AdvantAge Ontario

Advancing Senior Care

Response to Proposed Bill 235- *Support for Seniors and Caregivers Act, 2024*

December 2024

Response to Proposed Bill 235- *Support for Seniors and Caregivers Act, 2024*

December 2024

Summary of Recommendations

Fixing Long-term Care Act, 2021 Proposed Amendments

Recommendation: Remove references to 'Clinical Director' and instead keep the term 'Medical Director' and keep the proposed change to open up the Medical Director role to RNs in the Extended Class (nurse practitioners).

Recommendation: Do not proceed with individual offence provisions.

Recommendation: Remove the requirement for the licensee to pay for the expert assessment if no non-compliance has been found.

Recommendation: Do not proceed with the removal of the penalty reduction for NFP homes.

Recommendation: Do not proceed with the general offence provision.

Recommendation: Reduce the limitation period to two years to align it with other regulatory regimes in Ontario.

Recommendation: Do not proceed with the proposed amendments related to infectious diseases.

Retirement Homes Act, 2010 Proposed Amendments

Recommendation: Do not proceed with the proposed amendments related to infectious diseases.

Introduction

AdvantAge Ontario appreciates the opportunity to provide feedback to the *Support for Seniors and Caregivers Act, 2024*. We are in agreement with much of the intent of MLTC and MSAA regarding the foundations of the *Support for Seniors and Caregivers Act, 2024*, and applaud the requirements for all homes to have a dementia care program, as well as the extension of the Medical Director role to nurse practitioners. These are constructive and positive improvements for the sector.

With this wide-ranging bill which includes amendments to both the *Fixing Long-term Care Act, 2021* (FLTCA) and the *Retirement Homes Act, 2010* (RHA), there are elements we are supportive and others we have concerns about, and some of those concerns are significant.

With respect to the expansion of the investigation powers and compliance powers more broadly, our overall comments and concerns from our November 2024 submission on the proposed changes still stand, in that these changes will perpetuate a climate of fear amongst staff, leadership, and governance boards, at a time when compliance activity is already at an all-time high across the province.

Concerns related to increased compliance powers, in an environment where there are already 2 inspectors for every long-term care home and all the associated compliance activity that comes with that, are real and valid. There are foreseeable consequences of increased punitive compliance measures when there is no other place in the healthcare system that has anything close to an enforcement system as long-term care. This needs to be seen as the detriment to employment in LTC that it is.

Below you will find specific comments on the legislative amendments for both Acts.

Commentary

1. *Fixing Long-term Care Act, 2021 Proposed Amendments*

Dementia Care

We are supportive of the requirement for all homes to have an organized program for dementia care and services for the home to meet the care needs of residents with dementia and applaud the ministry for including this amendment. The funding announcement for emotion-focused care which coincided with this legislation will be instrumental in scaling and spreading those programs across the province.

They have proven to be a true game changer for both residents and staff in the long-term care homes that have implemented them, and we are thrilled of the ministry's recognition and endorsement of this approach which, among many others, is transforming the way residents with dementia are cared for.
If MLTC is considering assessments of these dementia programs and different models of care for the purposes of inspections, our Association would be happy to engage with the ministry on this. Any indicators and program measurement should be developed with the understanding that homes have implemented different dementia care programs, either from an established program or built by the home itself.

Addition of requirements related to cultural, linguistic, religious, and spiritual recognition and religious and spiritual practices

We are in full support of the proposed amendment requiring every home to ensure there is an organized program to recognize and respect the cultural, linguistic, religious, and spiritual needs of residents. We are equally supportive of the requirements of each licensee to ensure residents are given reasonable opportunity to practice their religious and spiritual beliefs. These are foundational aspects of many people's lives, and ensuring every home in the province recognizes this is essential to advancing person-centred care, no matter where you live. We applaud MLTC for this recognition.

Change to Clinical Director role and addition of Nurse Practitioner

Recommendation: Remove references to 'Clinical Director' and instead keep the term 'Medical Director' and keep the proposed change to open up the Medical Director role to RNs in the Extended Class (nurse practitioners).

We are pleased to see the proposed change to open up the Medical Director role to RNs in the Extended Class, or nurse practitioners. Our Association has heard from several homes who for years have had issues with trying to attract a physician to work as a Medical Director in LTC, and due to the chronic doctor shortage, have had significant challenges. This change will provide another avenue for these homes to provide the necessary medical oversight and leadership for their home, and the recent announcement for the increased funding to hire a nurse practitioner will greatly help with this.

