Ontario Long-Term Care COVID-19 Commission

October 5, 2020

Ontario Hospital Association

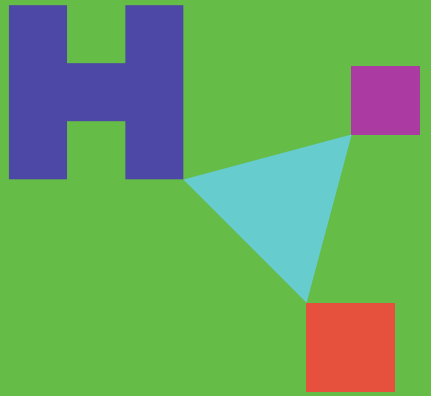
AGENDA

1) Introductions
2) OHA and Our Members
3) OHA's Role in the Pandemic
4) Hospital Preparation for COVID-19 and Support to Long-Term Care
5) Labour Considerations
6) Member Reflections on Wave 1
7) Considerations For Wave 2

1. Introductions

- **Dr. Gillian Kernaghan**, CEO, St. Joseph's Health Care, London
- **Barbara Collins**, CEO, Humber River Hospital
- **Anthony Dale**, President and CEO, OHA
- **Elizabeth Carlton**, Vice President, Policy and Public Affairs, OHA
- **David Brook**, Vice President, Labour Relations & Chief Negotiations Officer, OHA
- **Melissa Prokopy**, Director, Legal, Policy and Professional Issues, OHA

2. OHA & Our Members



About the OHA

Founded in 1924, the OHA is the voice of the province's 141 public hospitals. We are a member organization, governed by an elected board of directors, and are not a regulator of hospitals.

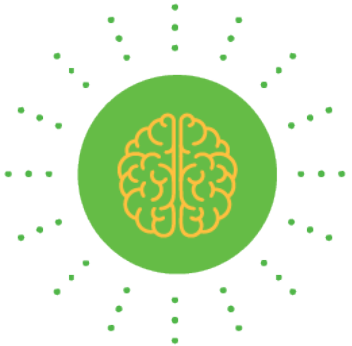
Our System: The OHA takes a long-term view of hospital evolution and the path to a high-performing system. We conduct evidence-based research, propose ideas, convene members and partners, and encourage responsible dialogue about change.

Our Members: Through advocacy, learning and engagement, labour relations and improved access to data and analytics, the OHA enhances the direct services it provides to members.

Our Organization: To deliver on our mandates, the OHA cultivates its culture, relationships and practices.

Serving Ontario's Hospitals

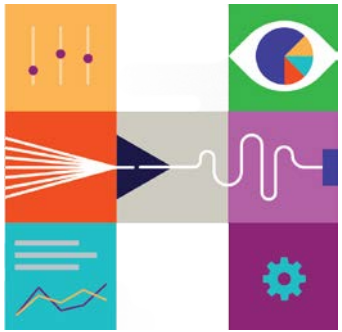
- **Advocacy:** Ensuring hospitals have a strong and respected voice in their relationship with the Ontario government, our partners and other organizations across the health care system.



- **Learning and Engagement:** As hospitals and their partners prepare for substantive system transformation, the OHA strengthens the capacity for change across the sector.

Serving Ontario's Hospitals

- **Labour Relations and Benefits:** Through collective bargaining and effective labour relations, the OHA seeks multi-year predictability that better positions hospitals to meet their objectives in a highly unpredictable labour relations environment.



- **Data and Analytics:** The effective use of data and analytics is a strategic imperative for any health organization or system that wishes to enhance quality and patient experience while managing limited resources.

Building A Better Health System

- **Thought Leadership:** The OHA actively contributes to health policy by generating and sharing ideas to improve the system. Current areas of focus include examining and shaping new integrated models of care and the health system of the future.

- **Funding Methodologies:** The OHA works closely with the MOHLTC and other system partners to shape the design and evolution of Ontario's funding methodologies improving system performance.

OHA Members

- Approximately 141 public hospitals that operate over 262 sites across Ontario.

