

ACE NEWSLETTER

Advocacy Centre
for the Elderly

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HOME FIRST: WHAT DOES IT MEAN FOR SENIORS LIVING IN ONTARIO?

By: Clara Ho, Staff Lawyer

Provincial Philosophy Statement Describing Home First:

When a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge.¹

The state of health care across Canada remains an important political issue for all levels of government. There has been a lot of publicity lately in the media about emergency room wait times and overcrowded hospitals as well as seniors requiring home care supports who are either not receiving adequate services or not receiving these services at all. As we approach the Ontario election in October of 2011, we are hopeful that provincial politicians will make improving health care a main focus of their platforms and campaigns.

It is no surprise that the demand for health care services across Canada continues to grow as our population ages. Efforts by all levels of government to meet these demands have been unsuccessful and unfortunately, it is the most vulnerable residents, such as high-needs seniors, who are most impacted. As dedicated as health care providers in

Ontario are, they simply cannot do more with less which consistently seems to be what they are being asked to do.

One of the main issues affecting the health care system across the province is the number of patients being admitted to hospitals that are then subsequently being designated Alternate Level of Care (ALC). ALC patients are those who are admitted to hospital for acute medical treatment but who remain in a hospital bed because they are waiting at one level of care but requiring another level.² The Local Area Health Integration Networks (LHINs) have been working on ways to address the demands being placed on hospitals due to the high number of patients who are deemed ALC. Many of these are seniors who end up in hospital waiting for a long-term care (LTC) bed because they cannot return home without extensive health care supports being put in place within the community. These patients are pejoratively referred to as "bed-blockers". Unfortunately for these vulnerable seniors, the waiting list for LTC is long; which is yet another issue that the LHINs are attempting to tackle.

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¹ Ontario. Local Health Integration Network Collaborative. *Sharing Best Practices: Transition Management in Ontario, Home First Implementation Guide & Toolkit*, (February 2011), online: <http://www.lhincollaborative.ca/uploadedFiles/LHIN_Collaborative/Home%20First%20Implementation%20Guide%20and%20Toolkit%20Feb%202011_Final_updated%2020110409.pdf> at 8.

² Leslie Starr-Hemburrow, Janet M. Parks and Susan Bisailon. "Home First: Reducing ALC and Achieving Better Outcomes for Seniors through Inter-organizational Collaboration" in *Healthcare Quarterly*, Vol. 14, No. 1, 2011 at page 70

MESSAGE FROM THE CHAIR

By: Timothy M. Banks, Chair, Board of Directors

As Chair of the Board of Directors of ACE, I have the honour of participating in the governance of one of Ontario's community legal clinics. These legal clinics provide amazing value for money. They provide legal services for individuals who would otherwise go without legal representation by a qualified lawyer. They are also a source of deep knowledge about poverty law issues. Clinic lawyers don't simply provide individual services, they see recurring patterns and themes that may go unnoticed. If listened to, they can bring practical know-how to public policy and law reform.

With more than a quarter century of service to Ontario's seniors, ACE has developed an unparalleled depth of knowledge of the poverty law issues that seniors living in the province face. Throughout its history, ACE's principal funder has been Legal Aid Ontario and its predecessors. Through this support, ACE has been able to deliver individual advice and representation as well as advocate for public policy and law reform. Among some of the issues at the forefront of ACE's policy and law reform activities are: (1) Responding to the consultation on fire safety for

vulnerable residents in Ontario being conducted by the Ministry of Community and Correctional Services; (2) Responding to the first set of proposed regulations under the new Retirement Homes Act, 2010; and (3) Responding to hospital discharge practices and fee policies.

We would like to do more! Please show your support for the work of ACE and Ontario's other community legal clinics. The upcoming provincial election in October 2011 is an opportunity for you to let the MPP candidates in your communities know how important legal clinics are to Ontarians. Consider getting involved and bringing the issue community legal clinics and Legal Aid Ontario to the attention of Ontario's politicians by contacting the offices of your local MPP candidates. Let them know that you support the work of ACE and community legal clinics in Ontario.

If you can afford to do so, we would also appreciate you considering a donation to ACE. ACE is a registered charity and issues tax receipts for donations of \$10.00 or more. Please see our website or call us for more information on giving.

HOME FIRST *...continued from page 1*

As a result of the number of ALC patients in hospital and the insufficient numbers of LTC beds in various communities to meet patient demand, reducing the number of ALC patients occupying hospital beds has become a provincial priority. At the same time, LHINs and Community Care Access Centres (CCAC's) across the province are also taking measures to divert patients from applying for LTC while they are in hospital with the objective of reserving beds in LTC homes for the most vulnerable seniors and reducing the waiting lists. Just who exactly are the "most vulnerable seniors", however, is unclear. Based on the telephone calls we receive at ACE from family members of seniors from across the province who have been admitted to hospitals, the bar for determining which seniors can or cannot

return home with the necessary home care supports in the community has been set rather high. To further complicate matters, which home care supports are available to high-needs seniors and the extent of these supports seems to vary from one community to the next. The "Home First Philosophy" was created by the province and the LHINs as a way of addressing these important issues.

There is much confusion, however, as to what Home First actually is and how its implementation will impact seniors living in Ontario. In particular, seniors who have been admitted to hospital as a result of an acute care episode and their family members may have already encountered Home First directly and many of them may not even realize it. While it may be the case that some seniors in hospital who qualify for LTC from hospital can and do want to return home, the question becomes just what services are available for these patients once they

return home? As well, the Home First approach applies specifically to high needs seniors no longer requiring acute care at a hospital and focuses on helping these patients get the supports they need so that they can go home instead of to LTC. ACE's concern, however, and the experience of some seniors who contact our office is that they have difficulty applying for and readily accessing these services. The extensive health care services that these high needs seniors are promised are not being provided by CCACs or community services agencies as neither have the resources to do so. In some cases, those seniors who return home to wait for a LTC bed require these services for a period of time that is not sustainable again due to limited resources.

What exactly is "Home First" and how is it changing our health care system? In this article, we will provide some information about the LHIN structure; we will explore the Home First philosophy and its implementation across the province by the Ministry of Health and Long-Term Care ("Ministry") through the LHINs; and we will provide a critique based on the experience of ACE as to how Home First is affecting the seniors we serve. The information in this article will hopefully shed some light on what Home First is and the implications of this system-wide philosophy for seniors living in Ontario.