However, we do believe that the proposed name change from Medical Director to Clinical Director needs to be reconsidered. We have heard that this name change may have a very negative effect across the LTC sector as there may be medical directors who will refuse to sign a contract as 'clinical director'. Keeping the name as Medical Director also aligns with the established role internationally and doesn't require other changes including the Medical Director Course. We understand many NPs have taken the course and have found it very useful.

This approach would enable collaboration between physicians and NPs. There also needs to be a leadership role in the home providing oversight on the medical services program, so in that interpretation the Medical Director could be NP or physician as they are providing medical oversight to the primary care providers (Attending physician/RN-EC).

Changing it to Clinical Director would also cause confusion as how that role differentiates from the Director of Care/Nursing, versus the Medical Director role being responsible for medical oversight that includes primary care providers (physicians and RN-EC) on the medical care.

We also believe that physicians acting as Medical Directors need an increase in compensation. As part of a recent Association survey which has informed advocacy on this issue, compensation was the number one barrier for a LTC home recruiting and retaining a physician. Medical Directors do not bill OHIP for their role as Medical Director- rather, the home compensates them through level of care funding. Unfortunately, the recent increases in the OMA Physician Services Agreement do not apply to Medical Directors in LTC.

Investigation Powers- Individual Offence for Abuse or Neglect of a Resident

Recommendation: Do not proceed with individual offence provisions.

Before providing our commentary on this specific proposal, we want to first reiterate that we share the government's goal of protecting vulnerable residents living in long-term care homes. However, we have several concerns with this approach.

The sector and broader public will question why this authority is necessary and being sought now, particularly when the Ontario long-term care sector already has a substantive regulatory regime. With the lack of transparency on investigations, we have significant concerns that the communications on this amendment will further perpetuate negative stereotypes of the entire long-term care sector and cause broad based fear and anxiety within the sector.

Second, the Ministry stated that this offence would address the gap in oversight related to unregulated health professionals. However, this is an unclear rationale because while regulated health professions can lose their license because of professional misconduct, they do not face potential liability for regulatory offences relating specifically to neglect or abuse of a resident, patient, or client.

Despite recent substantial investments by the provincial government, Ontario's long-term care staffing crisis persists. The sector continues to face challenges such as low wages, high turnover rates, and burnout. There is a growing public perception that long-term care is a difficult and undesirable field, which impacts homes' ability to attract and retain enough skilled workers.

Given that the workforce in other health care settings in Ontario do not face potential liability for a regulatory offence relating to the care they provide, the introduction of such an offence will likely greatly affect recruitment and retention of direct care staff in the long-term care sector, which is already extremely challenging. Why would health care workers choose to work in this sector, when they can work in acute care settings which have higher wages and where they would not face potential liability for a regulatory offence. It is hard to see how the threat of prosecution will act as an incentive for an already demoralized workforce.

Third, the Act already addresses offenses related to neglect of residents; there is an offense for licensees to fail to protect residents, which does not apply to individuals. We have concerns that with the persistent staffing shortages in the sector, this would mean that supervisors, management, and leadership in the home or municipality would be failing to take steps to prevent abuse or neglect if a resident does not receive adequate care, through no lack of trying to secure staff.

The sector should not be left in fear, and anxiety that they will be penalized for mistakes. It is imperative that homes can build and maintain a just culture where staff feel comfortable reporting incidents.

Investigation Powers- Individual Offence- Officers

Subsection (4) states that an officer or director of the licensee, or a member of a board or committee of management of a municipal home, are guilty of an offence if they "authorize, permit or concur in the commission" of the offence of abusing or neglecting a resident by a staff member or volunteer or a person providing services to the home or to a resident of the home.

The wording: "authorize, permit or concur in the commission of an offence" is taken directly from the *Child, Youth and Family Services Act, 2017* (CFSYA). But the qualification from the CYFSA is omitted. The wording in the CYFSA is, "a director, officer or employee of a corporation who authorizes, permits or concurs **in such a contravention by the corporation** is guilty of an offence". The CYFSA limits potential liability of employees, directors and officers of a corporation to authorizing, permitting or concurring in child abuse **by the corporation**. The FLTCA amendment is broader: it creates potential liability for authorizing, permitting or concurring in abuse by individuals who provide health professional services to the home and to external professionals providing health services to residents.

The broader scope of the offence is concerning because among other things the words "authorize, permit or concur" are each vague. For example, it is unclear what steps an individual corporate director must take from a governance perspective to ensure that they do not "permit" an external care provider to abuse or neglect a resident. Although the MLTC may offer assurances that it will limit investigations and prosecutions to egregious situations, the scope and wording relating to potential liability will unsettle the sector.

This is another reason as to why the individual offences provision should be removed.