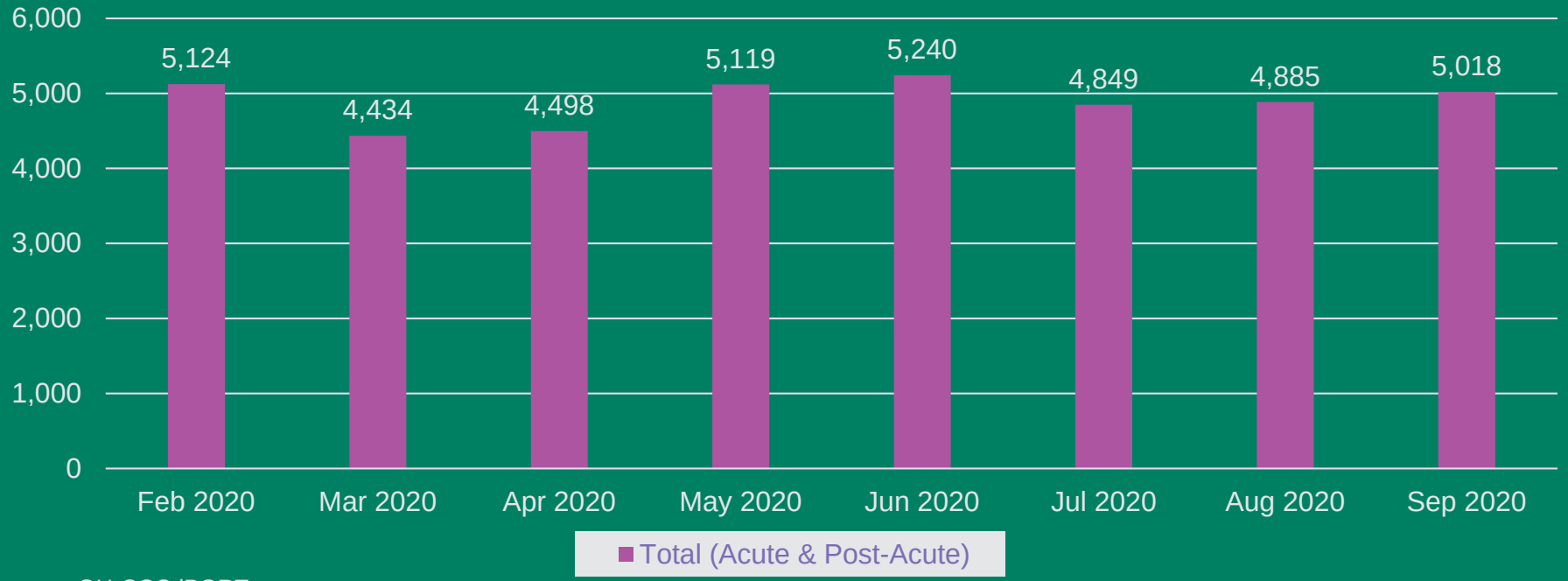
- Hospital types:
  - Small Community: 65
  - Large Community: 26
  - Medium Community: 20
  - Teaching: 15
  - Specialty (e.g. mental health): 8
  - Complex Continuing Care & Rehabilitation: 7

3. OHA’s Role in the COVID-19 Pandemic

Context: Government Strategy and Decision-Making

- Pre-pandemic the health system was already going through significant transition due to restructuring
- The lack of a formal provincial incident management structure created several challenges in the early stages and at the height of the Wave 1
    - There were too many players involved, without a clear and centralized decision-making process
- LTC decision-making took place separately from the rest of the health care system
- Government action to protect and support LTC was largely reactive rather than proactive, and early requests for support were not heard

Patients Designated as waiting for Alternate Levels of Care at Month End (Feb – Sept 2020)



Source: OH-CCO iPORT

OHA Advocacy Efforts During COVID-19

- The OHA has worked to support decision-making in key policy and labour relations areas, supported data collection and analysis, and bridged communication gaps with government to keep members informed and engaged
- Since March, the OHA has sent more than 15 letters to the Premier, CMOH, Minister of Health, Deputy Minister of Health and Ontario advocating for action to support hospitals and protect Ontarians, including:
    - March 13 – Need for Continued Urgent Action on COVID-19
    - March 19 – Urgent Need for Incident Management System for COVID-19 Pandemic Response
    - April 10 – Urgent Efforts Needed to Prevent Unnecessary Loss of Life in Long- Term Care
    - May 7 – Pandemic Pay
    - June 11 – Planning for the Second Wave of COVID-19
    - September 15 – Urgent Need to Support Health Care Workers as Schools Reopen
    - September 24 – Targeted Public Health Measures Needed to Avoid Provincial Shutdown

Note: Copies of letters have been provided to the Commission.

OHA Advocacy Efforts During COVID-19

- OHA directed maximum resources and around-the-clock attention to influencing decision-making at the highest level in key policy areas, and to supporting members on rapidly emerging issues
- A central focus of the OHA's advocacy during Wave 1 was to encourage capacity and health human resources measures to respond to a surge during COVID-19
- Advocated for and provided substantive advice on legal and regulatory issues (e.g. indemnity, credentialing order, temporary use of premises, etc.)
- Enabling hospitals to create additional system capacity – construction of temporary health care facilities, the extension of existing facilities, helping to identify strategies to accelerate the placement of ALC patients (e.g. use of hotels)

4. Hospital Preparedness for COVID-19 and Support to Long-Term Care

Hospital Learnings from SARS

- Adoption of the precautionary principle throughout Ontario's health, public health and worker safety system
- Need to strengthen local public health units and create additional capacity
- Public Health Ontario created in 2007 as a direct result of SARS
- Ministry of Health was responsible for ensuring that all Ontario hospitals had infection control personnel, resources and program components, including surveillance, control and education
- Hospitals develop robust emergency preparedness plans and incident management systems to prepare for future outbreaks

Hospital Approach to Preparing for COVID-19

- Legislation and standards guiding emergency planning and management have been in place for some time
- Implementation of pandemic plan critical
- Looking at entire infrastructure to assess where and how critical care could be provided if needed
- Involves considering staff deployment, ensuring adequate supplies of personal protective equipment and ventilators
- Extra training on donning and doffing, simulations for riskier (aerosol) procedures
- Considerations given to transitioning patients to a less acute environment - evaluating ALC numbers and transition options
- Assessing the postponement of non-medically necessary procedures