ABOUT LHINS

Each of the fourteen (14) LHINs across Ontario is responsible for the planning, funding and managing of health services in their respective communities. First created in April 2006, the LHINs gain their authority from the *Local Health System Integration Act, 2006* (LHSIA) which received Royal Assent on March 28, 2006. LHINs are responsible for programs and services including: public and private hospitals; CCACs; community support service organizations; mental health and addiction agencies; Community Health Centres (CHCs) and long-term care homes.³

The administration of health systems locally by LHINs is meant to foster community engagement and involvement. LHINs are required under the

legislation to engage their communities. Each LHIN has the ability to determine what type, format or frequency of activities to engage in to achieve this objective. Further, coordinating health services at a local level means that patients should have better access to health services as the disparate needs of different communities across the province are addressed. LHINs remain accountable to the Ministry and are required to meet performance goals, standards, objectives, targets and measures as part of the agreement between them. The legislation governing the LHINs requires that they submit annual reports, including audited financial statements, to the Minister of Health and Long-Term Care ("Minister").

The LHIN Collaborative ("LHINC") is a provincial advisory structure led by a Council of LHIN and health services provider representatives. Formed in 2009, its objective is to strengthen relationships between health services providers, their associations and the LHINs. The mandate of the LHINC is to support the work of LHINs by addressing systemic issues impacting the health care system. Home First is a project of the LHINC and according to the LHINC website, it was to be completed by April of 2011.⁴

THE HOME FIRST PHILOSOPHY

*The Home First philosophy effectively and proactively considers options for post-acute care by involving and engaging the patient and family in decision making. It requires a focus on providing the right care, at the right time, in the right setting and at the right cost to ensure successful transition back to the home/community setting.*⁵

In September 2008, the Halton Healthcare Services (HHS), a community hospital in the Mississauga-Halton (MH) LHIN experienced a doubling of the number of ALC days from the year before. HHS received a "crisis designation" for four weeks. Although there was no legislative authority to do so at the time, where lack of beds reached a critical point, hospitals would be designated as "crisis", allowing ALC patients to be placed in LTC on a crisis basis, ahead of most other applicants.

³ Ontario. Ministry of Health and Long-Term Care, *Local Health Integration Networks*, online: <http://www.health.gov.on.ca/transformation/lhin/lhin_accoutab.html>.

⁴ Ontario. Local Health Integration Network Collaborative (LHINC), *Sharing Best Practices: Transition Management – "Home First"*, online: <http://www.lhincollaborative.ca/Page.aspx?id=1902&ekmense=e2f22c9a_72_546_1902_3>.

⁵ *Guide & Toolkit, Supra*, note 1 at 4.

This is now allowed under the regulations to the *Long-Term Care Homes Act, 2007*.⁶ As a result, the HHS decided to partner with the MH LHIN and MH CCAC to create Home First.⁷ The main focus of Home First seems to be the phrase: "... providing the right care, at the right time, in the right setting and at the right cost to ensure successful transition back to the home/community setting."⁸

In February 2011, the LHINC published a document entitled: *Sharing Best Practices: Transition Management in Ontario, Home First Implementation Guide & Toolkit*⁹ ("*Guide & Toolkit*"). This document provides information concerning the Home First philosophy and suggested implementation strategies for LHINs to consider applying in their own region. It further describes the benefits of adopting the philosophy and approach; best practices demonstrated by different LHINs across the province in adopting and implementing Home First; strategies around how the LHINs can engage health services providers (i.e. physicians, nurses, allied health professionals, the Community Care Access Centres (CCAC's), community support services workers) in adopting the philosophy and facilitating its implementation; and how the performance of Home First will be evaluated/monitored.

In an effort to understand the various Home First approaches employed by local LHINs, the LHINC was approached to develop a theme-based questionnaire that was then forwarded to all the LHINs and the CCAC's across the province. The questions focused on what kinds of activities local LHINs and CCAC's had been involved in for the purpose of implementing the Home First philosophy in their communities. Interviews were then

conducted with each of the fourteen (14) LHINs and CCAC's to gather further information. At the end of this process, it was determined that each LHIN in Ontario was at a different stage in the planning and implementation of Home First due to the diversity and circumstances of their respective communities. The *Guide & Toolkit* was created from the information gathered by the questionnaires and the interviews.¹⁰ According to correspondence received by ACE from the LHINC, the *Guide & Toolkit*, including the suggested scripts within the document, are not meant to be prescriptive or directive but merely a resource guide and is not intended to override a health care professionals' judgment.¹¹

Home First was developed to address two key critical issues of impact on the health care system in Ontario: (1) the increasing number of ALC patients waiting in hospital for a LTC bed; and (2) the clear shortage of LTC beds in the community due to increased patient demand. LHINs are responsible for ensuring that all the respective health services providers are committed to the Home First philosophy in order to manage and optimize patient flow through the continuum of care. In other words, identifying those patients at risk of being designated as ALC (such as high needs seniors) at the point of admission so that instead of remaining at hospital or being admitted to LTC, these patients can be discharged back to their own homes with the necessary supports.

Although the objectives and goals behind Home First are not new, the approach to the philosophy being taken by the LHINs and CCACs is. The push now is for a paradigm shift so that all of the health services providers (i.e. health professionals, CCACs, community support services partners, hospitals, LTC homes etc.) that a patient will come in contact with upon being admitted to hospital for an acute care episode make it their priority to support that patient to go home on discharge. The fact that the fourteen (14) LHINs and CCAC's met on March 26, 2011, to discuss making the philosophy a priority through an initiative to develop of common language, tools and process and outcome metrics is further proof of this new coordinated approach.¹² Provincial Home First performance metrics have been developed and all LHINs and their health services providers are to adopt these metrics. Some of the outcome metrics highlighted in the *Guide & Toolkit* include, but are not limited to: percentage ALC days; Number of ALC-

⁶ O. Reg. 79/10 at s. 171.

⁷ "Home First", *supra* note 2 at 71.

⁸ *Guide and Toolkit*, *supra* note 1 at 4.

⁹ *Ibid.*

¹⁰ *Ibid.*, at 5-6.

¹¹ Email dated April 7, 2011, sent from Liane Fernandes, Interim Senior Director, LHIN Collaborative (LHINC) on behalf of Louise Paquette and Narendra Shah, Co-Chairs, Home First Working Group to Judith Wahl, Executive Director, Advocacy Centre for the Elderly.

¹² Ontario. South West Community Care Access Centre. "Home First Philosophy Blooms in South West" in *Connect with Care through Partnership*, Vol. 5, Issue 1, April 2011, online: < <http://www.middlesex.ca/council/2011/may/10/C%209%20-%20CW%20Info%20-%20May%2010%20-%20SW%20CCAC%20Partner%20News.pdf>>.



