Long Term Care Covid-19 Commission Mtg.

Ontario Community Support Association (OCSA),
Charles Beer and Monica Testa-Zanin
on Monday, December 21, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 21st day of December, 2020, 9:00 a.m. to 10:00 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:
Charles Beer, Principal, Counsel Public Affairs Inc
Deborah Simon, CEO, Ontario Community Support Association (OCSA)
Monica Testa-Zanin, Principal MTZ Strategic Consulting

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister Long-Term Care Commission Secretariat

Ida Bianchi, Counsel Long-Term Care Commission Secretariat

Kate McGrann, Counsel Long-Term Care Commission Secretariat

John, Callaghan, Counsel Long-Term Care Commission Secretariat

Lynn Mahoney, Counsel Long-Term Care Commission Secretariat

Derek Lett, Policy Director Long-Term Care

Commission Secretariat

Dawn Palin Rokosh, Director, Operations Long-Term Care Commission Secretariat

Jessica Franklin, Policy Lead Long-Term Care Commission Secretariat

Adriana Diaz Choconta, Senior Policy Analyst Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 9:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I'm Frank Marrocco. The second Commissioner is Dr. Jack Kitts, and the third Commissioner is Angela Coke.

COMMISSIONER ANGELA COKE: Morning.

DEBORAH SIMON: Morning.

CHARLES BEER: Morning. Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): We're all here. I guess, Mr. Beer, I don't know who to -- you were doing the talking, so whoever is -- are you waiting for anyone?

CHARLES BEER: No. We're all set whenever --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CHARLES BEER: -- you wish to begin.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, then let's begin. I don't know if you know the way we've basically been doing this, but this is the investigative stage of what we're -- what we're doing, and so we have been interviewing people. We have a court reporter, Janet, who's a professional transcriptionist and who will post a transcript of the conversation this morning.

We have a backgrounder. We have some material that I think you prepared, so we have that and probably can assume we've looked at it.

We tend to ask questions as we go along, if that's okay, and we're prepared to start when you're ready to start.

CHARLES BEER: Okay. Well, thank you. Thank you very much. And it's a pleasure for Monica and Deborah and me to be with you this morning. We very much appreciate the invitation.

I should also add that it's been a while since the three of us worked together on this project, and while we've been in touch over the years from time to time, it's been fun to go back and relive those years and the work that we did at that time.

We recognize that the pandemic is still very much with us and how critical your work is, and we hope that, in some of the things that we say this morning, that that can be of use to you in your -- in your work.

What we would like to do, if it works for you, is that each of us would make some comments at the -- at the outset, and that would be on our experience of developing and implementing

the first Ontario PSW registry and, really, what we've learned or what we feel we learned from that, and then also in the light of the Commission's mandate and our own individual ongoing work in the health sector, try to bring forward a number of points that we think might be relevant for your work.

Certainly, from the time we did the initial registry work and through today, the role of PSWs is so critical in the health system and anything that we can all do to strengthen that is really important.

So as we go forward, Monica will speak first and talk about health human resources, the first registry and the evolution of the role of PSWs.

Deborah will then talk about the central role of PSWs in home and community care and leveraging this sector going forward.

And finally, I'll share some thoughts on how more effectively to coordinate and provide oversight for PSWs in 2021 and beyond, and we recognize that you do ask questions. We haven't read all the transcripts, but we have read a number of them, so feel free to jump in as we go along.

And with that, I turn it over to Monica.

MONICA TESTA-ZANIN: Thank you very much, Charles.

And thank you all for the opportunity to speak with you this morning. My name is Monica Testa-Zanin, and I worked with the OCSA as the project lead for the first Ontario PSW Worker registry back in 2011.

In terms of my own background, I have over 20 years' experience as a policy analyst in the areas of health care, health professions, regulation, education, and I've done that in both consultant and staff roles. And I have developed over the years a keen interest in health professions regulation and the education of healthcare professionals and in health human resource planning.

So having reviewed the Commission's mandate, I'm hoping that our comments today will help to flesh out or contribute to two components, in particular, of your work. And that is to assess how the pre-COVID state of the long-term care home system contributed to the virus spread in long-term care; and secondly, the impact of existing staffing

approaches, labour relations, and clinical oversight and other features of that system that contributed to the spread of the virus in long-term care homes.

So as I said, back in 2011, the OCSA was engaged to establish a registry of personal support workers, and we believe that that first registry contributed to or laid some important groundwork in Ontario with respect to some very important dialogue that continues to this day. And in particular, I'm referring to the dialogue on the purpose of professional regulation, on alternatives to traditional regulatory structures, on the proper utilization of unregulated workers, and on what data is required to do good health human resource planning.

So we provided you with an executive summary of the OCSA's Public Report on that first registry experience, and of course, we don't want to get too much into the historical, you know, details about what, in particular, we experienced at every stage of the process, and we know you've heard from Dr. Brian Hodges and Marnie Weber who oversaw the second iteration of the PSW registry, and if you haven't seen, you will soon receive a

report from that project.

But I do want to offer some thoughts on the objectives of that first registry and some challenges that were experienced in trying to establish it. And in so doing, to, as I said, shed some light on that pre-COVID state of long-term care and on the PSW workforce that you're particularly interested in.