Hospital Accountability and Oversight

- Not-for-profit corporations comprised of independent, voluntary boards
- Directors appointed in accordance with by-laws
- CEO, Chair of MAC, Chief Nursing Executive and President of Medical Staff are *ex officio* board members
- Hospital membership – primarily closed membership (Directors are Members), also a significant number with open membership categories (can purchase a membership which provides voting and nomination rights)
- Governed by the *Public Hospitals Act*
- Three mandatory board committees – Medical Advisory Committee, Fiscal Advisory Committee, and Quality Committee
- Hospital has an Accountability Agreement with their LHIN (now Ontario Health): outlines accountability and performance obligations for planning, integration and delivery of programs and services
- Subject to value-for-money audits by the Auditor General of Ontario as a broader public sector organization receiving public funding

Hospital Accountability and Oversight – Medical Advisory Committee

- Responsibilities include making recommendations to the board on the:
  - provision of privileges (appointment) of all members of the medical staff
  - dismissal, suspension or restriction of hospital privileges of any member of the medical staff
  - quality of care provided in the hospital by the medical staff
- Must meet at least 10 times per calendar year
- Some hospitals have Chief of Staff (who must be Chair of MAC) or Vice President Medical Affairs in addition to Chair of MAC

Hospital Accountability and Oversight

- *Public Hospitals Act* – Hospital board must ensure that a plan is developed to deal with:
  - (a) emergency situations that could place a greater than normal demand on the services provided by the hospital or disrupt the normal hospital routine
  - (b) the failure to provide services by persons who ordinarily provide services in the hospital
- *Occupational Health and Safety Act* - Hospitals have a specific statutory requirement to develop, establish and put into effect measures and procedures for the health and safety of workers

Hospital Accountability and Oversight – Quality Improvement

- *Excellent Care for All Act (ECFAA)* came into effect in 2010
- Reinforces shared governance and management responsibility for quality of care, builds and supports boards' capability to oversee the delivery of high quality of care
- Health Quality Ontario (now part of Ontario Health) was formed to advise, support, and monitor quality of health care
- Provides hospital boards with a broad mandate for oversight of patient care
  - Creation of Quality Committee of the Board
  - Annual Quality Improvement Plan – outlines how hospitals will improve the quality of care they provide to their patients
    - Mandatory and Discretionary Indicators
- Significant number of hospital performance indicators in place (500-1000)

Pre-Existing Relationships – Hospitals and LTC

- Some hospitals and long-term care homes are “co-located” (N=51)
  - Same building (different wing or even same floor)
  - Two separate buildings (on the same campus or geographically separate)
  - Hospital corporation is the license holder for long-term care
  - Generally share staff, resources, etc.

- Collaborations and partnerships
  - Less formal, regular engagement across both organizations
  - Historically shared resources, training, expertise

Genesis of Hospital Involvement in LTC

- Amended Regulation 74/20 to allow hospitals to redeploy staff and assist LTC homes – assessments in relation to a home's infection prevention and control program; clinical supervision; nursing and personal support services
  - Some LTC homes were seeking assistance of staff only and had a limited interest in accepting hospital offers of assistance regarding IPAC, etc.

LTC Management Orders

- Ability for local medical officers of health to issue orders under the *Health Protection and Promotion Act* pre-existed COVID-19
- May 13 – Emergency Order under the EMCPA allowing the government to issue mandatory management orders to long-term care homes experiencing an outbreak (at least one confirmed case)
- In the spring, there were 11 homes that had come under hospital management*
- Government provided limited indemnity for hospitals that had management orders with long-term care, but these only applied when staff was physically deployed
- Similar supports in other congregate settings were not provided with indemnity

*Note: A chart listing these homes has been provided the Commission.

5. Labour Considerations

Labour Considerations

- March 23 – Emergency Order allowed hospitals to redeploy staff within different locations in (or between) facilities of the hospital; superseded collective agreement provisions
- March 28 – Emergency Order allowed homes to redirect their staffing and financial resources to essential task
- April 14 – Single employer directive issued
- April 17 – Memo from MOH, MLTC and OH requesting hospital assistance to homes
- April 24 – Introduced temporary pandemic pay
- April 25 – Expanded Emergency Order to expressly include hospital redeployment to homes

