Long-Term Care COVID-19 Commission

AdvantAge Ontario
on Tuesday, September 29, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 29th day of September, 2020, 1:00 p.m. to 3:00 p.m.

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

PRESENTERS:
ADVANTAGE ONTARIO:
Lisa Levin, CEO
Lynette Katsivo, Director of Public Policy
Jane Sinclair, Board Chair
Sarah Le Monnier, Manager, Financial Policy
Sarah Boesveld, Policy Analyst
Amit Joshi, Director of Financial Policy

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Hello, everybody. I think the Commissioners are here. Deana is here. And who is speaking for -- oh, sorry.

(DISCUSSION OFF THE RECORD.)

Who is speaking for AdvantAge Ontario?

LISA LEVIN: So it is Lisa Levin, I am the CEO, and we have Jane Sinclair, our Board chair.

JANE SINCLAIR: Good afternoon.

COMMISSIONER FRANK MARROCCO (CHAIR): I want to thank you for coming. It is very much appreciated. It is very helpful to us to get this kind of perspective.

Does AdvantAge Ontario have a website?

LISA LEVIN: Oh, yes, we do.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Levin, would you mind if we had a link on your website to our website so that somebody who was interested in what we were doing could very easily link to us?

LISA LEVIN: Absolutely, we can do that.

COMMISSIONER FRANK MARROCCO (CHAIR): That would be very helpful. There is Commissioner Angela Coke, and Commissioner Jack Kitts and myself. We are the Commission. And, you know, it is a bit of an odd situation for us because normally when there is an inquiry called it is looking back at something that happened and trying to explain what happened to the public.

Our situation is a little bit different. We have been created in the middle of something that is happening, or inside, before the thing is finished, and that is different, and it places different constraints on us.

We feel a pressure to make recommendations.

Typically, in an inquiry, first of all, you do an investigation, then you hold public hearings, and then you write a report. And that takes two, two and a half years. It is -- certainly two years would be reasonable, maybe on the low side of reasonable.

Well, as you can appreciate, us reporting for the first time two years from now is probably not as helpful as it could be.

So we are kind of doing it backwards in

the sense that we are going to try to get to some recommendations and then perhaps take a look at what happened previously and try to put a proper explanation to it.

So we are kind of at the first stage of this rather unique situation, so your intervention is very helpful because it allows us to get a perspective that we think we need.

And there is a reporter. It will be transcribed, and we will post that so that people know what we are doing. So, Ms. Levin, with that, we are ready when you are.

LISA LEVIN: Okay. Great. Well, thank you very, very much for giving us this opportunity to present, and we also have some of our staff here as well who can answer questions that Jane and I cannot answer, if you have any.

So we were really happy that this Commission has been called together to look at this critical issue, and it is unique that the issue continues as you are doing your deliberations, so it makes your role even more important.

So I believe Lynette is sharing the screen, so, Lynette, if you could advance to the next slide, please.

And do the Commissioners have this presentation?

COMMISSIONER FRANK MARROCCO (CHAIR):

We have on -- I have on my screen "Presentation Structure, Introduction, Context", if that is what --

LISA LEVIN: Yes, yes, very good, but we'll also --

COMMISSIONER FRANK MARROCCO (CHAIR):

And just let me ask the other Commissioners if everybody got it on their screen?

COMMISSIONER JACK KITTS: Yes, it is on my screen, yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right.

LISA LEVIN: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Coke, do you have it?

COMMISSIONER ANGELA COKE: Yes, I have it. Thank you.

LISA LEVIN: Okay. So today Jane and I are going to talk to you and just give you some context, go over our recommendations. We have a detailed lessons learned document we are just finalizing which we will be submitting for your

consideration, and then we are going to go through our conclusions and feel free to stop us at any point if you have any questions.

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes, that is exactly what we'll do. We'll ask the questions as we go along.

LISA LEVIN: Okay. Great. So next slide. So just to give you a little bit of information on ourselves, we have actually been around over 100 years. Last year was our one hundredth anniversary. And we represent community-based, not-for-profit, and municipal organizations who provide care across the full spectrum of seniors care.

