Submission to

The Standing Committee on the Legislative Assembly

regarding

Bill 37, Providing More Care, Protecting Seniors and Building More Beds Act, 2021

from

Ontario Council of Hospital Unions

CUPE

CUPE Ontario

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CUPE Ontario is the largest union in the province with more than 280,000 members in virtually every community in Ontario. CUPE members provide front line services that help make Ontario a great place to live. CUPE members are employed in five basic sectors of our economy, delivering public services in: health care, including hospitals, long-term care, and home care; municipalities, including ambulance services and libraries; school boards in both the separate and public systems in both French and English; social services; and post-secondary education.

The Ontario Council of Hospital Unions/CUPE is the bargaining council for 40,000 CUPE hospital workers in the province, including staff working in long-term care facilities connected to hospitals.

Over 35,000 of CUPE's 280,000 members in Ontario are long-term care workers who are employed in 65 public/municipal, 54 private non-profit, and 62 private for-profit homes across Ontario, from Kenora to Hawkesbury, Hearst to Windsor, and many more communities in between. CUPE members are employed in diverse classifications including activity aides, cooks, dietary aides, health care aides/personal support workers, nurse aides, nurse practitioners, Resident Assessment Instrument (RAI) Coordinators, registered practical nurses, registered nurses, and housekeeping, laundry, and maintenance staff.

Long-term care workers provide care that is integral to Ontario's health care system and essential to the seniors and people with disabilities who live in the homes where they are employed. Their work and sacrifices deserve our utmost respect, not just throughout the pandemic, but always.

Many CUPE long-term care workers have been infected with COVID-19, and at least three of our members have died as a result. Members have worked on the front-lines of the pandemic while simultaneously juggling child and elder care responsibilities due to day care, school, and elder care closures. They have suffered significant emotional, physical, and mental stress from working short, coping with high numbers of COVID-related resident deaths, and the fear of transmitting the virus to residents and co-workers, as well as their families and loved ones. These stressors will have long-lasting impacts on the health and well-being of our members for years to come.

While COVID-19 brought with it countless horrors in LTC, it also made unambiguously clear what numerous studies, expert panels, and most importantly staff, residents and families have been saying for years – that the system is chronically under-resourced, and fundamentally broken. One needs to look no further than the reports of Ontario's Long-Term Care COVID-19 Commission and the government's own Long-Term Care Staffing Study Advisory Group to confirm that the sector was in the throws of a staffing crisis before COVID-19, and the pandemic has only amplified that crisis.

Bill 37 is an opportunity to lay out a clear and decisive plan to fix the crisis and build the long-term care system that residents deserve – unfortunately, it has missed that mark. While this legislation does take some steps towards that goal it also leaves numerous big questions unanswered. It is vitally important that the new long-term care Act take on the challenge of creating a better care system for vulnerable residents – many of whom are at the end of their

life – which would also bring significant changes to working conditions for a large, dedicated and predominantly female workforce. Bill 37 as proposed fails that litmus test on several fronts.

There are a significant number of crucial details that are undefined or left to regulation. For example, the legislation provides for the creation of a Long-Term Care Quality Centre, but the purpose in the legislation remains vague. Aside from "supporting mission-driven organizations" (a term which is also un-defined and addressed in more detail below) the operation, roles and responsibilities for this Quality Centre remain unknown, to be laid out in subsequent, as-yet-undeveloped regulations.

Two other important omissions (which will be elaborated on below) are embedding a process for phasing out for-profit care and clearly asserting requirements for meeting the promised 4-hour daily care standard that would see bold systemic changes including to the conditions of labour of the workforce.

4 Hours of Care

We would be remiss not to note that the inclusion of a 4-hour legislated care standard has been a long-standing demand of staff, residents, families, and other advocates. This is both ambitious and long over-due – but we are gravely concerned that without a bold plan to address the systemic challenges around working conditions in the sector we will not be able to meet the targets in this plan.