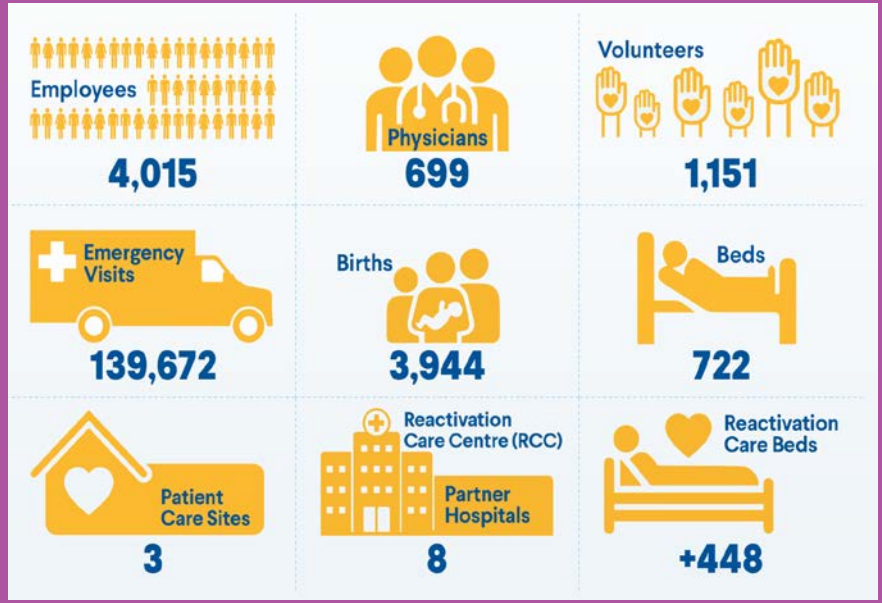
6. Member Reflections on Wave 1 – Interview Process

OHA Interviews of Hospital CEOs re: LTC

- Over the past two months, the OHA has had conversations with hospital leaders who have a range of relationships and experiences with LTC during Wave 1
- Purpose was to understand how specific hospital-LTC relationships and models have contributed to the local COVID-19 response
- Interviews focused on three questions:
  - What were the most difficult challenges during Wave 1 for LTC homes in your region?
  - What short term solutions could the government implement to best support LTC in preparation for Wave 2?
  - What specific changes should the government contemplate for LTC beyond Wave 2?

Humber River Hospital

Humber River Hospital – North West Toronto



HUMBER RIVER HOSPITAL

OHA

Humber River Hospital – North West Toronto

- **HRH Wilson (656 beds)**
  Programs: Critical Care, Oncology, Medicine, Surgery, Mental Health & Addictions, Maternal & Child, Emergency Department, Nephrology, Seniors Care and Outpatient Services
- **Reactivation Care Centre - Finch (250 beds)**
  Partners: Humber River Hospital, Southlake Regional Health Centre, Mackenzie Health, North York General Hospital, Markham Stouffville Hospital
- **Reactivation Care Centre Church (245 beds)**
  Partners: Humber River Hospital, Southlake Regional Health Centre, Trillium Health Partners, William Osler Health System, Sunnybrook Health Sciences Centre, St. Joseph's Health Centre Toronto
- **North West Toronto OHT** – 13 Founding members
- **Runnymede Health Center - Partnership – 206 Rehab & Chronic Care beds**

Humber River Hospital – Support

Downsview

- Mandatory Management Order: May 30 – August 30, 2020
- Oversight continuing until November 30, 2020
- IPAC, OCC Health and HR assessment on site – April 23, 2020
- Provided interim ED, patient care staff, Environmental services, & MDs on site fulltime for 10 weeks

Villa Colombo

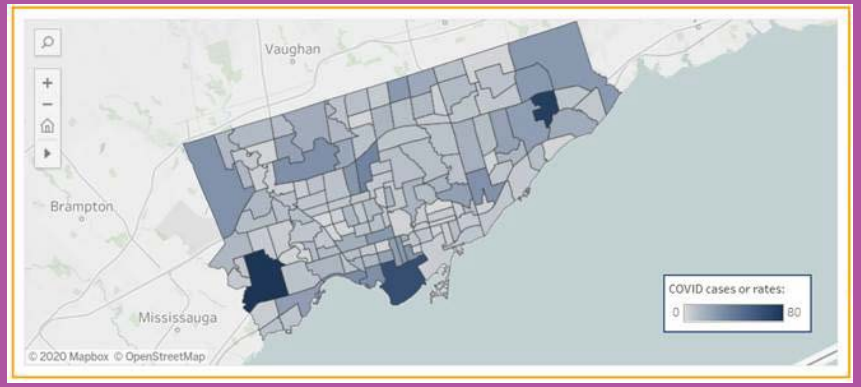
- Provided IPAC, OCC Health and HR support on site – June 1, 2020
- Voluntary Management Order - July 16 – September 20,2020
- Oversight continuing until November 30, 2020
- Provided interim ED and staff on site for weeks

Informal Partnership

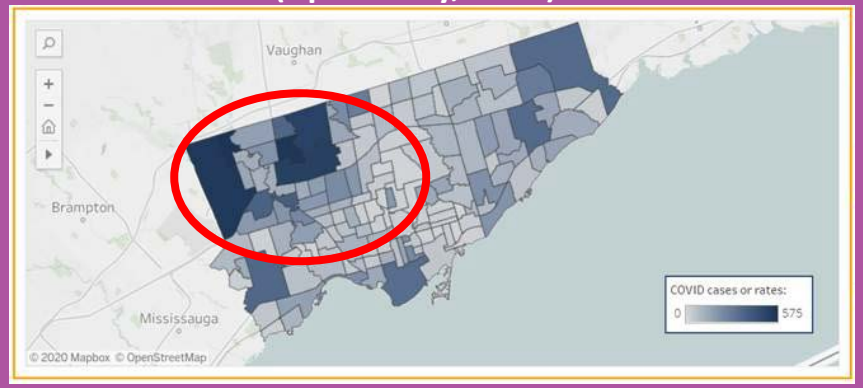
- 9 LTC facilities , 22 Congregate Settings

