Submission to the Standing Committee on the Legislative Assembly

Bill 175, *Connecting People to Home and Community Care Act, 2020*

Tuesday, June 16, 2020

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A. INTRODUCTION TO ACE

The Advocacy Centre for the Elderly (ACE) is a specialty legal clinic under the *Legal Aid Services Act* that was established to provide a range of legal services to low-income seniors in Ontario. Its mission is to uphold the rights of low-income seniors, and its purpose is to improve the quality of life of seniors by providing legal services which include direct client assistance, public legal education, law reform, community development and community organizing. ACE has been operating since 1984 and was the first legal clinic in Canada with a specific mandate to serve older adults and with expertise in elder-law issues.

ACE currently employs six lawyers, two paralegals, an administrative coordinator, and two administrative assistants. On average, ACE annually receives over 4,000 calls from older adults, families of older adults, health and social service providers and other callers. More than 65% of the intakes and client cases that ACE assists with are in the area of health law. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province. From time to time, ACE also receives inquiries from outside of Ontario.

Clients regularly seek our advice on issues relating to home care. Specifically, ACE has received numerous calls regarding:

- Callers being unable to access home care due to waiting lists;
- Callers advising that they do not receive sufficient home care hours to meet their health care needs;
- Callers advising that their home care hours have been reduced due to shortages of personal support workers (PSWs) in their area;
- Callers concerned about the poor quality of home care services;
- Callers concerned about violations of their privacy by home care workers;
- Callers advising that they are not receiving necessary home care due to workers, particularly PSWs, not showing up for scheduled shifts;
- Callers advising that they have a revolving door of PSWs, and do not receive any continuity with their caregivers;
- Callers reporting PSWs refusing to attend where the caller has previously complained about abuse by a PSW;
- Callers claiming service cuts imposed as retribution for being perceived as a “difficult” client, or for making complaints; and,
- Callers who require long-term care being forced out of the health-care system and placed in unregulated transitional housing, and who are unsure of their rights or complaint options.

ACE also has a high number of calls regarding unregulated care facilities that are used by hospitals and Local Health Integration Networks (LHINs) to house "alternate level of care" (ALC) patients while waiting for placement into long-term care homes.

ACE lawyers are in high demand as speakers on all issues relating to older adults including home care, long-term care homes, retirement homes, consent and capacity law, and elder abuse. ACE lawyers have made many presentations on these issues at the local, provincial national, and international levels.

Given ACE's experience in legal issues affecting the rights and interests of older adults in Ontario and throughout Canada, we trust that our submissions concerning the proposed changes to the Ontario home care system will be of some assistance.

B. DEMAND FOR THE WITHDRAWAL OF BILL 175

a. Timing and Haste of Bill 175

Bill 175 proposes sweeping changes to the home care system in Ontario. If passed, it will adversely affect the more than 700,000 people who rely on home care, the majority of whom are seniors. The Bill also has implications for the provision of care in public and private hospitals and for the delivery of non-licenced congregate care. This is not the time to be passing legislation which so profoundly changes health care in Ontario.

Discussion:

Bill 175 has moved at a rapid pace through the legislature, with minimal meaningful consultation with key stakeholders. Significantly, this Bill is being rushed through at a time when Ontarians continue to grapple with a global pandemic, which has had a catastrophic and disproportionate impact on our province's most vulnerable seniors and exposed the tragic human toll of a chronically underfunded and mismanaged long-term care system.

This is not the appropriate time to hastily overhaul home care, given the potential impact on the health and safety of Ontario's seniors. The pandemic has highlighted many issues related to the failure of the healthcare system to meet the needs of seniors: there has been no time to digest and analyze this information in any meaningful way. This legislation was written prior to the pandemic, and in no way takes into account the lessons that could be learned moving forward. Further, we submit that the sweeping changes proposed in this Bill will cause a further erosion of the legal rights of healthcare consumers, will eliminate important oversight of our healthcare system, and will fail to address the healthcare needs of Ontario's seniors.

ACE agrees that changes need to be made to the healthcare system, and to the home care regime in particular. However, these changes must be made with thought and consideration of lessons learned during the pandemic, as well as with broad and meaningful public consultation during a time when seniors', disability and patients' rights advocacy groups are not preoccupied with responding to Covid-19.