We have nearly 400 full members, and so they are not-for-profit, charitable, and municipal long-term care homes, as well as seniors housing, supportive housing, and community service agencies.

So the goals for our participation today and in general throughout your mandate is to provide you with useful factual information, highlight policy and system changes that need to happen, and provide recommendations for consideration in your interim and final reports, and we have some supporting information that we

will be submitting to you which is, as I said, our lessons learned paper, as well as some letters that we have written to government, and we have actually been on a little campaign the last week. We have more letters we can add to that list, so we will be sending that to you as well.

So long-term care represents 21.7 percent of the total COVID-19 cases in Ontario, with 6.5 percent of the cases attributed to staff and 15.2 related to residents.

288 homes had been in outbreak as of July 20th, which represented 46 percent of all homes, and that number has likely gone up because there is currently 40 homes in outbreak now, some of whom have been in outbreak before and some of whom haven't, and we haven't done that analysis yet to determine how many new additional ones.

74 percent of the deaths reported in the sector were from for-profit homes, 21 percent from not-for-profit homes, and 5 percent from municipal homes.

And just to give you a sense, though, in terms of the breakdown, 25.6 percent of all homes in the province are not-for-profit. 20.7 percent of all homes in the province are municipal,

but they only had 5 percent of the deaths.

So I am sure that you have been hearing this a lot as to why it was so severe, but basically residents are older, more medically complex than those living in many other congregate care settings, living often in crowded conditions, and the pandemic highlighted very long-standing issues that we have had to prevent, identify, contain and manage outbreaks, such as understaffing and underfunding, which our association has a long history of advocating to remedy.

And we also felt that specifically actions that were taken to safeguard homes were too little and too late.

But we also want to talk about what worked well because everybody really rallied together to assist during the pandemic, and it was really quite inspiring.

So we had amazing communication with the Ministry of Long-Term Care senior staff and a new Chief of Staff began in the Minister of Long-Term's Care office on March 24th, and once he started, there was quick action on a number of issues. Throughout, the Ministry has listened and implemented many of our suggestions, and they

continue to do so. In fact, today we were just on a call, and they said to us that something we suggested they are going to be implementing.

There is also a Long-Term Care Table that was set up with the Deputy and his staff, which was very helpful and regular one-on-one meetings, as well as with Ontario Health.

COMMISSIONER FRANK MARROCCO (CHAIR):

Can you just help me a bit with how the table functioned?

LISA LEVIN: So it is called Long-Term Care Retirement Home -- and I forget the exact title of it -- Table. And it is comprised of the Assistant -- the Deputy Ministers in both the Ministry of Seniors to represent retirement housing and the Deputy Minister of Long-Term Care, and as well as their staff were on that table as well.

One person from the Ministry of Long-Term Care was on that table to represent assistive living and supportive housing, although we never talked about that.

And then the membership also included the two associations and a number of our members, so long-term care homes and some assisted living and as well as -- oh, the Ontario Retirement

Communities Association, ORCA, and some retirement home operators, and Ontario Health, I think, was there, and so we would meet --

COMMISSIONER FRANK MARROCCO (CHAIR): And so -- sorry. So how would the table -- would the table take votes or make decisions? How did it make decisions or did it make decisions?

LISA LEVIN: It didn't make decisions. It was more of a, I would say, information-sharing and consultation mechanism. Fortunately, the calls were open so we didn't have to use slide-out to get our comments in as we did in other tables, and there was an agenda that was sent out.

And at first it was sent out in advance -- or shortly after they started it was sent out in advance, and we were asked to add items, and at this point we are not specifically prompted to add items, but we know that we can email them, and they will add items to the agenda.

And then there would typically be a presentation by Denise Cole from the Ministry of Seniors and a presentation by Richard Steele from the Ministry of Long-Term Care with an update and then specific other items would be updated and then

they would ask if there were any questions or comments, and we would provide those.

And that table is still ongoing. I believe it is every two weeks now.

So also pandemic pay was very helpful, but it ended August 13th and the pandemic did not. But we are hearing that some money is coming and will be announced potentially later this week that will assist.