LTC days; Percent Change in LTC Waitlist (Demand for LTC); 60-day ED readmission rate.¹³

The *Guide & Toolkit* discusses the importance of ensuring that all of the necessary players are involved in the implementation of the Home First philosophy in order for there to be a clear paradigm shift. A main part of this has to do with addressing the resistance on the part of hospital care providers to adopt the philosophy and any approach/procedure/protocol which supports it. According to the *Guide & Toolkit*, the resistance to the philosophy stems from the following:

In some cases, resistance to the philosophy is grounded as an ethical dilemma where hospital care providers feel they are violating their professional oaths by sending patients who are not fully recovered home and exposing them to risk. Resistance may also come from patients and families themselves, out of concern about the quality of care that can be provided in the home or fear of emergencies occurring at home.¹⁴

This entails changing the opinion of hospital care providers so that they are in agreement with the idea that home is where patients, including high-needs

seniors, should be discharged when they are ready to leave hospital by ensuring that care providers fully understand the capacity of the community care sector and CCAC to provide services to seniors who return home.

Elements required for successful implementation and sustainability of the Home First philosophy include effective leadership, monitoring and evaluation of the program, a communication and education strategy in addition to other things. These points are discussed at length in the *Guide & Toolkit*. While the document suggests the need for coordinated messaging, there is some recognition that each of the local LHINs and CCAC's are at a different stage of implementation with varying community factors to contend with.

From the perspective of the LHINs, hospitals and other health services providers, the benefits of Home First include: reduced demand for LTC beds; increased acute care bed capacity for hospitals; allowing patients to remain at home as long as possible; reducing the risk of patients contracting hospital infections; and allowing patients to obtain

¹³ *Guide & Toolkit*, supra note 1 at 41-42.

¹⁴ *Ibid*, at 36.

optimal functioning prior to making a major life decision such as applying for LTC.¹⁵ The principles upon which the philosophy statement are based is explained at page 9 of the *Guide & Toolkit*, and listed in brief below:

- Life changing decisions are better made at home
- People can choose to live at risk at home and in the community
- Institutionalized care presents risks that are not as prevalent in the home setting
- Individuals and families have a role in partnering with health care providers to care for their loved ones
- Avoid “Ageism”¹⁶

The *Guide & Toolkit* suggest that decisions such as whether to apply for LTC are best considered while a patient is at home. What it fails to mention, however, is that there is no requirement under the legislation (*Long-Term Care Homes Act, 2007*) that patients must apply for LTC from home nor does it require them to accept an “available” LTC bed when it comes up (one that was not one of their choices).



Some of the programs available at the local level through CCACs that support the implementation of Home First include: Wait at Home, Stay at Home, Enhanced End of Life, Enhanced Service Maximums, Occupational Therapy/Physiotherapy.¹⁷ Eligibility for these programs will likely vary across the province. There is no information readily available as to how many additional resources LHINs in Ontario are committing to these programs in an effort to implement Home First. Further, while Home First does not have eligibility criteria, the various programs offered in support of the philosophy do and we suspect that the eligibility criteria will differ from one LHIN and CCAC to the next.¹⁸

CRITIQUING THE HOME FIRST APPROACH

While in some instances patients who may otherwise qualify for LTC can and do wish to return home from hospital, provided they receive the necessary supports from CCAC, not everyone is in a position to do so. In our experience, there are some seniors in hospital who require high levels of care who may be stable enough after receiving treatment for an acute care episode to be discharged home, but the level of support that they would require at home (in some cases, twenty-four hour care or close to it) is not available either through the local CCAC. Because often seniors and their families have likely not discussed the possibility of going into LTC prior to being admitted to hospital as a result of an acute-care episode, they are unaware of their options. As a result of Home First, many of these seniors are dissuaded from applying for LTC, even though it may be the case that they would likely be eligible if they were to be assessed by the CCAC.

LHINs and CCAC's across Ontario that have implemented the Home First philosophy report that it is successful; if only from the perspective of seeing a reduction in ALC numbers and in the number of seniors applying for LTC. Included amongst this group is the MH LHIN and MH CCAC. While this may be true, this is not the entire picture. What has not been provided are corresponding statistics and data with respect to rates of attendance at emergency departments or readmission to hospital of high

¹⁵ *Ibid*, at 4.

¹⁶ *Ibid*, at 9.

¹⁷ *Ibid*, at 46.

¹⁸ *Ibid*, at 9.



needs seniors who were discharged home on these programs following a hospital stay. Other missing information is the number of supplemental hours of care that must be provided by the patients' spouses or family members due to the lack of adequate home care hours; and the increase in funding or reallocation of resources, if any, towards enhanced care services available for seniors returning home through Wait at Home or such programs.

Some of the incorrect information that ACE has received from seniors and their family members who contact us is:

- (a) that they cannot apply for LTC from hospital and that they must return home first;
- (b) that seniors must accept an available bed at a LTC home that is not of their choosing as an interim measure so that they do not continue to occupy the acute care bed at the hospital;
- (c) that they must select short waitlist homes as one or more of their choices even if it is not where they want to go; or
- (d) that they should pay personally for accommodation and care services and move to a retirement home while they wait for a bed at a LTC home, among other things.¹⁹

Unfortunately what happens in these circumstances, particularly with respect to high needs seniors, is that partners/spouses (who themselves are seniors) and family members are left with the responsibility of providing complex health care and support when the required services are not provided or what is being provided is inadequate.

ACE's concern based on complaints we have received from seniors and their families is that the necessary resources are not in place to ensure that the enhanced levels of home care and health care services required by high needs seniors who return home is readily available and being provided. Seniors and their families are concerned about health complications that may arise as a result of not being able to get the health care and support that they need at home.

It remains to be seen whether Home First and the various programs associated with it can effectively address the critical systemic issues facing health care in our province or whether is simply a short-term fix to the growing problem of the shortage of LTC beds in Ontario.

¹⁹ While most services in LTC are provided free of charge through provincial health care, all care in retirement homes is provided on a fee-for-service basis.

CHARGES IN HOSPITAL

- MINISTER CONFIRMS ALTERNATE LEVEL OF CARE PAYMENTS IN HOSPITALS NOT TO EXCEED \$53.23 A DAY

By: Judith Wahl, Executive Director & Staff Lawyer

On February 23, 2011, the Minister of Health and Long-Term Care (“Minister”), Hon. Deb Matthews, confirmed in the Ontario Legislature that:

I was very clear yesterday in the House, and I will be clear again today, that it is completely unacceptable for a patient in our Ontario hospitals to be charged in excess of \$53.23 per day if they are waiting for long-term care. I am communicating with the LHINs to ensure that the hospitals are aware of this policy.

Today I am happy to reiterate that it is completely unacceptable to charge anything in excess of \$53.23 per day for a patient who is waiting for long-term care.¹

This was a welcome announcement for seniors living in Ontario. It would appear, however, that hospitals may be ignoring the Minister’s announcement and may be continuing to “threaten” seniors with the high per diems in an effort to get them out of hospital. The challenge now is what will the government do to change hospital practices and what needs to be done to help seniors get appropriate care either at home in the community or in long-term care homes so that acute care beds in hospitals can be made available. This announcement is only one step in finding a solution to a very difficult problem.