Recommendation:

ACE recommends the withdrawal of Bill 175 in its entirety, pending further study and broad consultation with key stakeholders, particularly seniors and disability-rights advocacy groups, especially in light of the lessons that can be learned during COVID-19.

C. GENERAL CONCERNS RELATING TO BILL 175

a. Moving Statutory Provisions to Regulation

With the proposed repeal of the *Home Care and Community Services Act, 1994,* virtually all key provisions respecting home care in Ontario would be moved from statute to regulations.

Discussion:

ACE is acutely troubled by the transfer of substantive provisions, such as the Home Care Bill of Rights, from statute to regulation, which puts the rights at risk of change or elimination by Cabinet.

While merely technical matters that are necessary to make a statutory scheme operational may well be delegated to regulation-making authority, the substantive legal rights of Ontarians to receive high quality home care and the broad outlines of the home care program should remain enshrined by statute. Any changes to these rights and to the outline of the program design are matters that should always remain under the direct supervision of the legislature.

Ontarians receiving home care deserve to know that their rights and the processes for complaining and appealing violations of these rights are not subject to change without meaningful public consultation, and are enshrined by statute. We believe that many of the key provisions in the *Home Care and Community Services Act*, *1994,* should remain in statute, including, but not limited to:

- The definitions of Community Services, Community Support Services, Homemaking Services, Personal Support Services and Professional Services;
- The contents of the Home Care Bill of Rights;

- The broad service requirements imposed on provider agencies, including: development of a plan of service; provision of the service in a reasonable timeframe; and, the requirement to put people on a waitlist if the service is not immediately available;
- The nature and process of home care appeals and complaints; and,
- The nature of non-licenced residential congregate care.

Recommendation:

The bulk of the *Home Care and Community Services Act, 1994* plus any rules regarding new residential congregate care should remain in statute and not delegated to regulations.

b. Bill 175 Fails to Address Chronic Underfunding

The issues consistently raised by seniors calling ACE, as outlined above, will not be addressed by Bill 175. The root of most of the complaints ACE receives stem from underfunding of home care, hospitals and long-term care homes.

Discussion:

There are not enough long-term care beds in Ontario. As a result, seniors find themselves on lengthy waitlists for long-term care while struggling at home with insufficient home care support or they are waiting in hospital. Further, hospitals should have sufficient funding to provide care to patients in their care, and should not require assistance from home care to meet patients' needs.

While there is a place for other types of care facilities, these must be licensed, regulated and properly funded by the Government, to allow those who may not be able to stay in their homes, but are not yet ready for long-term care, to have appropriate care in a safe environment.

Recommendation:

The legislature must be amended to guarantee adequate funding to meet the care needs of those who require these services.

D. REVIEW OF SPECIFIC SECTIONS OF BILL 175

a. Bill 175, Schedule 1 *Connecting Care Act, 2019*: section 3

3. Section 21 of the Act is amended by adding the following subsection:

Home and community care services

(1.1) The Agency may provide funding to a health service provider or Ontario Health Team for the purpose of the provider or Team providing funding to or on behalf of an individual to purchase home and community care services.

The summary of the Proposed regulations provides further explanation of the above section:

- Proposed amendments to the *Connecting Care Act, 2019* would require organizations receiving direct funding from Ontario Health for the purpose of providing home and community care services to be not-for-profit. This is a continuation of the current home and community care delivery model where both LHINs and agencies approved by the Minister under the *Home Care and Community Services Act, 1994* were required to be not-for-profit.[1]

- As with the current model, the ministry is proposing that these not-for-profit organizations will be able to deliver services directly or indirectly through contracts with for-profit and not-for-profit providers.

- These Health Services Providers would be responsible for care coordination – whether they are part of an Ontario Health Team or not – and would have the flexibility to assign care coordination functions to contracted providers or, through mutual agreement, to partner organizations with the goal of improving system navigation, reducing transitions for clients and eliminating duplication in assessment and care planning [emphasis added].

Discussion:

Currently, the LHINs are public Crown agencies established by the Government of Ontario to plan, coordinate, integrate and fund health services at a local level. Each LHIN is governed by its own Board of Directors appointed by the Province. LHINs contract home care services to both for-profit and non-profit providers. LHINs also

[1] The proposed regulations misidentifies "approved agencies" as being funded through the LHINs when they are actually agencies approved by the Minister pursuant to section 5 of the *Home Care and Community Services Act*, *1994* and funded pursuant to the *Local Health Integration Act, 2006,* or the *Connecting Care Act, 2019.*

provide some direct services, such as placement and care coordination; limited direct professional services; direct personal support services in areas where contracting out was not possible; and school visiting nurse programs.