As referenced previously the sector has been facing a staffing crisis since well before the pandemic, and COVID-19 has had an undeniable impact on the staff working in long-term care. Staff are exhausted and burnt out, and many feel that they simply cannot continue to work in the sector. This is compounded by the departure of those who have left through normal attrition. In our experience homes are having trouble maintaining already insufficient pre-pandemic staffing levels, let alone the ability for a home to staff-up to meet the 4-hour standard. It is also important to note that these challenges are further compounded for not-for-profit homes who struggle to remain competitive when they are the only homes in the sector subject to the compensation restraints of Bill 124.

It is clear that we need a robust plan that seeks to recruit new staff to the sector – but even more importantly we need a comprehensive plan to address working conditions in the sector so that new recruits will want to stay on the job, but also as a means to retain existing staff who are leaving the sector in increasing numbers. We need only look across the border to Quebec to see a plan that managed to recruit more staff than Ontario, despite a population 40% smaller – and that was a plan created to address the needs of the pandemic, not to implement a 4-hour care standard as we seek to do here in Ontario.

While we support the inclusion of the commitment to a four-hour standard in the legislation, in our view there are a number of changes required:

- The timeline for implementation is too long. It is an unfortunate reality that many of the current residents of LTC will not live long enough to the implementation of a 4-hour

standard by 2025. A bold recruitment and retention plan will allow for this timeline to be dramatically shortened.

- The targets set out in the legislation need to be framed as requirements at both the provincial and home levels. The legislation as proposed sets targets, but also includes provisions for developing a plan when those targets are not met. Respectfully, plans need to be developed at both the home and provincial levels now to ensure that the thresholds set out in the legislation are met as a requirement.

- If the framing of the thresholds as targets - rather than requirements – remains, the consultation provisions of Sec 10 (6) that set out that the Minister "may" consult with "individuals or organizations that may have an interest in the target" need to be adjusted to provide that consultation in the development of a plan is mandatory.

- In the interest of transparency and accountability there needs to be an explicit requirement in the legislation for licensees to report the staffing data for each home, and that data must be subject to random audits to ensure accuracy. The public reporting referenced in Sec 10 must include data both provincially and for individual homes, and that data must be made available for staff, residents, and family members to be able to review. There must be a mechanism to address homes that consistently fail to meet the required target. They need to be held accountable in order to avoid a situation where homes that exceed the required targets raise the provincial average to provide cover for those "bad actors."

- We are encouraged that the legislation explicitly states that the hours of care are calculated using hours worked solely by Personal Support Workers, Registered Practical Nurses and Registered Nurses. Unfortunately, the staff mix required to achieve the required hours of care is not spoken to in the legislation. It is our view that for residents to achieve the best results from the implementation of a care standard, the hours of care must be focused at the bedside in the form of increased PSW and RPN hours.

- We are also encouraged to see that the calculations are to be based on hours worked, not on hours paid. This calculation is arguably the most integral part of implementing a 4-hour care standard, yet we are troubled that the details of defining "number of hours of direct care actually worked" and "resident days" are not included in the legislation but are instead left to regulation.

It is also important to note that the 4-hour threshold is many years old, and in the intervening time it is also clear that the acuity levels of residents in LTC has increased dramatically. The number of hours required will undoubtedly need to increase as resident acuity continues to rise. To that end, it is encouraging to note that the legislation provides that the threshold can be increased by regulation, but cannot fall below the levels outlined in the legislation.

Role of Profit in LTC

One of the unavoidable truths of the pandemic has been the significant disparity in COVID-related outcomes between for-profit and not-for-profit/municipal providers. As a result, there is clear and unprecedented public support for removing profit from the LTC system. This legislation is an opportunity to place a moratorium on new for-profit licences – and to transition existing for-profit homes to public and/or not-for-profit ownership. Unfortunately, the legislation goes in the other direction – instead adopting the relatively new concept of "mission-driven" organizations.