North Western Toronto – COVID-19 Spread

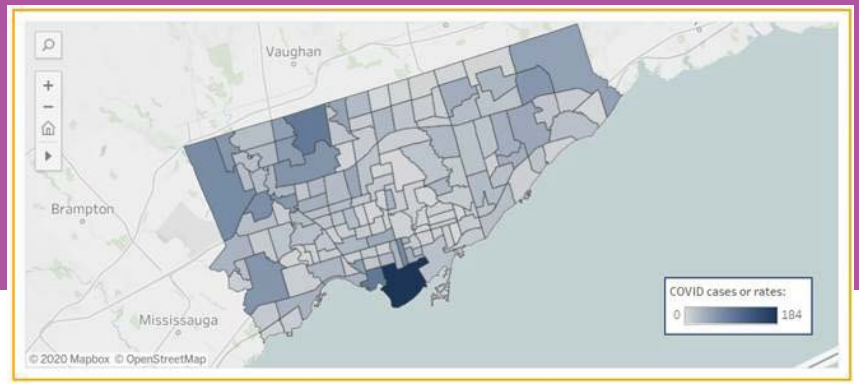
Beginning of Wave 1 (March 2020)



Peak of Wave 1 (April – July, 2020)



Beginning of Wave 2 (Aug 28 – Sept 29, 2020)



The North West Toronto community was disproportionately affected at the Peak of Wave 1 due to socio demographic factors as identified by Toronto Public Health

This is a key consideration for Wave 2 planning

The Humber River Hospital Experience

- Humber River Hospital (HRH) engaged in a coordinated response aimed to support its Long-Term Care (LTC) Homes in managing COVID-19 cases/outbreaks as their assigned Hospital Resource Partner
- HRH has deployed a standardized approach to providing support consisting of an onsite assessment, followed by a targeted strategy for each LTC Home, recognizing the unique needs of each facility (IPAC, environmental services, staffing, testing, PPE, etc.)
- Implemented twice weekly huddles with LTC champions, administrative leadership and IPAC lead from hospital as well as LHIN Home and Community leadership
- Regular meetings allowed for timely sharing of Ontario Health and Ministry directives, updates and impact on LTC homes
- Established community of practice for LTC homes attending to share successes and opportunities
- Conducted repeat IPAC assessments at LTC homes and RHs and provided recommendations and next steps
- Regular monitoring and processes for escalated contact

Humber River Hospital - Reflections from Wave 1

- Initially hospitals were advised to complete virtual assessments – inadequate
- LTC homes reluctant to allow anyone to attend
- Medical Directors as well as attending physicians in LTC homes were not on site and relying on virtual care when staffing levels where greatly reduced
- Lack of robust IPAC processes at the LTC homes and limited availability of qualified personnel in house to implement, audit and sustain these processes
- Challenges with timely access to PPE
- Challenges with obtaining swabs in a timely manner from Public Health
- Limited supports in the system to rapidly test staff and residents
- Laboratory turn around times too long: 5-7 days
- Mixed messages re isolation routines
- Ministry Inspections Branch – visit frequency, virtual
- Mandatory and Voluntary Management Order process

Humber River Hospital - Reflections from Wave 1

- Leadership Roles, Focus and Strength
- Communications
  - Between caregivers
  - For Staff: to allay anxiety
  - MDs
  - Families
- Policy, procedure development and adherence
- Value of role family and caregivers provided in “supplemental staffing”
- Visiting and wandering patients
- Environmental services resources, lack of environmental service standards and audits
- Staffing shortages were exacerbated by “single employer policy”
- Isolation units not developed (LTC homes are client homes) - resulted in many isolated too long