And pandemic emergency funding also came relatively quickly, but it hasn't kept up with the need, and many of our members are in financial distress but, as we speak, apparently the Premier or the Minister is announcing significant new funding going to our sector to pay for pandemic funding, so that will help a lot.

In addition, we receive funding from the government to provide education to the sector because that is one of the roles that our association has played historically over the years, is we provide education, but it has always for the most part in recent years been funded by those who attend our sessions, so the government provided funding for COVID education and supports, so we were able to provide that to the whole sector for

free, and they also gave us money for one-to-one support of our members because we were doing a lot of case management through wave one to help members get through outbreaks.

Another important measure or measures that helped were the Emergency Orders that loosened some of the very tight regulations in long-term care, recognizing that homes would be short-staffed, and those were very, very helpful and continue to be very helpful.

So Jane is going to take you shortly through the beginning of the issues and recommendations and then we are going to sort of go one after another, but we are going to talk about the seven key theme areas that we want to discuss today where we mention issues and recommendations.

The first is IPAC, and then staffing, funding, communication, long-term care representation, emotional well-being of staff and residents, and we wanted to talk to you about assisted living in supportive housing.

So if you are okay, I am going to pass it over to Jane now, who is our Board Chair and a General Manager for what with the County of Simcoe? Everything? General Manager of everything, Jane?

JANE SINCLAIR: Emergency services.

Thanks very much, Lisa. So we have four long-term care homes, significant seniors housing and service department, as well as I oversee paramedic services and our regional emergency management program.

So I am going to jump right into our IPAC area of focus, infection prevention and control, and the first couple of slides I am going to talk about the testing and surveillance issues that we have identified.

It is obviously a really critical strategy in early identification and containment, and what we, you know, found or identified through the first wave is testing and surveillance in long-term care sector, it didn't really work as it should have, and there are a number of factors that need to be considered.

So they had many false-positive results, and I can't emphasize the requirements put in place when we get a positive test result. So that was a huge issue.

Slow responses from Public Health Ontario, major delays in testing --

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I just stop you there? Slow responses, how does that -- what does that mean? I get what it means on the screen, but what are we actually talking about here?

JANE SINCLAIR: I'll get into a little more detail with some of the subsequent slides, but as some of this was a little late coming out, the testing and surveillance was a perfect example that, you know, we knew that there was asymptomatic spread and early identification, and yet the actual testing requirements and surveillance was late coming through Public Health Ontario.

So, you know, some of these themes that we'll talk about are related to timing, and when we get into the actual test results component, we still are struggling with getting our test results.

And when we, you know, get 80 percent of our test results from our regular staff testing, and there is still 20 percent that are lagging, and we are in an outbreak situation, it really puts us in a very precarious situation, and we are not really as effective in our strategies as we could be if we had, you know, more prompt test results.

LISA LEVIN: If I could just interrupt for one moment -- I'm sorry, Jane -- just to let

you know that this is an example of something that is continuing and that is happening right now, and we have homes, for example, in Ottawa that are in outbreak, and it is taking six to eight days to get test results. So how do you isolate people properly if you don't know who has COVID? This is going on across the province, and also, there is delays in getting staff tested and visitors tested, and so these all significantly increase the risk in our homes.

COMMISSIONER JACK KITTS: I understand it is still ongoing, but are you also talking about difficulty having symptomatic patients tested and then followed before the crisis in long-term care? In other words, did this pre-date the crisis, and if so, could it have contributed to the spread?

JANE SINCLAIR: I think this is really reflecting wave one, the observations and experiences. It is not really pre-COVID that we are highlighting. This is when -- and I can tell you just from experience as an operator, early on, you know, there is a whole host of different signs and symptoms, and so one resident demonstrating only one of those signs or symptoms of COVID, we would, you know, have to put significant

precautions in place, isolation. We would, you know, isolate the unit. We were engaged back and forth with Public Health, and we would do, you know, testing of co-residents, et cetera, staff that may have been in contact, that may have been exposed.

And getting the delays back in the testing and even scrambling to get enough swabs for the testing, you know, really impacts our entire ability to effectively and quickly manage these situations.

So I think this data really speaks to what we have experienced during the COVID pandemic.