WHAT IS THE PROBLEM THAT THIS ANNOUNCEMENT WAS MEANT TO ADDRESS?

ACE regularly receives calls about the issue of hospitals trying to discharge seniors to the community in order to free up a bed. A senior, who is in hospital and no longer requires acute care or their family will contact ACE to ask what are the senior’s rights with respect to applying for long-term care from hospital. They also ask what amount they

may be charged by the hospital while the senior is awaiting transfer to long-term care.

Often the senior and their family are told by hospital discharge staff that hospital policies require that the senior take the first available bed in any long-term care home that becomes available, even if the bed is in a long-term care home that is not one that they want to live in. The senior is told that they must accept the bed at the home where they don’t want to live and wait for an opening at a home that is of their choice. Sometimes the senior is told that they must move into a retirement home at their own cost until a bed is available in a long-term care home even if the senior is high needs and eligible for long-term care. We have also heard seniors and their family members being advised that they must select long-term care homes with short waiting lists and if they refuse, they will be discharged from hospital to the community. Given the stressful situation of having your loved-one admitted to hospital due to an acute care episode, even after the situation is no longer acute, the fact that families and seniors are then asked to make decisions about long-term care with sometimes very little time to consider all the options and know their rights further adds to the stress.

As for charges, hospital policies sometimes include provisions that seniors will be charged anything from \$600 to \$1800 a day unless they agree to take the first available bed at whatever long-term care home even it is one that is not of their choice or is in a retirement home. This despite the fact that retirement homes are not regulated in

¹ Ontario, Legislative Assembly. *Office Report of the Debates of the Legislative Assembly*, Second Session, 39th Parliament, (23 February 2011) at 4217 (Hon. D. Matthews), online: Debates of the Legislative Assembly (Hansard) < http://www.ontla.on.ca/house-proceedings/transcripts/files_pdf/23-FEB-2011_L084.pdf >

the same way as long-term care homes but are, instead, rental accommodations in which a person may pay for private health care.

ACE's position is that these terms in hospital policies requiring seniors to take the first available bed not of their choosing and the high per diem charges are not enforceable by the hospital and do not comply with the applicable legislation. Just what is the applicable law? The following is a brief summary to put the Minister's remarks in context. A detailed paper on these issues is available on the ACE website at <http://www.ancelaw.ca>.

The legislation is clear that anyone that is eligible for long-term care home placement has the right to choose to apply to up to five long-term care homes. They can choose whatever homes they wish to move into and the hospital discharge planner cannot require the person to choose only places with short waiting lists. They also cannot require the person to move to a home with immediate availability unless the person him or herself consents to that admission.

Hospital policies cannot require the person to move into a retirement home if he or she is eligible for and is awaiting admission to long-term care. A person may CHOOSE voluntarily to do that, but the hospital policies cannot require it. This is important because retirement homes are in fact rental accommodations and are not health care facilities. The fees for retirement homes are set by the market and increases are regulated only under the *Residential Tenancies Act*. Seniors who agree to move into a retirement home must pay rent and landlords of some retirement homes do make health care services available at a cost. People pay out-of-pocket for these services because they are not covered by provincial health insurance. In contrast, the maximum rates for accommodation fees in long-term care homes are regulated by the Ministry of Health and Long-Term Care. Health services are funded through the public health insurance and the individuals then are not charged for insured health care.

If a patient no longer needs acute care, the hospital may charge a per diem as set out in the *Health Insurance Act*. At present that charge is \$53.23 a day. The actual rate charged may in fact be less because this rate is subject to a rate reduction that is related to the patient's income and need to support dependents, if any. This rate

also would apply only if the patient is declared to be "alternative level of care" (ALC). Should the patient still require acute care, psychiatric care, or palliative care, however, the hospital cannot charge this daily rate.

So, what has happened since the Minister made these statements in the legislature? A Memo dated February 23, 2011, was sent to all LHIN CEOs from Ruth Hawkins, Assistant Deputy Minister, that reiterates the point the Minister made and describes the law in respect to discharge, similar to what is described above. The Memo is available on the ACE website at www.ancelaw.ca. The Memo was copied to all the Community Care Access Centre (CCAC) CEOs as well as to Mr. Tom Closson, President and CEO of the Ontario Hospital Association.

Have hospitals changed their policies in light of the Minister's statements? ACE will be doing a research project this summer, asking this question of all hospital and CCAC CEOs in Ontario. Since February, 2011, ACE continues to receive telephone calls from seniors and their family members complaining about hospital practices and policies around discharge and fees. Little if anything seems to have changed in practice. ACE sent a further letter to the Minister and the Assistant Deputy Minister in March and is still waiting a response. ACE is also preparing additional information for the Ministry with further examples of hospital policies that have not changed. Some CCACs appear to be going along with hospital policies that do not comply with the legislation.

ACE will continue advocating for change to hospital policies and practices as well as for options in home care and long-term care to help seniors move out of hospital and back home. This can only be done, however, if seniors get enough supports to meet their needs. For those seniors who cannot return home, the only option may be to go to a long-term care home of their choosing where they can receive the appropriate one that is of their choosing. Regardless of what seniors choose, however, what is of the utmost importance is that the health care system supports them in the best way possible to ensure that they can age with dignity, that their rights are respected, and that their quality of life improves.

IMPORTANT CHANGES TO THE *LONG-TERM CARE HOMES ACT* - SPOUSAL REUNIFICATION

By: Judith Wahl, Executive Director & Staff Lawyer

A recent announcement by the Ministry of Health and Long-Term Care (“Ministry”) has eased concerns of older spouses that they might be separated from each other if both needed long-term care but were unable to find a basic room that would accommodate them in a home of their choosing if they could not afford the cost of semi-private accommodation. This was a welcome and much needed announcement for many seniors in this situation.

When older couples apply to move into a long-term care home, most want to continue living in the same long-term care home and to share a room together. This is easier said than done due to the high demand for long-term care spaces as well as the fact that both spouses in a couple may not need to go into long-term care at the same time. With the proclamation of the *Long-Term Care Homes Act, 2007*¹ (*LTCHA*) on July 1, 2010, an additional barrier was placed in the way of spousal reunification if the couple were low-income.

To assist spouses in being reunited at the same long-term care home, a number of years ago a “spousal reunification” category was included in the waiting list regulations which gave spouses priority over other people for admission into the same home.

Crisis placement – where a person requires immediate admission into long-term care when a person needed such as a result of a crisis – was and continues to be the highest priority category for admission. Spousal reunification was also given a higher priority than most other admissions under the old system. Under the new *LTCHA*, spousal reunification continues to be recognized as a priority, but with important changes.

When a person is eligible for admission to a long-term care home, their spouse is also eligible, as long as they are over the age of 18, are an insured person under the *Health Insurance Act*, and their care needs can be met by the long-

term care home.² This means that the spouse does not have to any health care requirements in order to be admitted to a long-term care home.