I think it's really important to emphasize that that first registry in the first instance was meant to signal a recognition of the important role of PSWs in the provision of care, that this unregulated workforce, though it emerged rather rapidly to fill an emerging need in personal care services, it became very quickly an integral part of the healthcare system.

Nursing practice, naturally, had also evolved and nursing education as well over time, and nurses became recognized as professionals with a unique scientific body of knowledge and that they possessed through their educational preparation critical thinking and clinical assessment skills that evolved their practice and their status as a profession. And, in fact, a four-year university degree became the standard entry to practice for

registered nursing.

So as the nursing scope of practice evolved, personal care services like bathing and dressing and feeding, grooming, helping with mobility, all those sorts of activities of daily living that were previously part of the role of nurses became entrusted to an emerging group of unregulated workers.

And nobody will argue that the PSW's role cannot be overstated. The healthcare system simply couldn't function without them, and it couldn't even afford to have those types of personal support activity of daily living functions provided only by regulated health professionals.

So this registry was really about recognizing that this workforce had to be counted and recognized as critical to the provision of these very personal, very intimate services that form the continuum of care.

COMMISSIONER FRANK MARROCCO (CHAIR): And can I just to, sort of, you know, cut to it a bit? We've really, I think, heard a lot about how central personal support workers are to the care of residents in long-term care homes.

I guess, so in terms of their

importance, I just speak for myself -- it seems -- it seems obvious that they're -- that they're important.

I -- but the question -- the questions I have and -- are these: Should they be regulated? And if so, by whom? And those are to me the more fundamental questions, and I don't know if that assists in what you're saying or not, but I thought I'd like to get your views -- the -- all your collective view on that, those questions.

MONICA TESTA-ZANIN: Yeah, you certainly did cut right to it there. We do hope that in our remarks, we are laying the groundwork for that very question to be discussed. I really wanted to emphasize that the Registry in the way that it was set up, both the first and the second, was an alternate -- an alternative to regulation.

And I think through our remarks this morning, especially as we move through Deborah's and Charles', we might actually get right to that question of, is regulation the answer to all of the system's problems. And for my part, I think, and Charles will sum at the end, there are a number of other components of how we educate, supervise, and prepare this workforce and its regulatory

supervisors that have to be grappled with before we jump to that question of, do they need a separate regulatory structure and where should it sit.

So if I could just continue on showing you or describing to you the evolution of that discussion because when we were setting up that first registry, we were tasked with certain objectives that were not necessarily regulatory in nature.

We were asked by the Government to take a phased approach to, you know, counting, you know, creating a census, so to speak, of this workforce beginning with the home and community care sector. And at the time, it's because it was a priority of that government to really expand services provided in the home and community care sector because there was huge strain in hospitals, and there were terrible waits for long-term care beds, and people just wanted to age at home.

And so it was a priority of the Government to expand services in the home and community care sector, and it wanted to know what were the resources available to it, and how could it expand the workforce to be able to provide more care in those -- in those areas.

So it needed to understand the demographics of the PSW workforce, the employment status, the educational qualifications, all those things that previous to then had not been documented and did not exist in a central repository.

So that registry was meant to gather that data. It was a data gathering exercise for the purpose of better health human resource planning in home and community care in the first instance.

COMMISSIONER FRANK MARROCCO (CHAIR): But if I can just stop you there for a second, just as a matter of human resource planning, if it's -- if these are people that are going into other people's homes, for example, so as part of that census, doesn't there need to be some sense that they're suitable to go into someone's home and care for someone, let's say, who's suffering from dementia may not even remember being mistreated, for example.

MONICA TESTA-ZANIN: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Isn't that part -- isn't that part of it?

MONICA TESTA-ZANIN: Yes, absolutely.

And so what we were trying, also, to get a handle on was with what educational preparation or training had these people arrived at this role. And we saw -- there has been some movement on this front since then, but at the time -- well, to a certain extent, there are still multiple pathways to entry to this role that there are everything from programs offered through Boards of education, through continuing education, private career colleges, all the way up to six to eight-month community college certificate programs to gain the skills and competencies to be able to provide this level of care.

And at the time, that really shed a light on the fact that they were -- they had -- this workforce had arrived -- had emerged, and people arrived at this role through so many different pathways that it was difficult to identify the competencies and that entry-level skill and knowledge that was needed to be able to perform that role safely and that ethical component that needed to be imparted to individuals who wanted to earn a living as a personal support worker providing these very intimate, very critical services, so, yes, absolutely.

It was also part of the purpose of the Registry to try to understand better what are all these multiple paths, and how can we identify how we should be preparing these people to do these things and making it so that it is an attractive profession and that it is affordable and that it does provide a living wage. And all of those things came into -- came into view through those initial days of the first Registry.

We tried to capture as much of that workforce as possible, so even though we were asked to focus solely on home and community care, we quickly realized that it's hard to pigeonhole people into that sector because PSWs transition between sectors, and so we didn't want to preclude anyone from registering and being counted as a PSW just because they didn't necessarily work in home and community care or only in home and community care.

So we cast a very wide net to try to get a picture of how complex and how varied the preparation, the level of training, the level of oversight. The type of wage they were paid depending on where they worked, was just so varied and so complex, and that actually made it evident

that regulation of that group might be that much more challenging because if you narrow the pathway to entry of a profession, you necessarily will lose people. And the sector was in no position to lose any human resources. To this day, the shortages are staggering, and Deborah will talk a little bit more about that in her section of our discussion.