Under the proposed model, it appears impossible to ensure that these Health Service Providers are not-for-profit. To date, most Ontario Health Teams have no legal structure: that is, they are neither not-for-profit or for-profit entities. The composition of these teams includes members from a wide variety of sectors, including the for-profit sector. Even if the Ontario Health Team itself eventually obtains not-for-profit status, if the controlling groups are for-profit, we submit that this will undermine the intent of the regulations.

Furthermore, the proposed regulations indicate that other entities providing the various services could also have the coordinating function. As the vast majority of these are for-profit corporations, we believe that this not only would be contrary to the proposed regulations, but would also not be in the interest of the residents of Ontario.

We submit that allowing for-profit companies to provide the dual function of care coordination and the provision of direct services would create a serious conflict of interest that risks placing profits above the care needs of many of our most vulnerable citizens. We are concerned that these companies will engage in a "race to the bottom", by cutting corners in favour of saving money. It would be in the for-profit company's interest to underestimate the home care needs of a client, so that the client would be forced to spend their own funds paying privately for the gap in their care needs. The current pandemic has exposed the reality of privatizing health care, as privately run long-term care homes have had significantly higher rates of Covid-19 infections and deaths than non-profit homes.[2] We believe that allowing for-profit companies to have any part of the care coordination role would be contrary to the needs of the residents of Ontario.

At a fundamental level, ACE is concerned about the extremely fractured way in which this legislation would provide care co-ordination. One of the issues that we have identified through many years of advocacy is that access to and the amount of homecare, as well as access to long-term care, differs across the Ontario depending on which LHIN applies eligibility criteria. Instead of unifying care coordination functions across the province to ensure equal access by all Ontarians, the proposal is for even more fractured care coordination, as it will be provided by a variety of Health Services Providers, Ontario Health Teams or contracted providers, and will increase the problem that care coordination -- and the provision of home care generally -- will not be provided in a uniform or coordinated manner.

[2] https://www.thestar.com/business/2020/06/05/ontarios-for-profit-nursing-homes-which-have-significantly-higher-rates-of-covid-19-deaths-have-17-fewer-workers-new-star-analysis-reveals.html

ACE is also concerned about the lack of oversight, governance and accountability to the government structures of Health Services Providers, Ontario Health Teams or contracted providers. As these entities will not be Crown agencies, these functions will no longer be accountable to the Government, and they will no longer be under the purview of the Ombudsman of Ontario or the Auditor General of Ontario. Given the problems we have seen in the past, which are well documented in reviews and reports by both agencies, we submit that this lack of oversight will leave the system vulnerable to systemic problems without the proper resources to address and correct them.

Finally, the proposed statute and regulations would allow for a Health Service Provider, Health Team or contracted provider, to be both a care coordinator and a service provider. We believe that this is a conflict of interest as set out above. Further, we argue that the separation of these entities is important to allow for proper oversight. For example, at present, if a person receiving homecare wants to complain about a reduction of home care hours, a PSW not showing up, poor quality of service or concerns about violations to their privacy by a home care worker, the LHIN care coordinator can be contacted to discuss the issue and may also assist in resolving it. This separation of care coordination from direct service provision provides a layer of oversight and accountability, which would be absent if both roles were being provided by the same company.

Recommendation:

ACE recommends that all care and placement coordination remain publicly controlled and provided on a non-profit basis.

ACE recommends that the care and placement coordination role be unified and performed by a Crown agency which is not providing the direct services.

b. Bill 175, Schedule 1 *Connecting Care Act, 2019*: section 5

5. The Act is amended by adding the following section:

Charges for home and community care services

23.1 (1) If a health service provider or Ontario Health Team provides a home and community care service to an individual, the provider or Team shall not require payment from the individual for the service and shall not accept a payment made by or on behalf of the individual for the service, except as provided for in the regulations.

The summary of the Proposed regulations states as follows:

- The ministry is proposing to maintain the current practice of allowing charges for the proposed list of community care services (community support services as defined in the *Home Care and Community Services Act, 1994* and Ontario Regulation 386/99). Professional, personal support and homemaking services (when provided alongside personal support services) and security checks and reassurance services (when provided alongside other home care services) would continue to be publicly funded for eligible patients and no charges would be permitted by regulation.