Under the previous legislation, spouses always had priority admission status under the spousal reunification regulations, no matter whether they had care needs or not.³ This created several problems: (1) spouses with no care needs were being placed before applicants whose needs could not be met in the community; and (2) spouses were applying for long-term care with no intention of actually being admitted for the sole purpose of bumping their spouse into a higher priority category for admission.

Under the new regulations, the spousal reunification category has been amended. Now there is no priority for spouses **prior** to the admission of one of them, putting both married and single applicants onto an even playing field. Once one of the spouses is admitted, the second spouse is then moved into the spouse/partner reunification, but **only** if they have care needs requiring admission to a long-term care home.⁴ Spouses/partners who do not themselves have care needs can still be admitted, but would be placed into the lowest priority category.

The second change, which was identified as a significant barrier to spousal reunification, related to the accommodation charges for spouses sharing a room. Prior to July 1, 2010, if two spouses were low-income and could not afford to pay for semi-private accommodation in order to be able share a room they could apply for a rate reduction and if they qualified, the Ministry provided funding to long-term care homes to cover the difference in cost between

¹ S.O. 2007, c.8.

² O.Reg. 79/10, s. 157.

³ See for example, R.R.O. 1990, Reg. 832, s. 143.1 and 145.

⁴ O.Reg. 79/10, s. 172.

the semi-private and basic accommodation at the applicable reduced rate. This then permitted spouses to pay the basic rate and apply for a rate reduction, if their individual incomes made them eligible, while occupying a semi-private room so that they could be reunited.

The effect of the system under the new *LTCHA* post-July 1, 2010, was that the Ministry was no longer going to provide the supplemental funding to long-term care homes to make up the difference between semi-private charges and basic accommodation and rate reduced charges. Low-income spouses were then only able to afford to share a room together at a basic or rate reduced rate if the room design of the long-term care home where they wished to live had basic rooms that were double occupancy. While this was the case in newer homes, most basic accommodation room designs in older homes required four occupants to share a room, which made it impossible for low-income spouses to be reunited in a basic rate room with rate reduced charges. This meant that low-income spouses would not be able to be reunited and share a room in many long-term care homes around the province. At best, the spouses could end up in the same long-term care home if both needed long-term care, but might never be able to share a room again.

This was a concern to many seniors and their families. They raised their concerns with the Minister of Health and Long-Term Care and their local MPPs. Their efforts were acknowledged when on April 18, 2011, Minister Deb Matthews committed to change the rules to again make it easier for spouses who wanted to share the same room in a long-term care home by not requiring them to pay a premium to do so. On May 4th, 2011, the government approved amendments to the *LTCHA* regulations to remove the semi-private room premium for spouses occupying the same room. The basic co-payment amount as set in the regulations will now apply. Spouses residing in these rooms who are eligible could apply for a rate reduction if their incomes are insufficient to pay the full basic accommodation amount. The changes are retroactive to April 1st, 2011.

The Ministry is also implementing changes to the application funding rules for long-term care homes in order to offset the resulting decreases in home revenue.



However, there still exists an issue in that while the spousal reunification rules and the rate reduction make it easier for spouses/partners to reside together, it does not guarantee it. Usually a double occupancy room is not available when the couple is admitted to the home, so they must wait to transfer. There is no regulation that requires the home to make room for them. In older homes, where the spouses are admitted to four-bed accommodation, it may take a very long time for both beds in a double room to become available.

Credit should go to both the seniors and their families and the others that advocated for these changes as well as to the Ministry of Health and Long-Term Care for listening and responding so that spouses can continue living together upon moving to a long-term care home.

ALBERTA V. ELDER ADVOCATES OF ALBERTA SOCIETY

By: Graham Webb, Staff Litigation Lawyer

In May 2011 the Supreme Court of Canada (“Court”) decided that a class-action lawsuit claiming that Alberta long-term care residents have been chronically overcharged for their meals and accommodations may proceed to trial. In *Alberta v. Elder Advocates of Alberta Society*¹ (“*Elder Advocates*”), a full nine-member panel of the Court dismissed claims for breach of trust, negligence and bad faith in the performance of duty brought against the Province of Alberta (“Province”). However, it allowed the claim to proceed as a class action for restitution based on the doctrine of unjust enrichment, and for damages as remedy for an alleged breach of the equality guarantee in the *Canadian Charter of Rights and Freedoms*.

CHARGES FOR MEALS AND ACCOMMODATIONS IN LONG-TERM CARE HOMES

Under the *Canada Health Act*,² provinces are generally not allowed to impose user fees for access to insured health care services offered by provincial health insurance plans. Should a province impose such fees there is a risk that they may disqualify themselves to receive contributions from the federal government for health care expenditures. As an exception to the general rule, provincial health insurance plans can impose user-fees for meals and accommodation provided to persons who require chronic care and are more or less permanently resident in a hospital or long-term care home.³

As a result of this rule, long-term care residents in Ontario, as well as in Alberta and most other provinces, routinely pay a monthly charge or “co-payment” that is intended to reflect the costs of their meals and accommodation. These charges are informally called “hotel costs”. They are not intended to include the cost of insured health services, which under the *Canada Health Act*, should be fully paid under the provincial health insurance plan.

In Alberta, as in Ontario, the resident co-payment for meals and accommodation is set by the provincial government, and is collected by the long-term care home directly from the resident. In this way, the long-term care home has at least two separate sources of funding: one from the provincial health insurance plan for insured health care services, and the other from its residents to cover their meals and accommodation.

CHARGES THAT EXCEED THE COSTS OF MEALS AND ACCOMMODATION

The Elder Advocates of Alberta Society and Mr. James O. Darwish representing the Estate of Johanna H. Darwish (“Respondents”) alleged that the Province was imposing charges on long-term care home residents that far exceeded the actual costs of the meals and accommodation provided to them. In *Elder Advocates*, the Court heard that a representative claimant, Mr. James Darwish, discovered the alleged overpayments which led to the legal action as follows:

Mr. Darwish was his mother’s guardian and trustee when she lived in a LTCF [long-term care home]; he is now her executor. When preparing her income tax returns, he was advised by the local Regional Health Authority [which administered and operated Alberta’s health care regime] that approximately two-thirds of the monthly accommodation charge his mother had been paying was for a “care component”. He concluded the remaining one-third had been allotted for accommodation and meals. Mr. Darwish contends that the allocation for

¹ 2011 SCC 24.

² *Canada Health Act*, R.S.C. 1985, c. C-6.