But the question of regulation is really one that I think is still being grappled with today because its purpose is, in some ways, misunderstood. From my part, and speaking solely from my part and in my experience, I really do adhere very strongly to the notion that the purpose of professional regulation is public protection and its accountability for one's services as a regulated professional.

It's -- in many ways, I've heard the conversation that this is -- regulation would raise the profile of this group; that regulation would improve the status of this group as a member of the continuum of care; and that it would, you know, necessarily demand higher wages and so on and so forth. And those are all peripheral to the main purpose of regulation, which is public protection, protection of the public from harm by an

individual.

COMMISSIONER FRANK MARROCCO (CHAIR): You know, if I -- if I can stop you for a minute, let's assume that that's right. So you have protection of the public, the other -- the other thing you do as a regulatory body is educate on a continuing basis.

MONICA TESTA-ZANIN: What you do --

COMMISSIONER FRANK MARROCCO (CHAIR): So you protect the public on the one end, and you continually educate the members on the other.

MONICA TESTA-ZANIN: A regulatory body sets the standards for entry to a profession, so in that sense, yes, a regulatory body would be one to say that in order to be an 'X', in order to work as a PSW, which would necessarily become a protected title under a regulatory regime, you must have completed this level of education or a program approved by such and such a body.

We already have that in Ontario for PSWs particularly in the long-term care sector. I mean, we don't have it necessarily yet across sectors, but we do already have that in the long-term care sector.

In the long-term care sector, the

regulatory structures that govern that sector require that a PSW or an individual providing personal support services has to have completed an approved educational program -- so there are now educational program standards, and there are different streams through which you might achieve that -- and has to work under the supervision of a regulated professional.

So there are regulatory structures in place governing the role of PSWs. They're just not professional regulatory structures in the same way as physicians and nurses are regulated as health professions.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

MONICA TESTA-ZANIN: All right. So I think that's also an important note is that PSWs, they -- organizing that workforce presents a very complex challenge because of the fact that that workforce emerged very fluidly in response to a particular need in different sectors. They work under very different circumstances and legislative structures depending on where they are working.

So if you're in a long-term care home, you're governed by the structures of the long-term

care home and so on and so forth. And they fluidly transition from sector to sector in order to make a living wage.

What we learned from the demographic data that we were able to gather on about 33 or 35,000 PSWs that voluntarily registered back in 2011 was that it's a predominately female workforce, average age somewhere in the early 40s, lots of interruption in employment because of having to care for children or family members, casual and part-time employment, so almost always having multiple employers in order to cobble together a living wage.

And, you know, if you're talking about spreading -- or mitigating the spread of a virus, you have such a mobile workforce that's going from facility to facility or home to facility or whatever the case may be, that's a huge problem, and it's -- comes from the fact that they do have these -- it's a very transient workforce with very casualized employment even though the system is so incredibly reliant on them to function.

So it's not a uniform whole. It's not seen as a unified workforce with a set of skills that are unique to it and that are transferrable

and valuable. And there is this unhelpful hierarchy between unregulated workers and the regulated workforce such as RPNs and RNs. That's been a barrier to properly considering them as part of the team and part of the continuum of care.

You know, they comprise the vast majority of staff in long-term care homes where they are required to work under the supervision and direction of a regulated staff person. And it's very interesting; the July 2020 long-term care staffing study made recommendations about increasing, not just the size, but also the mix of care providers in long-term care homes, and I think rightly so. It has since addressed -- the Government has since addressed the recommendation that the number of hours per resident be increased, but it also made recommendations about ensuring that there's appropriate leadership training for registered staff, and in that, knowing how to include members of the team and lead members of the team in the interest of good care, and that all staff should receive be -- should receive proper training and better training on how to work in a long-term care setting as part of their educational preparation. That's huge, very, very important.

So all that to say a centralized repository of the PSW workforce still does not exist, and we have not succeeded in levelling the playing field or the expectations that we have of this workforce across all sectors. We, in 2011, were focused on home and community. Today, we're focused on long-term care. We've not succeeded in the levelling the playing field or really looking at this from a systemic perspective, and Deborah's comments will make it very clear that we can't go forward unless we do that.

A registry may have been helpful in a situation like the one that we're currently living through right now. It may have been a resource to us so that we could have seen in an instant, have a snapshot of where PSWs were working. It might have been able to track that they had completed proper additional training requirements like COVID screening protocols or the proper use of PPE and other infection control practices. It could have been a repository of that kind of information that would have been helpful in a pandemic, and it could have identified underutilized resources.

So where PSWs were not employed full time or were qualified to work but unemployed, it

could have identified where underutilized or unutilized resources existed so that they could be redeployed into pandemic hotspots or pandemic response roles.

And I think it would have also provided the concrete evidence that I think is needed to answer your question about the educational preparation of the workforce: What's the proper oversight for the workforce? What's fair remuneration for the workforce? And how do we level the playing field so that we're not poaching from sector to sector when, you know, people are driven by the wages offered from -- in one over another?

And it could have maybe provided the information to make good decisions about the proper utilization of the workforce. I think you'll hear more from Charles later that, until we address some of these very concrete issues around education, remuneration, utilization, you know, the regulation issue or the regulation question cannot be properly answered.