LISA LEVIN: And some of the initial outbreaks could not get enough swabs. They were given, like, two or three or four swabs, and if they -- and this went all the way up until April. And if they had been given a proper amount, they would haven't had as big of an outbreak.

COMMISSIONER JACK KITTS: So before it spread, then, you already didn't have sufficient testing equipment or turn-around time, even before it spread?

JANE SINCLAIR: Yes, we were having hiccups with timing delays before it actually

spread, yes, that is accurate.

So, you know, our recommendations around this is Public Health Ontario immediately identify and address the challenges that contributed to the significant number of false-positives, and I can tell you also that the impact from a mental health and a confidence perspective from staff and families and residents, when you are going through these processes, to find that you have a false-positive. And when you see a repeated pattern of false-positives, then it lends to a lack of credibility in the system and then, you know, we worry people don't take the test results as seriously as they should and may, you know, become more laissez faire or lax in seeing the, you know, critical need to diligently apply PPE, social distancing and et cetera, et cetera.

So there is a lot of ramifications from these testing pieces.

So we recommend the Ministry of Long-Term Care work with the partners, Public Health and Ontario Health, to ensure that the homes can have access to the swabs and not just for staff but for residents and provide funding to the homes for regular testing.

The testing for long-term care home staff and residents, it must be prioritized, so to get it back within 48 hours, that would be ideal in helping us manage.

LISA LEVIN: So if I can add --

COMMISSIONER FRANK MARROCCO (CHAIR): So it is now taking -- still taking 6 to 8 days?

LISA LEVIN: Yes, in many parts of the province, it is taking an inordinate amount of time, 6 to 8 days. It has gotten worse since this new wave has started, if you can say we are in a new wave, so it is definitely a huge issue.

COMMISSIONER FRANK MARROCCO (CHAIR): And why in your view is there a delay in getting the results back? You said they had to prioritize. Is it simply -- not simply, but is it a question of not being high enough up the priorities list, or is it something else?

LISA LEVIN: It is a combination of the fact that the system seems deluged since right before school went back with people going for testing, as society opens up, so the volume seems to be higher, so the labs don't have the capacity. I am hearing there is shortages of testing

supplies, but I don't know for sure.

But I could tell you that we have asked the Ministry of Health and we have asked the Ministry of Long-Term Care about testing and why long-term care can't be prioritized, and the Ministry of Health told us this morning in fact that -- on the call with the Ministry's emergency operations center, that prioritization doesn't work well because then 50 percent of the people who need to be tested would have to be prioritized, and it is not the kind of conversation where I could talk. We have to write it in Slido, but if I could have talked, I would have said, I beg to differ because long-term care was the hardest hit sector. Why on earth they can't be closer to the top than being part of the half of the people who are tested I find very hard to believe.

JANE SINCLAIR: If I may add to that, there is different testing sites, and we know this is a big issue as well.

So typically when we test all our residents in an outbreak scenario or we are doing the regular testing of our staff, we collect the tests. We send them all together. They are bundled, and they are off to the same lab.

We still have issues, unfortunately, even with that process, although it tends to be more efficient, but we have had scenarios where we have had to call Public Health because it is 10, 12, 14 days we still are missing some resident tests. And we have to, you know, stay the course with all the additional precautions, not knowing whether these, you know, lagging test results are positive or negative.

And we have had our local Public Health, you know, say, You know, at this point in time, we haven't been able to identify the test results. We can declare the outbreak over. We can assume it is negative. So these are the kind of situations.

And with our staff and family members, they are going out -- family members in particular, they are going out to local testing sites, and they are required to under certain circumstances to visit residents.

And I was on a town hall with our families from one of our homes today. 17 days it took for this person to get her test results back. The test results have to be within 14 days, so she cannot visit her loved one.

And we have had debates with local testing assessment centres on behalf of our families who are being turned away sometimes to say, You are not symptomatic, we are not testing you.

So I think, you know, if I may, that is part of the issue too, is that we need some consistency in application across all testing sites, whether we are working with, in our case, the local health unit or whether we are sending people out to the assessment centres in their local home area. We are seeing huge variances and a lack of consistency in information from the testing centres.