We first saw the notion of mission-driven organizations referenced in the final report of the LTC Commission who noted at page 7:

> *Currently, there are not-for-profit, for-profit, and municipal homes. The characterization of homes based on their tax status is not helpful. It is more pertinent to consider if the owner is involved in long-term care as part of its mission or in order to profit. Some owners whose tax status is for-profit operate as mission-driven entities. Others have shareholders and owners whose motive is profit.*

Respectfully, we view this as a false distinction. If a facility is operating on a for-profit basis then by definition some or all of their motivation is driven by profit. If not, they would be a not-for-profit facility. The distinction is really a matter of to which degree their operational decisions are motivated by profit. The idea of being mission-driven is entirely subjective, and in our experience every for-profit operator that we deal with would describe themselves as being mission-driven.

In our submission, the far more important point is the principle that there is no place for profit in the provision of care for our loved ones.

Not only does this legislation fail to take the bold step of removing the profit-motive from the LTC system, the addition of "mission-driven" organizations to the preamble of the legislation moves us in the opposite direction and should be rejected.

Palliative Care

The legislation requires that homes provide care and services that integrate a palliative care philosophy - but that subjective term is undefined in the legislation and the regulations respecting that philosophy have yet to be developed.

We also must note that palliative care is a highly skilled specialization – and while adopting such a philosophy in LTC may make logical sense it is essential that it is more than just words on a page – it must be done properly. This is a commitment to residents and their families that cannot be done on the cheap and must be adequately resourced. If palliative care is to be done in long-term care homes it should come with all of the services, care, and staffing levels of hospital-based palliative care. That means a substantial investment in training for staff, and it also requires a commitment of significant, ongoing funding to be able to ensure the best possible care for residents in their final moments.

Emergency Planning, IPAC and PPE

We are encouraged to see the additions to the Infection Prevention and Control Program (including a designated lead) set out in Sec 23, but given the conclusions of the LTC Commission, and the Campbell Commission before it, we are frustrated by the lack of any reference to the precautionary principle in the legislation. There should be an explicit acknowledgement and adoption of the precautionary principle as a requirement for any IPAC program.

Access to appropriate, fit-tested PPE has been a significant challenge throughout the pandemic leading to unnecessary infections among staff and residents. Workers should never feel that they need to fight for adequate protection in the workplace. The requirements for the IPAC program should include the use of appropriate, fit-tested PPE in accordance with the precautionary principle.

This is yet another area of the legislation where important details – including the provisions for "accountability mechanisms" and the required qualifications for the IPAC lead – are left to be determined by regulation.

We support the inclusion of epidemics and pandemics in the provisions of Sec 90 regarding emergency plans. Given the lessons of SARS these arguably should have been included in previous plans - and the testing of those plans – but their inclusion now makes the question unambiguous.

We also note the necessity of including workplace Joint Health and Safety Committees in the development, review and testing of IPAC programs and emergency plans.

Protection of the Skilled Nature of PSW Work

All members of the team provide essential services for the care of residents – but for many years the contributions of personal support workers have not been valued as they should be. The experiences of the last couple of years have shown beyond a doubt, the difficult and skilled nature of the work performed by this classification.

The current regulations provide (at Sec 47) that personal support services are only provided by those who have achieved a minimum standard of training. These regulations are essential for the safety of the residents that PSWs serve. It is essential that the skilled nature of this work not be left to regulation, but be enshrined along with the definition of "personal support services" in Sec 11 of the legislation.

Whistleblower Protection

We are discouraged to see that the whistleblower protections in the act are still not pro-active. The current provisions of the Act are clearly insufficient as the protections are reactive and leave staff members to respond to punitive action and prove that it was issued as reprisal for providing information under the Act.

Despite the current provisions there is still a pervasive culture of fear within the sector, not only for staff, but also for residents or family members who fear reprisal if they report issues.

Provisions should be added to Sec 30 that provide for an anonymous means for information to be reported without fear of being exposed.

Thank you for considering our submission.