I'm happy to chat more about that, this historical learning, but I think it would be helpful if we moved on to Deborah now, and she can

talk about the home and community care sector and how that sector figures into the long-term care sector's ability to respond to crises like the one we're currently living through.

DEBORAH SIMON: Hi. Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

DEBORAH SIMON: So I'll just -- I'll just jump right in. Thanks, Monica.

And thanks for the opportunity to speak with you this morning. Deborah Simon, the CEO of The Ontario Community Support Association, been the CEO for about eight years. By background, I'm a clinician. I'm an RN, and I've spent about 30 plus years working in the home and community care sector, so I've really good insight into some of the challenges and the opportunities in home and community care and actually the work of personal support workers. So just I will spend very little time on background but do think it's important given the context of your investigation in long-term care as it, really, I think, shed enough light on home and community care, and if there is a question of regulation of personal support workers, it has to also incorporate -- incorporate, sorry,

PSWs working in home and community care because they're a great -- a large component of the workforce.

So our association formed way back in '92. It's a legacy organization of organizations that were serving meals on wheels back at the time what was called Home Making Services and that came together to provide, sort of, a more -- a powerful voice for the sector which was quite segmented at the time.

We have -- represent a pool of about 220 not-for-profit home and community providers. They're various sizes. They range from organizations like ESSE Health which is international in size to very small local community support or meals on wheels organizations in various communities across the Province.

Our members are, again, not-for-profit. They're community-based. They provide a multitude of health and wellness services. It makes them diverse. It makes it difficult sometimes to really appreciate the scope of community support services and home care, but they also provide services that help, not just seniors, but people with disabilities. And that's a large component of what

happens in home and community and, I think, has to be factored in when you're looking at the workforce supporting people in communities.

It's because of our longstanding work in the community that our association was chosen by the Ministry to operate that first PSW registry. It was a voluntary registry, first of its kind, and it was developed in collaboration with many stakeholders in the Ministry.

I do want to do my -- at the outset, say that I am not a regulatory expert. I have Charles and Monica here to speak a little bit more to their knowledge and experience in regulation.

My -- I came on board when OCSA had started the contract for the PSW Registry, and I brought my knowledge and experience of the sector to the table, but, again, not a regulatory expertise.

Our organizations and community provide over 25 different services, and they're mostly in the order of health promotion, preventative services, and services to actually help people to get back into independence.

It's -- our sector is divided into three really distinct areas. One is home care, and

this is the procured services through Local Health Integrated Network, the LHINs, formally the CCACs. Then there's community support services that are with accountability agreements directly to the Local Health Integration Networks, the LHINs. And then there's independent living services which tend to be more regional in nature, and those are the organizations that provide attendant care services to adults with disabilities and operate on a very different model of service.

So the range of services include, as you know, in-home nurses and therapies for home care and rehab, adult day programs, assisted living programs, personal hygiene programs. There's a myriad of homemaking services that help support seniors to stay independent in their homes, things like meal prep and light cleaning and transportation to medical appointments.

Over the past decade, there has been a really seismic shift in the acuity level of people being cared for in the community, as you know, as hospitals have been taking on a role of really moving clients more quickly and sickly, as some would say, into the community. The sector has taken on a large number of clients that have the

highest needs including individuals who are on ventilators in the community and are supported there.

So in our sector, there's approximately 35,000 PSWs working in home and community care, and the last stats that we had received from the Ministry indicated that there's about a shortage of about 6,000 PSWs across all sectors, and that's just to meet what we're thinking is current need, not foreseen needs.

Only about 38% of PSW positions in our sector are reported as full time, and -- as compared to as what I understand is about 41% in long-term care. Approximately 29% of personal support workers working in home and community have multiple jobs, and there is a huge wage gap.

So right now, PSWs working in the community sector versus the hospital sector have an average wage gap of about 18.7% or $3.57 an hour. The gap is about 9.2% or $1.75 an hour for those PSWs who are compared to -- or who are working in long-term care. So of the pecking order, hierarchy of wages, home and community is the lowest on the -- on the totem pole.

Our association knows that home and

community care sector could actually be leveraged better currently to support the Province's battle against COVID. The members are there to help, and during the peak of the pandemic, with the government forced into a lockdown, the utilization of our sector dropped, and that's completely opposite to what we thought might -- what might have happened during the pandemic.

From March to June of 2020, client home-care assessments were down 34% compared to the same period in 2019. The biggest drop came in April when community assessments dropped by 60% compared to 2019. Initial screening assessments took an even bigger drop in that month, and they were recording about a 77% reduction.

When the sector is utilized, it thrived, and it was very safe. Just an example of that would be the investment that the Ministry of Seniors made, $11 million investment for the Ontario Community Support Program, a program which delivered meals on wheels, and it delivered almost half a million meals and food hampers and essentials in a very safe manner in a matter of weeks with very little challenges.

So during the four-month period from

January to May in 2020 where there was 200 -- two thousand and -- over 2,000 positive case of COVID in long-term care and retirement homes, home-care sector had only 3.48% of positive cases, and this is really a tribute to the IPAC practices that were in place with employers in the home and community sector, the fact that we are actually dealing with much less congregate settings for seniors and those who are vulnerable in the community, and to some degree, really the strong oversight in practices that actually happen in home and community care. And we do have, and -- if I --

I don't think, Charles, I gave you the paper, but I can actually make sure that you get the IPAC paper that was done on home and community care as a safe haven for those receiving care in the community.