Inspector Powers- Requirement for Expert Information

Recommendation: Remove the requirement for the licensee to pay for the expert assessment if no non-compliance has been found.

This proposed amendment refers to a power to require expert examinations and assessments at the licensee's expense. Further, that this provision would provide new information where non-compliance has not been determined. This power is generally applicable to any non-compliance, rather than applying in the context of offences. We have two areas of concern regarding this proposal, which we outline below.

First, under the Act, inspectors already have the power to use expert assistance during an inspection through FLTCA clause 150 (1), so MLTC could arrange for testing and an expert report, if it wants to minimize compliance burden. This would be more appropriate than requiring the licensee to do this at its own expense before the inspector has determined non-compliance.

Second, it is hard to see the rationale for an examination or assessment being at the expense of the licensee if non-compliance is yet to be determined, especially as inspectors already have the power to use expert assistance during an inspection, as noted above. The government's identified purpose of inspectors is to determine compliance and non-compliance with the Act, and as such, it should be under the purview of inspectors to gather the appropriate information to determine compliance.

The long-term care sector is already under resourced and subject to financial penalties under the Act for findings of repeated non-compliance. We have concerns that introducing a power to require expert information at the expense of the licensee will exacerbate financial burden. Members are very concerned about the potential of having to pay for experts to help determine compliance, especially when there appears to be no limit to the type or cost of said experts.

This looks like downloading of inspection costs onto licensees. If inspectors use this with any frequency it will increase the compliance burden on homes.

Investigation Powers- Removal of Penalty Reduction for NFP Homes

Recommendation: Do not proceed with the removal of the penalty reduction for NFP homes.

Recruiting voluntary board members for non-profit homes under the Act is already challenging enough due to a combination of regulatory requirements, governance expectations, and the evolving complexities of the long-term care sector. The Act already has heightened legal and reputational risks associated with serving on a board of a long-term care home versus other boards including hospitals, and the personal liability is a significant barrier to recruitment.

This proposed amendment removes the reduction in penalty for officers and directors of non-profit long-term care homes (which includes a municipal home, joint home or First Nations homes) upon conviction of the offence of failing to ensure that the corporation complies with all requirements under the FLTCA.

This proposal would have a devasting impact on voluntary board governance in Ontario health care. It ignores the fact that directors on for-profit boards receive payment and may hold investments in the licensees on whose boards they serve, which compensates them financially for the risks relating to personal liability. It also ignores the fact that municipal officials serve on boards in connection with their public service and elected status. While insurance is available to protect non-profit directors and members of municipal boards, we understand that it does not cover compliance related claims.

Voluntary board directors and municipal councillors have made a longstanding and valuable contribution to LTC and health care more generally in Ontario. There is no evidence showing that this change is necessary to protect residents, yet we know there will be a recruitment and retention chill that will result from this change, not to mention the message the change sends to the non-profit and municipal sectors and to the principle of voluntary governance in health care more generally.

Moreover, long-term care homes that are affiliated with hospitals could have boards that oversee both the hospital and home. This proposal will significantly impact current and prospective board members' comfort in sitting on such a board.

Given some municipalities are already questioning their involvement with long-term care beyond the requirements of the FLTCA, we have heard from municipal members that additional punitive measures like the individual offence provision, as well as this removal of the penalty reduction for NFP homes, will further these discussions.

Investigation Powers- General Offence Provision

Recommendation: Do not proceed with the general offence provision.

This proposed change means that MLTC may investigate and prosecute a licensee for breaching any provision in the FLTCA. This lacks proportionality given the sheer number of compliance requirements in the FLTCA. The typical approach in regulatory statutes is to designate a

relatively small subset of compliance requirements as offences. However, there are precedents for a general offence provision, for example section 66 of the *Occupational Health and Safety Act, 1990* (OHSA). But it is important to note that OHSA inspectors do not have the power to issue AMPs, nor is there as wide a range of orders (compliance orders, supervisors, etc.) under the OHSA as there is in the FLTCA.

The issue of proportionality relates to minor non-compliance requirements having enforcement consequences that are out of proportion to the significance of the requirement. The MLTC may reassure the sector that they will not investigate and prosecute licensees for minor or repeated non-compliance, but it is unclear why MLTC needs such a comprehensive offence provision if it already has a full range of enforcement actions to respond to widespread or repeated non-compliance that are far more cost-effective than investigations and prosecutions, most notably AMPs. The ability to investigate and prosecute a licensee for any non-compliance isn't rationally connected to the problem of "egregious non-compliance" (which can be better addressed by a limited set of offence provisions and use of AMPs and orders).