VCT KPI/Metrics		07-Sep	08-Sep	09-Sep	10-Sep	11-Sep	12-Sep	13-Sep	14-Sep	15-Sep	16-Sep	17-Sep
RESIDENTS												
Total Beds		395	395	395	395	395	395	395	395	395	395	395
Total Bed Vacancies		70	70	68	69	69	69	69	70	67	67	67
Discharged to Community		0	0	0	1	0	0	0	1	0	0	0
No of residents in hospital		3	3	3	3	3	4	4	3	3	4	4
Current Census		322	322	324	322	323	322	322	321	325	324	324
COVID-19												
Daily # of New Positive Residents		0	0	0	0	0	0	0	0	0	0	0
Total Positive Residents		173	173	173	173	173	173	173	173	173	173	
Current COVID-19 Positive in Home		0	0	0	0	0	0	0	0	0	0	0
# of COVID-19 Residents in Hospital		0	0	0	0	0	0	0	0	0	0	0
# of New Residents Under Investigation		0	0	0	0			1	1	1	1	3
# of New Recovered Residents		0	0	0	0	0	0	0	0	0	0	0
Total recovered residents in the Home		139	139	139	139	139	139	139	139	139	139	139
Resolved and in Hospital		0	0	0	0	0	0	0	0	0	0	0
New resident Covid-19 Death		0	0	0	0	0	0	0	0	0	0	0
TOTAL Covid-19 residents death		33	33	33	33	33	33	33	33	33	33	33
New Non-Covid deaths		0	0	0	1	0	0	0	0	0	0	0
Total non-Covid death		47	47	47	48	48	48	48	48	48	48	48
STAFF												
Total Staff Cases		64	64	64	64	64	64	64	64	64	64	64
No of new staff cases		0	0	0	0	0	0	0	0	0	0	0
Total Active staff cases		0	0	0	0	0	0	0	0	0	0	0
No of staff completed 14 day isolation recovered and eligible to return to		64	64	64	64	64	64	64	64	64	64	64
Total Staff Covid-19 back to work		61	61	62	62	62	62	62	62	62	62	62
DAILY STAFFING												
No of staff unable to return due to working in other facilities		76	76	76	76	76	76	76	76	76	76	76
	RN	6	8	8	9	3	8	8	8	7	8	9
	RPN	24	24	24	23	27	22	22	23	26	25	21
	RSA	0	0	0	0	0	0	0	0	0	0	0
Staffing	PSW	92	95	92	86	86	87	88	87	86	87	83
sustainability:	**Total Regular Staff**	**122**	**127**	**124**	**118**	**116**	**117**	**118**	**118**	**119**	**120**	**113**
RED: less than 70% of	1-1 PSWs	**12**	**12**	**12**	**9**	**9**	**12**	**9**	**12**	**15**	**15**	**12**
regular staff working	Agency	8	10	3	6	16	18	12	3	9	7	5
YELLOW: 70-85% of	% in house clinical staff	92%	95%	93%	89%	87%	88%	89%	89%	89%	90%	85%
regular staff working	Dietary	20	22	22	22	24	20	20	22	22	23	23
GREEN: >= 85% of	Cooks	3	3	4	4	4	3	3	4	4	4	4
regular staff working	Recreational Therapist	6	8	9	9	6	5	5	7	6	9	6
	Allied	0	5	6	5	4	0	0	4	6	6	5
	Visitation RSA	0	1	1	1	1	0					
	Laundry	6	6	6	6	6	6	6	6	6	6	6
	Maintenance	2	3	3	3	3	1	1	4	4	4	3
	Housekeeping	20	20	20	20	20	20	20	15	15	20	20
	OHS											

Risk Level | Preparednes Level | Metrics | Leadership | IPAC | PPE | Testing | Staffing | EVS | OHS | Education | Physician Support

Long-Term Care Homes (North West Toronto) Dashboard – September 2020

OHA

Humber River Hospital - Managing Wave 2

- Need a coordinated system approach that includes Home and Community Care, Community Health Centres, and other partners
- Regular meetings with the homes and partners to ensure timely sharing of key information, with an opportunity to address questions and concerns in a timely manner
- Implementation of LTC trigger tool *(next slides)* with clear expectations and accountabilities around IPAC assessments, follow up, and timely submission of positive cases, hospital admissions and other key metrics by the LTCs
- Deployment of external environmental service resources to support
- Staffing strategy beyond hospital- include colleges and universities, home and community care
- Broaden the definition of “essential caregiver”, allow family and caregivers to continue to provide personal care to residents
- Consider flexibility in the single employer policy where safe to do so
- Communications plan to allay anxieties, better distribute pandemic-related information to homes
- Medical Directors on site and role of geriatrician

Humber River Hospital - Wave 2 Plan / Triggers for LTC Pandemic Activity Response

Focus Areas:

1. **Preparedness.** Ensure mitigation strategies and supports are in place to prevent avoidable outbreaks
2. **Response.** Planned and structured response to issues, focusing on early detection and engagement