We did a survey of home-care patients, and it showed that 93% of the respondents really feel safe receiving home care from their home healthcare provider which includes primarily PSWs as they're the backbone of our sectors.

So just to talk a little bit about the connection between home and community care and long-term care, both sectors, as Monica has

indicated, are intrinsically connected and linked, and we're supportive of the most recent report from the National Institute on Aging when you start thinking about home and community care and starting to think about home care and community care as a continuum of long-term care as opposed to a standalone sector.

And they have a definition that we think is really, you know, important. It's that we provide this range of preventative and responsive care and supports for older adults that include the ADLs, activities of daily living, and the IDLs, provided either in a not-for-profit or for-profit way or by uncare -- caregivers which is a large component of the service delivery in our -- in our sector that are not location specific and thus include -- (AUDIO MALFUNCTION)

COMMISSIONER FRANK MARROCCO (CHAIR): I think --

DEBORAH SIMON: -- can include designated -- yeah. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Simon, I think mine froze a bit for a few seconds, maybe, so just the last, maybe the last point you made, you might want to make it again.

DEBORAH SIMON: Okay. I apologize. In Pickering, we get periods of bandwidth that does not hold.

What I was saying is that the National Institute on Aging has defined long-term care, really, as a continuum, moving from, sort of, in-facility long-term care retirement homes to in-home settings such as those that are provided by home and community care services. So we're not seen as distinct pockets of long-term care.

So right now, there's approximately 38,000 Ontarians on a waitlist for long-term care. We know that. An average wait time on this list is a staggering 147 days to be placed into long-term care. The report from CIHI confirms that 8% of newly admitted residents to long-term care could have been kept at home with the right supports. And that's close to 8,000 Ontarians.

So what I'm offering to the -- to you is that I think that the alternatives for people, some percentage of individuals who are waiting to get into long-term care could be filled by home and community care. And keeping those people at home would have lowered their risk of exposure to COVID as well as generated system savings, and we

estimate that savings, if we were able to, to be around 238 million by not putting people in long-term care facilities that don't need to be there.

So between -- just by background in terms of admissions to long-term care, between 2008 and 2017, Ontario doubled the number of high-needs seniors being cared for at home from 42,170 to 90,141. One in three clients served by the sector -- our sector had moderate to very high medical complexity. And there are currently over 24,000 seniors and 4,500 adults with acute brain injury living well in assisted living services that provide them with 24-hour urgent care response and personal care, with also medication compliance, light housekeeping, and others.

So we are managing in the home and community sector, with the use of personal support workers, very high-acuity clients very safely.

In Ottawa, there was a project called the Enhanced Assisted Living Services that's enabled people who were ALC to be -- and waiting to be placed in basic long-term care to report -- return home safely. That program cost $114 a day which is 37% less costly than long-term care and

produced better results.

Being cared for at home seems to be the right care setting for most of these clients; 56% of those enrolled in the program saw their health condition improve, and 78% experienced no hospital readmissions.

As part of the government funding for the high-intensity supports at home announced in the last budget, two of our members partnered to target individuals with complex care needs having been on waitlists for long-term care and were able to avoid being placed in a facility.

I just want to talk a little bit more. I think -- I think what I'm trying to make my case here is that you've got an alternative in home and community care that is probably not tapped as much as it could be and should be, and these are good programs that -- to look as -- look at as alternatives.

But human resources is an -- is an issue, and the workforce of our two sectors, long-term care and home and community care is intertwined. The introduction of the single workplace restriction for frontline staff resulted in some of our home and community care

organizations losing up to 50% of their frontline staff. There's tough competition between the sectors for a very scarce health human resource. Many of our home and community care organizations are reporting losing staff to higher paying long-term care and hospital sectors; 21% of respondents to an OCSA survey cited losing PSWs to other healthcare sectors as the main reason staff leave their organizations, and 39% cited lower pay reasons -- lower pay rates as the main reasons.

So from the perspective of recommendations in our budget submission to Government, we've called on the Government to significantly increase service capacity across home and community care sector. We need to create enough capacity in the home community care sector to ensure that those who could have been kept at home are able to do so.

So as there is -- as we see the resources in home and community care diminish, it simply pushes more pressure onto long-term care and inappropriately so.

In 2018, '19, the Ministry of Health noted that it was to simply maintain the sector's ratio of supporting 76% of Ontarians that are 75

years or older at home and in communities, the Province needs to provide funding for more than 23,000 more patients or clients. And as Ontarians continue to age, these funding pressures on our sector continue to grow at a rapid rate.

The home and community sector is more than able to keep people safe at home when properly resourced. So we are calling on an integrated, comprehensive, cross-sector health human resource strategy that leads to wage parity across sectors to ensure that all sectors have adequate supply of qualified resources.

The long-term care staffing plan that was just released last week may have positive impacts on the quality of care for residents in long-term care, but it could come at the expense of those receiving care at -- in the home -- in their home and in their communities without adequate human health resources to keep seniors and those with disabilities well and safe at home and those with disabilities who -- I'm sorry -- the pressures will continue on long-term care facilities.

And we estimate the cost of eliminating that gap between home and community care and other sectors to be about $235 million. It's not a drop

in the bucket. We recognize that, but historically, that drift has been -- is continuing to grow.

