Submission Regarding Bill 37

Nov 25 2021

My name is Jan-Paul Tibensky and I think Bill 37 is an attempt at a good effort.

So, that being said, attempt it.

Pump the tires. They've been run flat, any effort will put air into them.

However I think the act can be considered fine already. It is just how it is interpreted and enforced that has wrought such havoc over my own family.

In my personal experience, as a son and citizen, the Ontario health system has paid private companies to make an attempt to care for vulnerable people for around a year, then has allowed those companies, through their permissive oversight, with their hired help of self regulating medical professionals, to ignore congregate care ailments in those settings if the specific resident should cost more to care for than profit from.

I can defend this statement through life experience of seeing the (in)actions of those professionals while wanting only the care and dignity that extends my mothers life, and the frustration and subsequent trauma of realizing that dignity and life preservation is not a part of the system although it could be cheaper, and create more enriching better regulated jobs.

I don't see this as some purposeful or pre planned act. I hope it is the outcome of the independence of the different aspects of the health system reacting to one another to form an unintentional monster.

The major issues my family saw cause arise from:

1) MDS RAI 2.0 - funding shortfalls, the blind purses funded - nursing, operations, food, and when they are funded per diem vs end of fiscal year. All setting up success through failure

2) Common congregate care ailments - urosepsis, pneumonia, cellulitis, common viruses, and thyroid dysfunctions. All taught to students who become professionals that do not see what is all around them. COVID exposed this pattern and people

saw what looks to them like a singular event of mass death but it followed in suit to the pre-existing pattern for minor ailments going overseen.

3) Physician care: The logical fallacy used is that my mom has not shown symptoms until it is too late. If proper testing is done, and double checked for correct method of sampling, and shared with family, the fallacy does not exist. Paperwork catches it in advance, not the doctor specifically, with my moms historical susceptibility to congregate ailment.

4) Private vs. public long term care and how the actual resident placements occur with LHIN oversight as 'no-versight' allows short term stays for vulnerable people in private homes. Which by inherent design, allows a profit be made by human turnover. IE; The homes can "profit", or better put "not lose too much" profit, on a high needs resident, who by process of assessment reaches the maximum funding possible out of the MDS RAI 2.0 algorithm. Once maxed, the person costs the private corporation per diem monies to keep safe, and then a natural means in the system kicks in to protect profit IE normalizing the ability to ignore congregate ailments in congregate settings.

5) Lax documentation of admission, lax documentation of care conferences, private documentation (progress note inconsistencies/hiding notes/reluctance to share with family), disregards family and patient transparent involvement - creates best atmosphere to isolate the vulnerable in first months or year in LTC.

6) The colleges and professional unions and self regulation. There is only two reasons to file a complaint regarding a medical professionals provision of care: incompetence and ignorance. The unions, standing by professionals, only look for incompetence (IE malpractice). Approving ignorance, unless in a 30 day window, you file to HPARB to hopefully take another look and review a review. Forcing an observation towards ignorance essentially.

7) Who oversees HPARB, what outcomes can really be achieved? What happens when ignorance is identified? The challenges to finally be there (slow response, misplaced releases, redacted vs un-redacted, slow timelines and removing statue of limitations from concern)

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My mom, Sharen Tibensky, has been in the hospital for weeks over months combined. All unnecessary. And at such unnecessary cost to her health and to the soundness of our system.

1 week in hospital is around 8 weeks the cost of a senior in long term care in Ontario.

4 weeks at healthy and happy, split the difference we can just say.

So essentially every hospital trip takes months of current care away in the system. And weeks of care at the ideal.

Add to that too it is a double dip every time. Since my mom hasn't died, her bed is waiting at the home. My mom is continuing to pay the accommodation but the government is still paying the long term care costs too even though they are paying the hospital costs.

All vs the cost of keeping my mom's life well managed in private long term care.

Then start adding in all the costs to provide oversight to the bad math. Actionline and inspectors, ombudsman, public health costs etc etc. All unnecessary.

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So now to end, how would I see fixing long term care if I were to, and possibly do it for an offsetting cost:

First, Bill 37 simply needs to devalue the private long term care companies. The purpose of the bill should be to have care facilities sold back to the province at cost simply put. Allow the private companies become property managers as they actually are, no longer the (mis)managers of human life as the facade has now been broken irreparably.

Create 3 Province wide funded Pools:
- Nursing Pool,
- PSW Pool,
- Equipment Pool.

Funding goes to those 3 pools. Emergency management needs are complimented with regional/greater provincial floating pools of care where it is needed, etc. Scrap MDS RAI 2.0 and funding the 3 blind purses of nursing, operations, and food.

Listen to seniors. End future large scale congregate care. But also realize the limitations of finances. There are lots of viable models of long term care in the world. But these models already exist. If we start building new now, those who need long term care will be late to see the results of large scale infrastructure builds.

I have read we need 40,000 beds for long term care in the province. The province has 140 hospitals. Hospitals could help end hallway healthcare with oversight to long term care. IE - Providing ‘community hospitalists’ and physical/dietary/overall medical support to homes acting as semi-autonomous ‘subsidiaries’ to the crown corp hospitals. This in collaboration with the municipal regions acting as the greater oversight as inspectors.

I imagine 40,000 beds spread out into homes from the community repurposed for long term care beds.

Seniors want to age in the community. While their own homes might be too challenging, finding appropriate homes in the community and renovating to long term care standards can be pragmatic.

40,000 beds spread out to the 140 hospitals in the province is 286 beds per hospital, not considering capita per hospital. 286 beds spread out at a rate of 6 people per home is 48 homes.

48 residential homes 10km or less to each hospital in the province, renovated to long term care standards, solves the bed shortage.

Staffed and equipped with the pools of service, each with a small kitchen and laundry with 1 or 2 independent to the home employees for cooking and cleaning.

A city contract for lawn maintenance. Redrawn ambulance routes. Utility subsidies. Other details of course.

To make it even more affordable, these homes would be mortgaged through the banks with the province acting as guarantor in a way. The banks would own these home

initially. The communities could pay for the renos. The mortgage payments, food, and cleaning services would essentially be the accommodation fees for the 6 people.

Over time the mortgages are paid and the province becomes ‘owner’ of these homes. The accommodation fees now turn back into a means to pay back the initial costs spent years prior.

As the baby boom ends, homes can be emptied, renovated back into a livable state or sold to families with extenuating cares needs etc. for a lump sum gain to help off set the original costs of the long term care switch over.

With audits done on ailments and value added to the vulnerable, people triaged to homes appropriate to them, equipment and staff floating to where need is, the system would be all right.