Discussion:

Pursuant to this new provision, the regulations allow for private payment for home care. There is no clear indication as to on what basis recipients would be allowed to be charged: whether it might be as some type of co-payment, based upon income; or based upon the type of service. If the intent is for the care coordinator to arrange for services that are not funded services, for example Meals on Wheels, this should be specifically enumerated in the regulations.

Recommendation:

Bill 175 should state clearly in the *Act* that professional, personal support and homemaking services (when provided alongside personal support services) and security checks and reassurance services (when provided alongside other home care services) would continue to be publicly funded for eligible persons, and that no extra charges would be permitted. As the Bill is currently written, Cabinet could change the regulations to allow co-payments or charges for previously publicly funded services without legislative oversight.

Any regulations allowing for co-payments should enumerate both the types of services that can be charged for and under what circumstances, as well as the types of services cannot be charged for and must be provided free of charge.

c. Bill 175, Schedule 1 *Connecting Care Act, 2019*: s. 11

11 The Act is amended by adding the following Part:

PART V.2 HOME AND COMMUNITY CARE COMPLAINTS AND APPEALS

43.10 A health service provider or Ontario Health Team that is funded under section 21 to provide home and community care services shall establish a process for reviewing complaints respecting such services that are made to it in accordance with the prescribed requirements.

43.11 A person may appeal to the Appeal Board a prescribed decision of the health service provider or Ontario Health Team concerning a complaint if the prescribed requirements are met.

43.12 If a person appeals a decision of the health service provider or Ontario Health Team to the Appeal Board in accordance with the prescribed requirements, the Appeal Board shall promptly appoint a time and place for a hearing in accordance with prescribed requirements.

Discussion:

Part IX of the *Home Care and Community Services Act, 1994* sets out the law respecting complaints and appeals in home care. The statute sets out a list of the matters that may be the subject of a complaint; timelines for review and response of the complaint; a requirement to respond to the client in writing; notice provisions; as well as outlining the process for appeals (including provisions on notice, hearings, standing and evidence). Bill 175 moves most of these provisions from the statute to regulation.

While the Proposed regulations state that the ministry is proposing to maintain many of the requirements that currently exist, these requirements are currently unknown.

The rules regarding complaints and appeals should remain in statute, not in regulations. The rules of appeal require the oversight of the legislature, and should not be delegated to regulation. Appeal processes are important in a fair and equitable society and should not be able to be amended without the full participation of the legislature. It is not in the public interest to remove the appeal process from statute into regulation.

Recommendation:

ACE recommends leaving all provisions respecting home care complaints and appeals in the statute, not in regulations.

d. Bill 175, Schedule 3 Home Care and Community Services Act, 1994, Repeal and Consequential, section 1

Home Care and Community Services Act, 1994

1 (1) The *Home Care and Community Services Act, 1994* is repealed on a day to be named by proclamation of the Lieutenant Governor.

(2) A proclamation under subsection (1) may provide for the repeal of one or more provisions of the Act at different times, and proclamations may be issued at different times with respect to any of those provisions.

As discussed above, ACE has a number of concerns about shifting key elements of the home care statute to regulation and policy. Of particular concern to ACE's client base is the removal of the Home Care Bill of Rights from statute to regulation.

The summary of the Proposed regulations states as follows:

- The ministry is proposing to include a Bill of Rights for home and community care patients in regulation, similar to that outlined in the *Home Care and Community Services Act, 1994.* As is the case currently, patients who believe their rights have been violated would be able to make a complaint to their provider (both providers funded by Ontario Health as well as contracted providers).

- The Bill of Rights contained in the *Home Care and Community Services Act, 1994* would serve as the model for the Bill of Rights proposed for regulation. As the Bill was developed in 1994, the ministry is seeking feedback on updates that may be required related to the equitable inclusion of all Ontarians in the delivery of home and community care services.

Discussion:

Similar to our concerns regarding Complaints and Appeals, there is no public purpose served by moving the Bill of Rights to regulation and in fact, we would submit that it is contrary to the public interest.