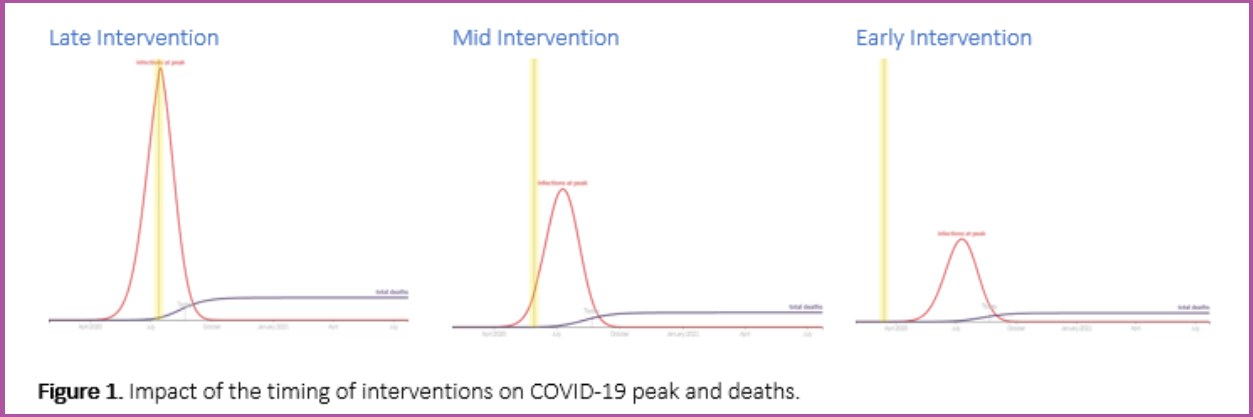
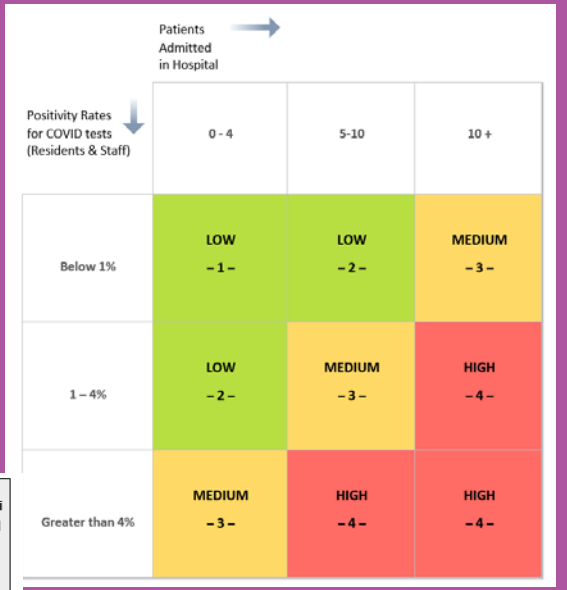


Figure 1. Impact of the timing of interventions on COVID-19 peak and deaths.

HRH Wave 2 Plan / Triggers for LTC Pandemic Activity Response

- Based on lessons learned early in Wave 1 of COVID-19, a planned and measured approach with incremental increases in supports based on triggers has proven effective in many programs including the critical care and surgical services. This framework adopts these principles and is tailored to the LTC sector.
- This proposed framework can be used by each LTC home to identify the level of support they require based on their COVID-19 positivity rates and patients admitted to the hospital. Example below:



LTC Home	Response Level
LTC Home 1	Level 1
LTC Home 2	Level 1
LTC Home 3	Level 1
LTC Home 4	Level 3
LTC Home 5	Level 3
LTC Home 6	Level 2
LTC Home 7	Level 4
LTC Home 8	Level 4

Trigger / Response	LTC Huddle	IPAC Assessment Submission	Onsite IPAC Assessment	Onsite SWAT Team	Additional Supports as per SWAT Recommendations	Recommendation / additional staffing support
Level 1	Weekly	Weekly	No	No	No	No
Level 2	2x / week	Weekly	Weekly	No	No	No
Level 3	Daily	Weekly	Weekly	Yes	Yes	No
Level 4	Daily	Weekly	2x / week	Yes	Yes	Yes

Humber River Hospital - LTC Home Data (from assigned LTCs) - Residents

LTC Home	Bed Capacity prior to COVID	New Bed Capacity to support IPAC (no quad or triple rooms)	Current Bed Occupancy
Long-Term Care Home 1	120	102	101
Long-Term Care Home 2	75	55	70
Long-Term Care Home 3	160	160	152
Long-Term Care Home 4	192	168	165
Long-Term Care Home 5	224	224	165
Long-Term Care Home 6	152	152	139
Long-Term Care Home 7	254	194	184
Long-Term Care Home 8	395	395	320
Total	**1572**	**1226**	**1296**

LTC Home	Wave 1 # of COVID Resident Cases	Wave 1 % Infection	Wave 1 # of COVID Resident Deaths	Wave 1 Number of Recovered Residents
Long-Term Care Home 1	62	52%	15	47
Long-Term Care Home 2	0	0%	0	0
Long-Term Care Home 3	0	0%	0	0
Long-Term Care Home 4	72	38%	22	50
Long-Term Care Home 5	93	42%	58	35
Long-Term Care Home 6	66	43%	10	56
Long-Term Care Home 7	150	59%	66	84
Long-Term Care Home 8	173	44%	33	140
Total	**616**	**39%**	**204**	**412**

LTC Home	Wave 2 # Residents that can be infected	Wave 2 Forecasted # Infected
Long-Term Care Home 1	54	21
Long-Term Care Home 2	70	27
Long-Term Care Home 3	152	59
Long-Term Care Home 4	115	45
Long-Term Care Home 5	130	51
Long-Term Care Home 6	83	32
Long-Term Care Home 7	100	39
Long-Term Care Home 8	180	70
Total	**884**	**345**