The majority of home and community care organizations, as I mentioned before, continue to have that pressure with the transition. And so I guess my message to you as Commissioners looking at long-term care is that we need to look at a balance, and that anything -- the domino on long-term care will have that ripple effect on home and community care, and I think it's important to keep a balanced approach when we're looking at anything that has an impact on personal support workers and the workforce supporting it.

So, Charles, I'm going to flip over to you unless there's any specific questions for me right now.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kitts.

COMMISSIONER JACK KITTS: I'm just wondering what your opinion is on the fact that once frail elders with, you know, chronic disease and other -- the acuity, as you said, is going up in the hospital, in the home, in the -- in the long-term care and in the home and community. And

so you talk about if we fund long-term care, home and community care may suffer. If we fund hospital, it would be other one.

Do you see a time where the flow of patients becomes at a state where you want them in the right place at the right time --

DEBORAH SIMON: Yeah.

COMMISSIONER JACK KITTS: -- and that's not fixed at home and community or fixed at hospital or fixed at long-term care, yet it seems once you're labeled, that's where you need to be?

So the funding envelope would be much larger, and the collaboration would be much better, and the patient would be more likely to be in the right place --

DEBORAH SIMON: Yeah.

COMMISSIONER JACK KITTS: -- at the right time.

DEBORAH SIMON: And, Dr. Kitts, you're hitting on exactly the right -- the same -- the point. I think through the Ontario Health Teams, the OHTs were actually going to see that same continuum shift.

The issue of parity, if it doesn't get addressed now, is going to get addressed there. So

if you are providing a continuum of care, you're providing personal support services in hospital, and you're part of the same team, and you shift to the community because that's the right place for you to be. You're not going to get -- you're not going to get workers to stay in that sector if you're not paying them at the same rate for the same work, so we're moving there anyway.

COMMISSIONER JACK KITTS: Thank you.

DEBORAH SIMON: Charles, you're on mute.

CHARLES BEER: A former politician should never be on mute. So let me -- and I'm going to come back to your question, Mr. Chair, with respect to regulation and moving forward. And let me frame it in terms of, sort of, two questions, when and how.

And what I'd like to do at the beginning is just get us to step back and look at the past decade and, indeed, a few years more than that. In 2006, the Health Professions Regulatory Advisory Council, HPRAC did a review on PSWs and said that at this -- at that point, they shouldn't be regulated as a college nor should they be regulated with a registry. It was a fairly fulsome

report.

Then move ahead a few years, the government of the day announced that there would be a registry and then created the committee that, at that time, I chaired to try to flesh that out and develop it.

And in each of those, as Monica has said, in addition to talking about the form of the -- of the Registry, we had to look at the nature of the workforce and a number of attendant elements to that.

When the Government decided that they wanted to move in a different direction and closed down the first registry, they brought in an organization from the UK, the Professional Standards Authority. Now, I'm going to comment more on that a little later.

But again, their report, which went into a great deal of detail about need and the state of the -- of the sector and provided a series of possible options that the Government could look at to move forward. And I always found it interesting that with all that they put forward, the government of the day actually went back and said, no, we'll -- we want to create a registry,

perhaps somewhat differently, but we want to create a registry. And so Michener came in. We haven't seen, as yet, the final report that Michener did, but I suspect, in having talked with Marnie Weber on this, that a number of the issues that they were looking at were similar. I know both Monica and Deborah were involved in discussions with them as they went about that work.

So we had, if you like, in 2006, 2011, 2015, and then 2017 to '20, which is the Michener work, a pretty exhaustive analysis of PSWs and the issue of regulation and issues around what they do.

At the same time, on the -- on the, sort of, content and substantive side, you know, the Ministry of Health was doing a number of things, and there's work that I'm sure has been shared with you around how they were looking at the PSW workforce.

Another group that, if you haven't had a chance or been told about it that has done some very interesting work on the regulatory and substantive aspects of health -- of the health professions is at McMaster, and it's the Master Health Form.

In 2017 and 2019, they carried out two

extensive reviews, the last one, 2019, was entitled Examining the Efficiency and Effectiveness of Ontario's Health Workforce Regulatory System. And one of the things they noted that needed to be addressed was that of personal support workers.

But in those two works, what they did was they looked at a variety of jurisdictions, compared how those jurisdictions dealt with different kinds of regulatory issues, not so much in terms of a specific health profession, but really looking at the structure of reform and going back to a point Monica made around the fact that one of the key overriding objectives of regulation is protection of the public.

The McMaster work was funded by the Ministry of Health, and it is partly responsible for the proposal that the Province brought out earlier this month in terms of its regulatory colleges called the New College Performance Management Framework, and that flows very directly from the work that was done through the MAG process.

The other thing to look at is other jurisdictions, and I'm only going to comment on two in Canada, but normally in the Province, we look

at -- and in the past, I've worked on perhaps half a dozen or so colleges and their scopes of practice and various elements. But we normally look at the U.K., Australia, New Zealand, a few of the States. Often, we find that the U.S. is not transferrable, but Alberta and B.C. are ones that we look at, and they look at us. And both Alberta and British Columbia have registries, not exactly the same as what was developed with the first one, but nonetheless, they're comparable.