The current Bill of Rights[3] is a substantive provision that gives people who have applied for or receive home care services through the LHIN the following rights:

1. To be treated with respect and to be free from abuse;
2. To have your privacy and dignity honoured;
3. To have your needs and preferences respected;
4. To receive information about the services you get;
5. To take part in decisions about your services;
6. To consent to or refuse services;
7. To comment or criticize without anyone taking action against you;
8. To receive information about home care laws and policies and how to make a complaint; and,
9. To have your home care records kept confidential.

[3] *Home Care and Community Services Act, 1994*, s. 3

The Home Care Bill of Rights is vital to safeguard the dignity, autonomy, safety and privacy of home care users. Home care users are dependent on their caregivers for personal care, food or companionship, and the services are provided in the privacy of their home. Unfortunately, this creates significant power imbalances between consumers and care providers that can open the door to problems with the provision of services as well as the opportunity for abuse.[4] It is therefore of utmost importance to ensure that the rights of people who receive home care are enshrined in statute and not be subject to change without public consultation and the consent and approval of the legislature.

Of additional concern to ACE is the apparent removal of a current provision respecting the Minister's ability to approve an agency to provide a community service based on the Minister's assessment that the agency is or will be operated in compliance with the Bill of Rights and with competence, honesty, integrity and concern for the health, safety and well-being of the persons receiving the service.[5]

Moving the Bill of Rights to regulations and removing a key enforcement mechanism by the Minister sends a message to the more than 700,000 users of home care in Ontario that safeguarding their rights is not of importance to the Government.

Recommendation**:**

ACE recommends keeping the Bill of Rights in the statute, not in regulation, and maintaining the Minister's ability to approve an agency based on their ability to operate in compliance with the Bill of Rights and with competence, honesty, integrity and concern for the health, safety and well-being of the persons receiving the service.

[44] Beverley Bertram, one of Elizabeth Wettlaufer's victims, was a homecare user. See Ontario. Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, Vol. 2. *A Systemic Inquiry into the Offences*. Toronto: Queen's Printer for Ontario, 2019.

[5] *Home Care and Community Services Act, 1994*, s. 5(1)(a)(ii)

e. Non-licensed residential "congregate care"

Ministry of Health - Proposed new regulation under the Connecting Care Act, 2019 (Pending passage of the Connecting People to Home and Community Care Act, 2020)

The ministry is also proposing to add "residential congregate care settings" as a location in which home and community care services can be delivered. Proposed changes to the Connecting Care Act, 2019 would provide a legal framework for the funding and oversight of non-licensed residential congregate care models. These models would introduce new settings of care in the community for patients who do not require the intensity of resources provided in a hospital or long-term care home, but whose needs are too high to be cared for at home. These models may provide care to patients on a transitional or rehabilitative basis, or over longer periods of time.

Details of each residential congregate care model would be defined in regulation under the Act. The ministry would engage with the public, clients and caregivers and health system partners to develop each model and outline them in regulation.

The proposed regulations to Bill 175 introduce a new level of care which is referred to as "residential congregate care" for persons who "do not require the intensity of resources provided in a hospital or long-term care home, but whose needs are too high to be cared for at home." "Residential congregate care" is left to be defined in the regulations.

Discussion:

While the proposed regulations indicate that Bill 175 includes amendments allowing for the funding and oversight of non-licensed residential congregate care models, we fail to see this included. Should the Government intend that such models of care be allowed, the Bill should include clear legislative authority for same.

ACE is concerned that this model is non-licensed. We submit that any new model of residential congregate care should be licensed, and have regulatory standards, inspections and oversight, similar to what is presently in place for retirement homes. As we have seen through the COVID-19 pandemic, congregate care for vulnerable adults is susceptible to a variety of problems, including but not limited to issues of public health and safety. Only a licensed and properly regulated and inspected system will be able to safely provide care to vulnerable adults in the community.

ACE is also concerned that this proposed new tier of care is merely the expansion of what is presently known as short-term transitional care beds. This unregulated model is fatally flawed, having been created to meet the needs of LHINs and hospitals, and not those who reside in them. Under this scheme, hospital patients who require admission to a long-term care home are pressured to move into often unregulated 'housing', which cannot meet their care needs and that have little or no standards or oversight.

Alternative Level of Care (ALC) patients are hospital patients who do not require the intensity of resources or services provided in an acute-care setting but who are unable to move to another level of care such as long-term care, a retirement home, complex continuing care, rehabilitation, or community care due to lack of resources and the non-availability of an appropriate discharge destination.[6] These pressures within the hospital sector have everything to do with the underfunding of our existing healthcare system that causes both hospital and long-term care beds to be in short supply. While it is expensive to keep ALC patients waiting for long-term care in hospital, waitlists for long-term care are lengthy and ever-increasing.