HRH - LTC Home Data (from assigned LTC homes) - Staff

LTC Home	Total Number of Staff	Wave 1 Number of Staff COVID Cases	Wave 1 % Staff Infection	Wave 1 Number of Staff COVID Deaths	Number of Staff unable to work as per Directive 3
Long-Term Care Home 1	177	25	14%	0	31
Long-Term Care Home 2	53	1	2%	0	28
Long-Term Care Home 3	160	1	1%	0	21
Long-Term Care Home 4	100	30	30%	0	25
Long-Term Care Home 5	170	0	0%	0	43
Long-Term Care Home 6	242	31	13%	0	34
Long-Term Care Home 7	272	108	40%	1	42
Long-Term Care Home 8	416	66	16%	0	75
Total	**1590**	**262**	**16%**	**1**	**299**

LTC Home	Wave 2 # Staff that can be infected	Wave 2 Forecasted # staff infected
Long-Term Care Home 1	152	24
Long-Term Care Home 2	52	8
Long-Term Care Home 3	159	25
Long-Term Care Home 4	70	11
Long-Term Care Home 5	170	27
Long-Term Care Home 6	211	34
Long-Term Care Home 7	163	26
Long-Term Care Home 8	350	56
Total	**1327**	**212**

St. Joseph’s Health Care, London

PARKWOOD INSTITUTE'S MENTAL HEALTH CARE BUILDING

MOUNT HOPE CENTRE FOR LONG TERM CARE

PARKWOOD INSTITUTE'S MAIN BUILDING

ST. JOSEPH'S HOSPITAL

SOUTHWEST CENTRE FOR FORENSIC MENTAL HEALTH CARE

Our Patients – Our People

St JOSEPH'S HEALTH CARE LONDON

St. Joseph's Health Care – Collaborative Support

Regional support of 77 long-term care homes and 8 residential hospices

- Huron Perth: 18 homes and 3 hospices
- Grey Bruce: 19 homes and 2 hospices
- Oxford: 9 homes and 1 hospice
- Elgin: 8 homes
- London-Middlesex: 23 homes and 2 hospices

Member Reflections on Wave 1 – Key Themes

Interviews: Key Themes

1) Infection Prevention and Control and Personal Protective Equipment

- Many of the LTC homes had no IPAC resources or training, or had policies that were never implemented
- Those with resources and training found that these opportunities were overtaken by the complexity of needs and demands
  - PPE supply procurement was a big issue
- Where hospital IPAC support was welcomed, barriers remained (e.g., cluttered rooms, resistance to over-hospitalized culture)
- For many interviewees, public health was not effective in offering support

Interviews: Key Themes

2) Medical Oversight and Staffing

- Many long-term care homes had limited physician expertise, and there was a general unwillingness by physicians to attend onsite
- Staffing challenges were significant – how “single employer policy” was implemented created challenges for many long-term care homes, particularly in smaller and more rural communities
- Further complicated by concerns about PPE/IPAC and wage disparity across sectors

Interviews: Key Themes

3) LTC Inspections

- Inspections were occurring virtually
- Existing model promotes a culture where staff and leadership are scared to admit mistakes – punitive and no connection to quality improvement

4) Role of Family Caregivers

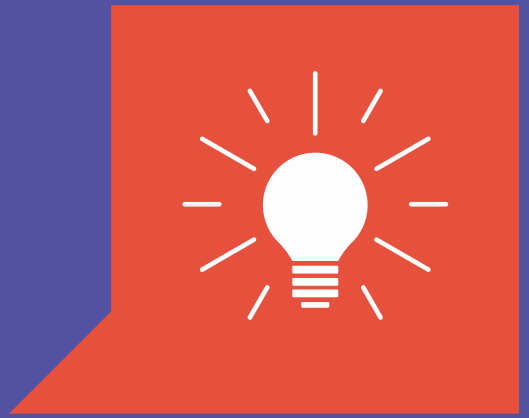
- Lack of appreciation for the role that family caregivers service in providing care support
- Government continued to consider visitors and family caregivers as a single group

Interviews: Key Themes

5) Relationships Between Health Service Providers

- The LTC homes that were most easily able to prepare for and weather the storm had pre-existing strong links to hospitals (same organization or actively working together)
- Hospitals who were able to leverage other health system partners such as home care, paramedics, and primary care physicians felt relatively less strain

7. Considerations for Wave 2



A) Linkages between LTC Homes and Hospitals

- Consider linking long-term care homes to hospitals within their communities
  - Any approach cannot be universally applied – not a one-size-fits all
  - Diversity of hospitals cannot be overlooked – collaboration and partnership between hospitals and long-term care has been extremely successful in many instances
  - Include mobilization of other community partners
  - Need a coordinated, standardized process that allows for escalation where appropriate
- Consider criteria/threshold to escalate contact and level of support
  - Leverage data and status of long-term care homes (green, yellow, red) provided at regional tables
- Indemnity and immunity for hospitals needs to reflect ongoing support and assistance

B) Staffing Shortages / Concerns

- Revisit universal applicability of “single employer policy” where safe and appropriate (or increase hours to offset)
  - Single employer policy has been particularly challenging for communities where health human resources are particularly limited (e.g. small, rural and northern)
- Increase funding to facilitate more hours for existing health care workers
- IPAC support and interventions with reliable and timely access to necessary PPE to protect and reassure employees
- Consider situations where family caregivers could be utilized with proper IPAC support, training and personal protective equipment

Questions?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