³ *Ibid.* at para. 8, citing *Canada Health Act*, s. 19(2).



accommodation and meals that residents must pay is more than required, and in effect requires residents to subsidize medical care costs that are entirely the responsibility of the Province, and for which Alberta is not entitled to charge residents under the legislative scheme. Together with the Elder Advocates, he commenced an action to recover the amount of the overpayment.⁴

Matters were further exacerbated when, instead of reducing the residents' co-payments to bring them more into line with the actual hotel costs, the Province increased them. The Court states that:

On August 1, 2003, Alberta's Minister of Health and Wellness . . . raised the maximum accommodation charge payable by residents of the province's nursing homes and auxiliary hospitals. The plaintiff's contention is that the Minister increased the permissible charge even though he was aware of a "past practice" on the part of [long-term care homes] to apply the accommodation fees "to subsidize health care and off set care funding", and that, despite this knowledge, the Province instructed operators to charge the maximum allowable.⁵

The Elder Advocates claim in their class-action lawsuit that the Province should compensate long-term care residents for the alleged overpayment of their long-term care fees.

FIDUCIARY DUTIES

The Respondents claimed that the Province breached a fiduciary duty to act in the best interests of its vulnerable long-term care residents by overcharging them for meals and accommodation. While the Respondents were unsuccessful in arguing before the Court that the Province both breached its fiduciary duty to the elderly residents of Alberta's long-term care homes and were negligent, the decision examines the issue of whether fiduciary duty arises within the governmental context such as that in this case. Specifically, the Court provides some direction with respect to the circumstances under which the actions of government may be subject to an *ad hoc* fiduciary duty.

A "fiduciary duty" is an obligation of trust imposed by law to act in the best interest of another person. A fiduciary duty is easy to recognize in

⁴ *Ibid*, at para. 13.

⁵ *Elder Advocates*, *supra* note 1 at para. 14.

well established and clearly defined relationships such as a trustee and the beneficiary of a trust; an executor and the beneficiary of an estate; a lawyer, accountant or other professional person and his or her client; and a parent or guardian and a child. However, a fiduciary duty may also exist in other novel or unusual circumstances on an *ad hoc* basis (i.e. the duty arises due to the situation). It can be difficult to determine when an *ad hoc* fiduciary duty might exist.

AD HOC FIDUCIARY DUTIES

In *Elder Advocates*, the Court found that in addition to the traditional and well established fiduciary relationships, an *ad hoc* fiduciary relationship may exist where the claimant can show the following facts:

(1) an undertaking by the alleged fiduciary to act in the best interests of the alleged beneficiary or beneficiaries; (2) a defined person or class of persons vulnerable to a fiduciary's control (the beneficiary or beneficiaries); and (3) a legal or substantial interest of the beneficiary or beneficiaries that stand to be adversely affected by the alleged fiduciary's exercise of discretion or control.⁶

The Court did not find that the facts before it in *Elder Advocates* were enough to show that there was an *ad hoc* fiduciary duty owed by the Province to the elderly residents in long-term care homes. The Court went further to state that an *ad hoc* fiduciary would seldom if ever be imposed on government acting within its legislative or public law function. In reaching that conclusion, it decided that “. . . the same broad principles apply to private actors and governments, though they play out differently where the alleged fiduciary is a public authority.”⁷ It did find that while long-term care residents are a vulnerable population, this characteristic alone was not enough to ground a fiduciary obligation.⁸

AN UNDERTAKING TO ACT IN THE BENEFICIARY'S INTEREST

The Court found at paragraph 48 of its decision:

In sum, while it is not impossible to meet the requirement of an undertaking [to act in the person's best interest] by a government actor, it will be rare...It [the necessary undertaking] may also be met

where the relationship is akin to one where a fiduciary duty has been recognized on private actors. But a general obligation to the public or sectors of the public cannot meet the requirement of an undertaking.⁹

Citing earlier case law, the Court found that “. . . imposing such a burden on the Crown is inherently at odds with its duty to act in the best interests of society as a whole, and its obligation to spread limited resources among competing groups with equally valid claims to its assistance.”¹⁰ In general, the Court was sceptical that such a duty of undivided loyalty to one vulnerable group could easily arise, stating “. . . the circumstances in which this will occur are few. The Crown's broad responsibility to act in the public interest means that situations where it is shown to owe a duty of loyalty to a particular person or group will be rare.”¹¹

On this point, the Court concluded that there was no undertaking by the Province to act with undivided loyalty in the best interests of its vulnerable long-term care residents.¹² For that reason alone a fiduciary duty does not exist, and a claim for breach of trust could not succeed.

A DEFINED PERSON OR CLASS OF PERSONS

The Court also felt that it would be difficult in most cases brought against a governmental authority for a claimant to prove the second element of an *ad hoc* fiduciary duty; that being “. . . a defined person or class of persons vulnerable to the fiduciary's exercise of discretionary power.”¹³ The Court felt that generally, the government must act in the interest of all citizens in the performance of its public duties but it is entitled to make distinctions between different groups in imposing burden or providing benefits, subject to the equality section of the *Charter of Rights and Freedoms*.¹⁴ While it could be possible to meet

⁶ *Ibid*, at para. 36 citing *Frame v. Smith*, [1987] 2 S.C.R. 99.

⁷ *Ibid*, at para. 26.

⁸ *Ibid*, at para. 57.

⁹ *Ibid*, at para. 48.

¹⁰ *Ibid*, at para. 44, citing *Sagharian (Litigation Guardian of) v. Ontario (Minister of Education)*, 2008 ONCA 411.

¹¹ *Ibid*, at para. 44, citing *Harris v. Canada*, 2001 FCT 1408.

¹² *Ibid*, at para. 58.

¹³ *Ibid*, at para. 49.

¹⁴ *Ibid*, at para. 49.

the second requirement where the government is acting in a private-law function (such as the trustee of money belonging to a specified trust fund) “. . . Outside of such cases, a specific class of persons to whom the government owes an exclusive duty of loyalty is difficult to posit.”¹⁵

A LEGAL OR SUBSTANTIAL INTEREST

The third element of an *ad hoc* fiduciary relationship is that the claimant must show “a legal or significant practical interest” that is affected by the discretionary power of the alleged fiduciary.¹⁶ With respect to government, the Court found that “The interest affected must be a specific *private* law interest to which the person has a pre-existing distinct and complete legal entitlement . . . [such as] property rights, interests akin to property rights, and the type of fundamental human or personal interest that is implicated when the state assumes guardianship of a child or incompetent person.”¹⁷ In addition, the Court found that “the interest must not be contingent on future government action.”¹⁸ In short, the Court found unequivocally that the specific interests that are potentially the subject of a fiduciary duty on the part of government are limited to private law interests that exist independently of the public law functions of government.