Instead of fixing the problem through appropriate funding of long-term care home beds, the introduction of "residential congregate care" would only increase the pressure on those destined for long-term care homes to accept placement outside the healthcare system in these 'holding areas' while they wait for admission to long-term care, despite the fact that these facilities are not long-term care homes and would not be able to provide this level of care. Someone who is approved for admission to long-term care by definition has care needs that cannot be met in the community, and it is never appropriate to force someone who needs long-term care to wait for admission outside of the healthcare system.

This is not a new model. In 2017, the Government began funding temporary short-term transitional care models through hospitals and LHINs in response to the pressures associated with maintaining ALC patients within the hospital sector. At the time, the goal was identical to what is being proposed in Bill 175: to provide subsidies to low-income older adults who were having trouble coping in the community. It was intended to target those who could otherwise manage in retirement homes, but could not afford one.

However, what these programs actually did was to shift the care of older adults waiting for long-term care beds to a less regulated private sector. It took hospital patients waiting for admission to long-term care and placed them in housing that had little or no oversight, that were not equipped to meet their basic care needs, and that often violated the legal rights of residents by illegally restraining and confining residents, and providing treatment without informed consent in contravention of the legal requirements of the *Health Care Consent Act*.

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[6] The Provincial ALC definition was created in 2009. See *Access to Care, Alternate Level of Care (ALC): Reference Manual*, version 2, January 2017, page 13.

It is inevitable that private for-profit retirement homes and other for-profit entities would expand into this tier of non-licenced unregulated long-term care with public funding if it were provided. This would result in a reduction of oversight. Those beds now located in licenced retirement homes might no longer have to be licenced, to meet the standards set out under the *Retirement Homes Act,* or to be under the supervision of and inspected by the Retirement Home Regulatory Authority.[7]

In the 2009 *Nineteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner of the Providence of Ontario*, the committee was critical of the use of such facilities where a person required admission to long-term care. At page 41, the Committee specifically stated:

> Programs in private care or retirement homes in the Province of Ontario providing care to the frail elderly residents awaiting placement in a licensed long-term care home should be held to the same standards for care and services as a licensed long-term care home. Implicit in this recommendation is the need to ensure the same regulations and inspections with regular public reporting of findings that exists for licensed long-term care homes.

We have recently seen the devastating impact of COVID-19 within the Ontario's long-term care homes. Serious pre-existing problems in long-term care that were identified and amplified during the pandemic were already widely known long before the pandemic. On May 7, 2020, the Government announced a review of the long-term care system, which it identified as being "broken" due to "years of neglect".[8] It is inappropriate and short-sighted for the Government to hastily create at this time yet another tier of congregate care that has no clear purpose; a complete lack of standards, regulation and oversight; and that provides an overly permissive environment of operations for for-profit home operators.

Recommendation:

Properly funded residential congregate care settings which provide care for those who can no longer live in their current community setting but do not yet qualify for admission to long-term care would be beneficial. However, consultation with the various stakeholders is required before legislation can be contemplated. Further, any such legislation would need to set out specifics regarding the parameters of the level of care, as well as mandatory licensing, standards and inspections, amongst other things. Finally, it would have to be made clear that those who have

[7] Generally, homes that receive government funding, both directly or through hospitals or LHINs, have been exempted from the *Retirement Homes Act, 2010,* s. 2.
[8] Minister of Long-Term Care, Merrilee Fullerton, May 7, 2020, Twitter @Dr. FullertonMPP

been found eligible for admission to a long-term care home would not be required to use these settings in order to deal with any ALC or other systemic problem.

E. CONCLUSION

We urge the Government to withdraw Bill 175, *Connecting People to Home and Community Care Act, 2020*, as it is not in the best interest of the citizens of Ontario. In the alternative, we ask that the Government amend the legislation to ensure equitable, quality homecare services throughout Ontario, as we have outlined above.

Thank you for the opportunity to provide comments respecting Bill 175, *Connecting People to Home and Community Care Act, 2020.*

We urge the Committee to consider our submission and welcome the opportunity for any further discussion.

Yours very truly,

ADVOCACY CENTRE FOR THE ELDERLY

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