We recommend removing the provision, as existing enforcement tools and the existing list of offences are sufficient to deal with egregious non-compliance. Building a bigger and disproportionate arsenal won't improve resident care and well-being, and introducing a general offence provision will unduly increase anxiety in the sector. We recommend focusing on tools for encouraging compliance and preventing non-compliance. Enforcement addresses issues after the fact.

Four-Year Limitation Period

Recommendation: Reduce the limitation period to two years to align it with other regulatory regimes in Ontario.

The proposed amendment to include a four-year limitation period is problematic, as the standard in Ontario regulatory statutes is 2 years. The OHSA, RHA, CYFSA, *Motor Vehicle Dealers Act, 2002* and the *Residential Tenancies Act, 2006* all have two-year limitations. We suggest reducing it to two years.

2. *Proposed Retirement Homes Act, 2010 Amendments*

Directions and Recommendations Regarding Infectious Diseases

Recommendation: Do not proceed with the proposed amendments related to infectious diseases.

The proposed section 60.1 gives a senior Ministry employee the power to issue a direction to all or class of retirement home licensees relating to the prevention and management of infectious disease. A licensee must ensure the direction is implemented. Section 60.1 does not set any limits or due process with respect to directions.

This will give a senior employee in the Ministry of Seniors and Accountability (MSAA) similar powers to a Medical Officer of Health issuing an order under section 22 of the *Health Protection and Promotion Act* (HPPC), but without any of the qualifications or limits or due process set out in the HPPC.

HPPC section 22 orders require among other things: (a) conditions precedent for the order, for example that there is an outbreak or risk of outbreak which puts people at risk, (b) notice to the person or class subject to the order, and (b) reasons for the order. Importantly, the person subject to the order, or each member of a class subject to the order, may appeal the order. This means that an official at MSAA can direct retirement home licensees to do something relating to infectious disease, without limit or grounds and without any recourse for the licensees affected by the direction.

This adds yet another source of authority in a confusing jurisdictional environment. Retirement homes already must interact with and follow direction or consider recommendations from the RHRA, the MOH, and public health boards and medical officers of health. This expertise also already exists in the MOH and public health agencies, yet it is unclear whether there is similar expertise at MSAA.

The RHRA regulates retirement homes in Ontario. The RHRA is responsible for ensuring that retirement home licensees comply with the provisions in the RHA relating to infection prevention and control. The Registrar of the RHRA has the power in section 92.1 of the Retirement Homes Act (RHA) to make an order in extraordinary circumstances requiring a licensee to do something or to refrain from doing something to respond to circumstances. Section 92.1 provides examples of the sorts of orders this would include.

One example is requiring a licensee to comply with the advice, recommendations and instructions of a local medical officer of health. In addition, one of the RHRA's objects is to educate licensees about best practices for the operation of retirement homes. Given the role of the RHRA and the powers of the Registrar, it is unclear why a Ministry employee needs the power to make recommendations and give direction to licensees with respect to outbreaks.

The lack of an appeal is a denial of fairness and results in an unlimited government power which is inappropriate in Ontario's regulatory environment. (Note that the proposed section 60.1 does not identify any consequences for failing to follow a direction.)

A more suitable approach would be for the Ministry to collaborate with the RHRA and failing that, the Minister may issue a policy direction to the RHRA under section 16 of the RHA requiring it to provide guidance to all or a class of licensees with respect to the prevention and management of outbreaks.

Residents Bill of Rights and Caregiver Supports

We are in support of the addition to the Residents Bill of Rights with confers 'The right to ongoing support from individuals who are, as determined in accordance with the regulations, the resident's caregivers to support the resident's physical, mental, social and emotional well-being and quality of life'. This is a central and crucial right for residents, and we are pleased to see this in legislation.

Conclusion

We share all of the stated objectives of this legislation and its associated financial investments: to improve the lives of seniors through enhanced dementia care and supports, increase assistance for families and caregivers, and to create more opportunities for seniors to build stronger social connections in their community.

We remain hopeful in working with the whole sector for a proportionate and constructive compliance system rooted in quality improvement and staff retention, and appreciate the opportunity to contribute to those discussions.

About Us

For more than 100 years, AdvantAge Ontario has been the voice of not-for-profit seniors' care in Ontario. We represent more than 500 providers of long-term care, seniors' housing, supportive housing and community service agencies, including 98 per cent of all municipal long-term care homes and 86 per cent of all not-for-profit long-term care homes. We are the only association representing the full continuum of seniors' care in the province

Information Contact

Lisa Levin
Chief Executive Officer
905.851.8821 x 230
llevin@advantageontario.ca