LEGISLATIVE FUNCTIONS OF GOVERNMENT

Finally, the Court held that the setting of long-term care rates is a legislative function of government. According to the decision “Where the government acts in the exercise of its legislative functions, courts have consistently held that a fiduciary duty does not arise.”¹⁹

CLAIMS FOR RESTITUTION

Despite the dismissal of the claim for breach of fiduciary duty by the Respondents, the Court confirmed in its judgment that a claim for restitution based on the doctrine of unjust enrichment may proceed based on the following three elements: (i) an enrichment of the defendant [the Province]; (ii) a corresponding deprivation of the plaintiff; and (iii) an absence of juristic reason for the enrichment.²⁰ It found that the application of these principles “is a matter of some subtlety”,²¹ and without predicting whether or not the claim would eventually succeed, found that it should be allowed to proceed to trial because it is one that is capable of success.²²

In examining the three elements of a claim for unjust enrichment, there is little doubt that if the claimants were overcharged for long-term care fees there would be an enrichment of the Province and a corresponding monetary deprivation of the long-term care residents. The more difficult question is whether the authorization of these charges under provincial legislation is sufficient “juristic reason”, or legal cause, for the enrichment and corresponding deprivation.

The Court found that in law it is possible for courts to award restitution against governmental authorities for taxes and other charges paid under statutes later found to be constitutionally invalid.²³ Furthermore, it held that compensation as a *Charter* remedy could conceivably follow where one of the claims made is that the regulation setting long-term care rates is itself constitutionally invalid under the *Charter*.²⁴

The principles of restitution are fundamentally important to older adults as the basis of legal claims made by them in a wide range of contexts, and it is encouraging that the Elder Advocates claim may proceed to trial on that basis. One hopes that if it can be proven on a balance of probabilities that the amounts charged for meals and accommodations far exceeded their actual costs, that restitution would be available in the amount of the overpayments. Surely, the costs of meals and accommodation and the long-term care residents’ co-payment should have a factual correspondence that withstands a high degree of scrutiny.

The success of this class-action lawsuit is of ongoing interest to all long-term care residents and other older adults.

¹⁵ *Ibid*, at para. 49.

¹⁶ *Ibid*, at para. 51.

¹⁷ *Ibid*, at para. 51.

¹⁸ *Ibid*, at para. 62.

¹⁹ *Ibid*, at para. 62. citing *Guerin v. The Queen*, [1984] 2 S.C.R. 335 and *Wewaykum Indian Band v. Canada*, 2002 SCC 79.

²⁰ *Ibid*, at para. 82, citing *Garland v. Consumers’ Gas Co.*, 2004 SCC 25.

²¹ *Ibid*, at para. 84, citing Maddaugh, P.D. and McCamus, J.D., *The Law of Restitution* at p. 22-1.²² *Ibid*, at para. 49.

²² *Ibid*, at para. 95.

²³ *Ibid*, at para. 86-91.

²⁴ *Ibid*, at para. 92.

DEALING WITH COLLECTION AGENCIES

By: Rita Chrolavicius, Staff Lawyer

In Ontario, collection agencies have to follow certain rules that are set out in the *Collection Agencies Act* and Regulations.

The Regulation provides that if a debtor sends a registered letter to a collection agency stating that the debtor disputes the debt and suggests that the matter be taken to court, the collection agency shall not thereafter contact or attempt to contact the debtor, unless the debtor consents to the contact.

If a debtor does not intend to pay the debt and if the debtor is insolvent and receives only income which is exempt from garnishment, such as pension income or social assistance payments, it may be a good idea to notify the collection agency of this fact in writing and to provide evidence of this. Collection agencies are generally reluctant to spend money to file a court action when they know that they will not be able to collect on a judgment.

Collection agencies are not permitted to contact the debtor's spouse, relatives, friends, neighbours or acquaintances, except for the purpose of obtaining the debtor's home address and telephone number if the collection agency does not already have this information.

Collection agencies are not permitted to contact the debtor's employer unless the contact occurs once only, and is for the sole purpose of confirming the debtor's employment, the debtor's business title and the debtor's business address. Collection agencies can contact a debtor's employer in order to enforce a court judgment.

If a collection agency contacts a person and the person is not the debtor they are seeking, the person should inform the collection agency that they are not the individual and ask the agency not to contact them again.

The Regulation also contains rules about when collection agencies can call, how often they can call, and the types of written notice that they must provide to the debtor.

Collection agencies are prohibited from giving false or misleading information or from making misrepresentations. They are not allowed to

use threatening, profane, intimidating or course language. Collection agents cannot use excessive, undue or unreasonable pressure, or to otherwise communicate in such a manner and with such frequency as to constitute harassment.

It is quite appropriate for a debtor to try to negotiate a reduction in the amount of the debt owed or the amount of the interest charged on the debt. Any reduction agreed upon should be confirmed in writing.

In Ontario, the limitation period for starting a court action to collect a debt is two years from the last payment or the last acknowledgement of the debt. If a limitation period is approaching, consider getting legal advice. Once the limitation period has expired, the debt does not disappear. The debt can be revived if an individual makes another payment on the debt or acknowledges the debt. There have been cases where banks who were owed money years ago seized new deposits made by individuals to offset the old, outstanding debt. One alternative to ignoring a debt is to consult with a trustee in bankruptcy about undergoing bankruptcy proceedings. You should find out from a trustee in bankruptcy what all the implications will be if you decide to pursue such proceedings.

Individuals with complaints about collection agencies can contact the Consumer Protection Branch as follows:

E-mail:

consumer@ontario.ca

Phone:

Toll-free: 1-800-889-9768

In Toronto: 416-326-8800

TTY: 416-229-6086 or 1-877-666-6545

Fax: 416-326-8665

Mail:

Ministry of Consumer Services

Consumer Protection Branch

5775 Yonge Street, Suite 1500

Toronto, ON M7A 2E5

(Walk-in service is also available)

NEWS AND ANNOUNCEMENTS

UPDATE ON THE RETIREMENT HOMES ACT: IMMEDIATE PROTECTION MEASURES IN EFFECT

On May 17, 2011, the Ontario government put into effect limited portions of the new *Retirement Homes Act, 2010 (RHA)* and its regulations giving effect to certain Immediate Protection Measures.

For seniors living in retirement homes across Ontario, this means that anyone who suspects harm or a risk of harm to a retirement home resident, resulting from abuse, neglect, improper care or unlawful conduct, must report their suspicion to the Registrar of the Retirement Homes Regulatory Authority (“Authority”). The government has announced that reporting of abuse can be made to the Complaints Response and Information Service (CRIS line) at 1-800-361-7254. CRIS line staff is then required to report the suspected abuse to the Authority for action.

The CRIS line is funded by the Ontario government but is operated by the Ontario Retirement Community Association (ORCA) – the trade association for some retirement home operators in Ontario. CRIS line operators, who are employees of ORCA, will be in charge of triaging calls and have the discretion to determine which ones will be redirected to the Authority for immediate action. Those matters not reported to the Authority will be handled by CRIS staff.

