to do this. The voluntary management contract is a contract that's taken on voluntarily, just like the name implies. So there is a process. There's a number of levers that we have, but our role here with the Ministry of Long-Term Care is really to allow that to happen. I know the term gets used: "taking over homes." The Ministry of Long-Term Care does not take over homes. It coordinates actions and support for the homes using partnerships. That is one mechanism.

The other mechanism that's available is through the medical officers of health. That has been used on a number of occasions through the Health Promotion and Protection Act to allow these partnerships to be required.

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

Mr. Richard Steele: Thank you, Minister. Yes, the decision is situational. Really, it is a question of looking at a particular home situation, Norwood being an example. In that case and many others, despite the best efforts and great efforts of the home, a collective decision, in many cases, is made that the home could benefit from additional management support in managing the outbreak and in ensuring that the infection can be contained. So it is situational around an assessment by the ministry and Ontario Health, sometimes in collaboration with the home and sometimes not, that the home could benefit from additional management support, in addition to whatever other support hospitals may be providing.

It is important to note that in many instances hospital support is being provided without the need for any kind of management contract in place, and that can work very well too in certain circumstances. Again, Norwood would be an example of a voluntary management contract where it is a collective decision, including with the home, that they could use some additional support from hospital management.

In terms of the second part of your question, as to who pays: Where we do put a management contract in place with a hospital, then that is the responsibility of the licensee to pay for any additional costs the hospital may have.

Ms. Teresa J. Armstrong: I didn't quite get an answer to the criteria. You mentioned it's situational, but is there a trigger of criteria that makes that a situational piece where there's an agreement, voluntary or mandatory, where it's being taken over?

Mr. Richard Steele: Yes, typically—between a voluntary management contract and a mandatory management order, they both end in the same place, which is a management contract with a hospital. A voluntary management contract is a situation where the home and the hospital are voluntarily entering into an agreement. That is the tool we've used most often.

There have been a few instances where we have used mandatory management orders, which is essentially where we are using a compliance tool under the Long-Term Care Homes Act. There are a couple of scenarios that could trigger that. One is if there is, for whatever reason, a sense that the licensee may not be moving quickly enough to either implement your direction and advice or agree to receiving outside management. The mandatory management order does allow things to move a bit quicker too, so in some circumstances, even if there's agreement, the mandatory order can just allow things to move that bit faster if that's what we believe to be necessary.

Ms. Teresa J. Armstrong: I'm going to squeeze in another question, if I could. How does the ministry track or monitor whether long-term-care homes are spending the COVID money on the actual response to COVID? What's the auditing process to ensure that the money is being spent on the residents for the response to COVID?

Mr. Richard Steele: When the funding is provided, there is a funding agreement that goes with that funding that does require them to account for how it is being spent and, ultimately, to attest—this forms part of their published accounts—that the money is being spent for the required purpose.

We have, as I mentioned earlier, put out a kind of interim request for homes to identify what they have been spending that money on so that we can understand, again, (a) has it been sufficient, (b) where are the needs, and (c) do we need to adjust the funding allocation formula that we've been using so far? At year end, we will do a full reconciliation of the spending to, again, ensure that it has been spent where it was intended to be spent.

Ms. Teresa J. Armstrong: Any more time, Chair?

The Chair (Mr. Peter Tabuns): You have about 30 seconds. Use it well.

Ms. Teresa J. Armstrong: I think I'll just say thank you for the responses you did give to us. I look forward to some of the numbers that we talked about: the $72-million percentage of the total long-term-care budget and the operational piece of that.

We'll see everybody in the morning. Thank you.

Mr. Richard Steele: No, in two weeks, I think.

The Chair (Mr. Peter Tabuns): Yes.

That is, in fact, all the time we have available today. The committee is now adjourned until October 20 at 9 a.m.

The committee adjourned at 1800.

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