Just in the past few weeks, Alberta has announced that they are going to take -- for them, personal support workers are call healthcare aides, and they are now moving their healthcare aides into what's called the College of Licensed Practical Nurses, and that college is going to be called the College of Licensed Practical Nurses and Healthcare Aides. Now, this was just announced. It hasn't happened yet, but that is what they are intending on doing. The --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask you, Mr. Beer --

CHARLES BEER: Yeah. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- the College of -- I think you called it

Practical Nurses.

CHARLES BEER: Yeah, licensed --

COMMISSIONER FRANK MARROCCO (CHAIR): What's the -- what's the Ontario equivalent?

CHARLES BEER: Okay. Because -- and that's a good point because in Alberta, they have two colleges. There is a College of Nurses as well as the licensed practical.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

CHARLES BEER: And the licensed practical would be similar to the RPNs.

MONICA TESTA-ZANIN: And so in Ontario, the College of Nurses regulates both RNs and RPNs.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

CHARLES BEER: Right. Right.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, thank you. That -- yes, thank you.

CHARLES BEER: Right. The -- in British Columbia, they are now in the midst or about to begin a major change in their regulatory structures, and I want to comment a bit about that, and then I've got some suggestions, perhaps, to make to the Commission.

I noted before this body called the Professional Standards Authority from the U.K., it has become very influential in English-speaking countries in terms of the work that they've done on all aspects of regulation. They have actually done a review of the Royal College of Dental Surgeons of Ontario and in British Columbia, and they carried out the PSW review.

In 2019, B.C. had asked the former head of that group to come in and, among other things, look at the overall structure of their regulated Health Professions Act. And this -- it -- the McMaster work has some of this that they've demonstrated, but the report in British Columbia is very far reaching, and I think its importance for you, as we talk about regulation, is that it does suggest, hey, we can look at this issue differently.

In the B.C. report, they have some 21 colleges, and those are going to be brought down to six. And those colleges, what is really happening is apart from the physicians and surgeons, the nurses, and I believe the third one is pharmacists, they're going to be grouping various professions in two other colleges. And this has been an element

of what the U.K. group has done, and they do it in the United Kingdom as well.

And I was trying to think of a way to make this, sort of, clearer, and it -- one of the things they're saying is that regulation is about protecting the public. It's setting various structures to ensure that, as you said before, it has a focus on standards and education. But a lot of those elements are not dependent on the profession specifically.

So they're saying you can group different professions, but there's certain key functions that, regardless of the profession, need to be undertaken.

So just to give you an example -- and I'm not saying that this is something that Ontario should do, but it's a bit like if one were saying, let's take the personal support workers; let's take developments service workers; let's take those workers in addiction and mental health, and we could create a regulatory body in which they would be involved. And the different structures around admissions, the keeping of records, the complaints and discipline and so on would all be -- would all be similar.

So this is one of the ways that -- and B.C. is just starting, and it's going to be interesting to see how that works out. Alberta in the legislation they brought in this week made reference to that work and said that they were going to be making changes to their structure.

Now, in Ontario, I mentioned that just this week, the Ministry announced that they were going to have a college performance measurement framework. This came out of one of the reports of the McMaster forum. It's just starting, and they're going to be asking the colleges to report under certain headings so that they can begin to get a picture of how effective colleges are.

Now, where that will ultimately lead is not known. Ontario is much larger than British Columbia, so is it likely that we go to fewer colleges? Perhaps, but that -- that's not clear at this point.

But I think what's got everybody in the regulatory world interested is the B.C. report really saying, start thinking outside the box. Are there different ways that we can do this with one of the issues being around either smaller groupings of healthcare workers who wouldn't be able to

support a college or larger groupings, such as PSWs, who may not have the financial wherewithal that others would in order to support a college?

COMMISSIONER FRANK MARROCCO (CHAIR): Do you not think, Mr. Beer, there's also an experience, it's -- that, you know, being a regulatory body isn't something that you just start doing, that there's experience -- that you need experience in order to do that effectively?

CHARLES BEER: Absolutely, and I think you make a really good point. When one reads the chap who did the B.C. work -- his name is Harry Cayton -- when you read what he wrote in the -- sort of, the second part of the report that deals with the reforms, I think that is very clear in the way he's suggesting colleges could be better organized and better regulated.

Now, I think one of the -- one of the questions, then -- and I want to come back to this is, so how does this now relate to Ontario and to your work? And this is the, sort of, the when and how becomes really important.

I think it's clear from what Monica and Deborah have underlined that there's some major issues, and that while they're not unrelated to

regulation, they don't need regulation to be addressed and dealt with.

In, it was, I think, the end of 2017 or early 2018, the Ministry brought a lot of people together to look at the PSWs and, sort of, identified access and quality, education, and accountability and oversight is key things that they would need to do. And I think those still resonate today.

And at the local level, I'd -- I want to mention because I think it was a very well done report, the North Simcoe Muskoka Local Health Integration Network in 2018 looked at the availability of PSWs in their area and tried to forecast what the issues would be. And they all reflect what Deborah was saying, and I think that those issues would be reflected in other parts of the Province.

I live in Newmarket in York Region, and we have a very innovative group here called the Community & Home Assistance to Seniors Group, or CHATS as it's known, and they do all kinds of different kinds of programs, and they have been struggling to find PSWs. And as Deborah said, while we all understand why the Government made the

recent announcement and understand its need and it's not one saying it isn't, but that integration of PSWs globally is very important so that there's an equal playing field. So we have those two -- those two realities.