ACE has questions and concerns about this arrangement. The *RHA* requires that reports of abuse, improper or incompetent treatment or care, unlawful conduct resulting in harm or risk of harm, or misuse or misappropriation of a resident’s money shall be immediately reported to the Registrar. By requiring reporting under the Immediate Protection Measures to the CRIS line instead of reporting directly to the Registrar, ACE

is concerned that the perception of the Authority’s objectiveness will be compromised. Should the CRIS line eventually become a branch or department of the Authority, this will make it even more difficult to view the Authority as separate and apart from the retirement home industry.

As part of the government’s Immediate Protection Measures, all retirement home operators are required to post an Authority approved sign with the CRIS line telephone number in a visible and accessible location and extending the hours of the CRIS line to 8:00 am to 8:00 PM.

Keep in mind that while the sections of the *RHA* and regulations relating to mandatory reporting of abuse and neglect have been proclaimed, the remainder of the *RHA* and regulations is not yet in effect. As it stands, the Authority can receive reports of abuse or risk of harm from the CRIS line and is required to send out an inspector. However, because the bulk of the *RHA* and its regulations have not been fully proclaimed, the Authority is unable to take any action as those provisions of the legislation are not yet in force.

In April 2011, ACE made submissions to the Ontario Seniors’ Secretariat concerning the proposed initial draft regulations to the *RHA*, which can be found on our website. The final version of the first phase of the regulations have been filed and are available online, but they have not taken effect. On May 20, 2011, the Ontario government posted the second phase of proposed regulations under the *RHA*. Interested parties and stakeholders have until June 20, 2011, to provide comments and submissions to these proposed regulations

Stay tuned to ACE’s website where we will provide more information as the situation unfolds.

NEW MINISTER OF STATE (SENIORS) APPOINTED

Alice Wong, Member of Parliament for Richmond, BC, was appointed into cabinet as the Minister of State (Seniors) on May 18, 2011, taking over the position previously held by Julian Fantino since January of 2011.

Ms Wong was first elected to the House of Commons on October 14, 2008. She has served as the Parliamentary Secretary for Multiculturalism. Ms Wong is an educator, entrepreneur and active community leader. She holds a PhD in Curriculum and Instruction from the University of British Columbia. Prior to being elected to the House of Commons she worked as the Manager of International Programs at Kwantlen Polytechnic University (formerly Kwantlen University College).

ACE congratulates Ms Wong on her new appointment. We look forward to any future opportunities to work with Ms Wong and her staff on issues of relevance to seniors across Canada.

FIRE SAFETY FOR VULNERABLE RESIDENTS IN ONTARIO: A CONSULTATION

Four elderly residents died following a fire on January 19, 2009, at the Muskoka Heights Retirement Residence. Six others were critically injured as a result. In December 2010, the Office of the Chief Coroner announced that an inquest will be held into the deaths

of the four elderly residents. No date has been set for the inquest. In ACE's Fall/Winter 2010 newsletter, an article entitled "Fire Safety in Residences for Older Adults" written by Lisa Romano, former staff lawyer at ACE, provided information on fire safety and prevention laws in Ontario.

The law in Ontario currently requires that residential care facilities built after 1997 be equipped with automatic sprinklers. There is, however, no mandatory requirement to retrofit those residences built pre-1997 with automatic sprinklers. There is ample evidence supporting the fact that automatic sprinklers save lives – not only the lives of vulnerable residents such as seniors but lives of fire fighters as well. The Ontario Association of Fire Chiefs continues to advocate for retroactive installation of sprinklers in not only all retirement homes and long-term care homes, but any buildings housing vulnerable residents in Ontario.

ACE provided submissions to the Ministry of Community Safety and Correctional Services in March 2011, as part of their "Consultation on Fire Safety for Vulnerable Residents of Ontario." The submission can be found on the ACE website at <www.acelaw.ca>. We will continue to follow up with the Ministry and the Government of Ontario on this very important issue and report any updates on our website and in future ACE newsletters.





REGISTRY FOR PERSONAL SUPPORT WORKERS

On May 19, 2011, the Ministry of Health and Long-Term Care (“Ministry”) announced that Ontario will create a registry for personal support workers (PSWs) that the Ministry anticipates will be up and running no later than the summer of 2012. PSWs will have the opportunity to sign up with the registry and provide information such as contact details, educational background, years of experience and current employment. The information on the registry would be available to the public and to employers.

The range of support that PSWs provide varies from activities of daily living (assistance with

personal hygiene, light housekeeping, transferring clients between bed and chair) to delegated health procedures. According to the Ministry, of the estimated 90,000 PSWs working in Ontario approximately 57,000 provide care in long-term care homes and 26,000 provide home care through community health agencies.

Further details about how the information will be collected and managed is not yet available. The Ministry has advised that they will be consulting with PSWs, their representatives and stakeholder groups regarding the development of the registry. ACE will provide any additional information on our website as it becomes available.

NEW STAFF AT ACE

Clara Ho joined ACE in January 2011 as the research lawyer.

Clara graduated with her LL.B from Queen's University in 2000. She was called to the Ontario bar in February of 2002. Clara has worked at the Metro Toronto Chinese and Southeast Asian Legal Clinic. Most recently, she worked as staff lawyer at the Human Rights Legal Support Centre. When not editing the ACE newsletter, Clara writes fiction and prose. She most recently performed at the Mayworks 2011 Poetry Marathon.

Clara is pleased to join the knowledgeable and dedicated staff team at ACE.

COMMENTS FOR THE EDITOR

Comments about this newsletter may be sent to the editor, Clara Ho, via regular mail or email (hoc@lao.on.ca).

ELECTRONIC NEWSLETTERS

To receive a copy of this and future newsletters electronically, please send an email to gillardt@lao.on.ca.



APPLICATION FOR MEMBERSHIP

Advocacy Centre for the Elderly*

2 Carlton Street, Suite 701, Toronto, Ontario M5B 1J3 • Phone: 416-598-2656 • Fax: 416-598-7924

Please feel free to photocopy this page and send it to ACE to become a member!

Name (Individual/Corporate): _____

Corporate Contact (if applicable): _____

Address: _____ Apt.: _____

City: _____ Postal Code: _____

Telephone (Home): _____ Business: _____

Email: _____

MEMBERSHIP FEE (check one) Individual (\$10.00 enclosed) Corporate (\$25.00 enclosed)

In addition to my membership fee, a donation of \$ _____ is enclosed.**

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway.

Committee Membership:

I am interested in seniors' issues and would consider membership on an ACE Committee.

Yes No

Membership Expiry Date: Annual General Meeting, Fall 2012

By-Law No.1, 14.9 states: No owner or management official of a long term care facility, or employee of any organization representing long term care facilities shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

* ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc."

** A tax receipt will be issued for donations over \$10.00.