Now, can one move forward in developing a regulatory regime and also do those other things at the same time? I think that's a critical question.

One of the thoughts that we had is -- and I'm going back just to the outline of what's been going on over the last decade -- I think there is enough information before you with the Ministry both around PSWs, what they do, what they need, what the issues and the problems are in order to enhance the profession and ensure that it can play the role that we'd like it to play, and there's all kinds of examples now around different forms of regulation.

It may well be that in the Michener Institute's Report, that they found the silver bullet. I know that it's almost by default at times, and we thought about this eight, nine years ago, the question of, well, would the College of Nurses be the appropriate place?

And I guess one of the things that struck me both during the process I was involved with and I think since then is a certain ambivalence within Government to get into this regulatory piece, and then it's like there's a hesitation. Is this the way to go? And do they provide -- you know, is it going to be mandatory so the appropriate -- are the appropriate rules in place to handle discipline and so on?

So does it make sense, then, to take a group of some 120,000 and put them together with a somewhat larger group of 175,000 nurses? Can that be an effective, workable arrangement? And according to the testimony that was given to you from Michener, they seemed to have talked with people and feel that that could work.

But I just raise a caution around finding that appropriate structure, and I want to just quote one thing to you. The U.K. Professional Standards Body had developed what they call a Right-touch regulation. And I think it's a useful way to look at regulation, and I'll just read briefly part of it:

> "Right-touch regulation means understanding the problem before

jumping to the solution. It makes sure that the level of regulation is proportionate to the level of risk to the public. It builds upon the principles of good regulation."

And Harry Cayton, who was involved in that, talks about that in the -- in the work in B.C.

So from all of that, I'm wondering if it might be useful both for your work and for the sector if you ask the Ministry to come but to speak to you about PSWs, not just about long-term care homes, but the -- their vision, the way in which now they see that role encompassing the three sectors where we find PSWs, and then also talk about the Michener Report and the specific recommendations that are made around regulation.

And then what I would be looking for is, are they clearly addressing some of those supply issues that are critical, that the shortages, the compensation issues, and, again, as Deborah said, the increasing complexity of what is being handled at home and the availability of people to deal with that?

So I think there's a balance in needing the overall supply question addressed, and can you

do that while you're also addressing the regulatory issue, or are some of those things you need to do first, and then you do the regulatory? I don't have the answer to that, but I think that the Ministry or I guess I should say the Ministries in Ontario are perhaps now at a point where they could address some of those questions and how they would move forward.

COMMISSIONER ANGELA COKE: Just if I may just make sure that I understand what you're saying. To think of this in terms of phasing or the timing, what is a priority to be dealt with, and if you dealt with some of those other issues and then decide to look at regulation, might you look at regulation a bit differently if some of those other issues were dealt with?

CHARLES BEER: Yes, and I'd include in that -- I mean, you might feel you can do both at the same time, but I think that if I look back -- and Monica and Deborah can correct me here -- I think if in 2011, if some more work had been done before we started the regulatory piece, it might have been more effective.

I think we found ourselves -- for example, there was a separate piece of work going

on in terms of developing educational standards, so we didn't have that to look at.

So it's how to do those, you know, together or separately, but I think just being conscious now that the PSW sector is critical, and we need to be looking at it in those three areas. And then what is the regulation that is most suitable, and I would suggest taking into account some of the recent thinking about different forms.

And if, out of all of that, it's felt that, look, we think the best answer is that the PSWs should become part of the College of Nurses, at least I would hope the other issues have been addressed, and we've been able to make progress.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, if that completes your remarks, Mr. Beer, and thank you all very much for --

Were you -- was there something else you were going to say?

CHARLES BEER: Well, if I may, the only other thing I wanted to say which is just, I think, an interesting observation on regulation, in British Columbia, after the report was presented, the Minister of Health then created a committee to look at that report. And it was an unusual

committee because the committee was made up of the Minister and his two opposition critics. And the three of them then produced a report which had some variance on the initial document, but the three of them agreed on what needed to be done. And I -- I just -- I found that, again, as somebody who's been in the political system a fascinating way for this to go forward. And, I guess, to place us in the Christmas period, perhaps, we can wish for a spirit that would allow all the parties at Queen's Park to come together and be able to move us forward on this issue.

But we thank you for your time this morning and hope this has been somewhat helpful to your deliberations. And if there's anything else any one of us can do, I know we'd be glad to assist.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it certainly has been -- it has been helpful because this issue of how you have some effective oversight is one that has come up in our discussions, and so your collective comments have been very, very helpful, and the importance of integrating home care with what we're thinking about is something that perhaps we might not have

thought about if you hadn't mentioned it.

So thank you very much for the presentation, and it's given us, I think, some very useful things to think about.

CHARLES BEER: Thank you very much.

MONICA TESTA-ZANIN: Thank you all.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

MONICA TESTA-ZANIN: Bye-bye.

COMMISSIONER JACK KITTS: Bye, Charles.

DEBORAH SIMON: Bye now. Happy holidays.

CHARLES BEER: Yeah.

COMMISSIONER JACK KITTS: Same to you.

COMMISSIONER ANGELA COKE: Same to you.

-- Adjourned at 10:13 a.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 22nd day of December, 2020.

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WORD INDEX