LISA LEVIN: We also had a home that was in outbreak because a staff member had COVID, and then a resident had COVID, and they did testing. They didn't get results back from everyone until eight days, and then there were two tests that were missing, and it turned out -- so they called. They thought to call, and they found out a couple of days later that one of those tests was positive.

So that had been like ten days where there was someone who was positive in their home

and, you know, they didn't know.

JANE SINCLAIR: So really, you know, if we have more consistent approach with timely results and adequate testing equipment, we see this making a substantive difference in the effectiveness of long-term care homes managing these scenarios.

Next slide, please.

COMMISSIONER FRANK MARROCCO (CHAIR): Just a second. Yes.

COMMISSIONER JACK KITTS: If you had the realtime testing and results back in 24 hours, do most of the homes have the capacity to isolate those who test positive away from the rest?

JANE SINCLAIR: No. Lisa can elaborate, but I would suggest that the capacity is limited. You know, all long-term care homes across the province, the requirements are a 40/60 split of basic accommodations versus preferred, so that is private or semi-private.

So even the newer homes have a lot of shared rooms under the basic standard, and so, you know, we are having to put in additional provisions under isolation precautions where it is only two people, not three or four, only two residents that

share a bathroom. We know that is a significant source of potential contamination.

So having to put in an additional commode and figure out how to re-think our care of two residents who are sharing, you know, those basic amenities, a single bathroom.

So that ability to ensure private, it is a challenge, I would suggest to you, for homes across the province.

LISA LEVIN: Yes, I would add to that that you also have people with dementia who are wandering, and how do you safely isolate them without one-on-one care, which we certainly don't have in our homes.

30,000 of the 79,000 long-term care beds have to be re-developed by 2025 because they are older and many of those have three- to four-bed wards, cramped common areas, cramped spaces for staff as well.

So that is why we did write a letter to the Minister of Health and the Minister of Long-Term Care saying that if there is a long-term care home that cannot isolate residents properly, that when they get the first few cases of COVID in their homes, they immediately be transferred to

hospital where they can be isolated.

And we understand that hospitals are now facing crushing pressure, so that might seem like a naive request, but if that means we have to build field hospitals, then we need to build field hospitals because many of our homes cannot safely isolate the residents.

JANE SINCLAIR: If I can add to Lisa's comments too, we know there are some field hospitals that have been already erected and are ready to go. There is one in my region in particular.

But guidelines in terms of who are the patients that will be cared for in these field hospitals I think is -- you know, I believe is a critical component as well because the conditions for admitting into those field hospitals may, you know, prioritize ALC patients and other needs of the acute care sector and not avail to the needs of long-term care homes who are struggling that don't have the amenities and are, you know, desperately trying to prevent, you know, further spread once they have COVID in their facilities.

So some guidelines to acute care centres and those managing these field hospitals to

prioritize long-term care would be a priority.

Next slide.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any sense of how long it takes to put up a field hospital?

JANE SINCLAIR: Lisa, I can only speak to the one that occurred here in Simcoe County. The Royal Victoria Regional Health Centre has a field hospital that has been erected, and it was several months.

I know it was a whole team of individuals. Because I'm in emergency management, our emergency management -- regional emergency management staff were part of that process as well and part of regular planning meetings with that group, and it took several months to get it up and available for use.

LISA LEVIN: There is also isolation pods that can be erected. There is a vendor that is selling these special quarantine units that are $200,000 a bed, and we did provide that information to government.

That would be added on to a long-term care home. I guess a hospital too.

JANE SINCLAIR: So if I move into the

next slide, we are going to talk a little bit -- again, it is about testing and surveillance, and as I mentioned, how critical it is in early identification and containment and prevention in our homes.

And unfortunately, it was introduced later. I alluded to that in the first slide. So, you know, our recommendations are we recommend regular mandatory testing for all residents and staff, and currently it continues under the recommended testing.

So, you know, many operators and many long-term care homes have had issues with staff complying because of, you know, poor experiences with the testing procedures themselves or other apprehensions. It is not mandatory. It is recommended.

And so that is a struggle. And residents as well, to be proactive and to, you know, identify early. Residents don't always present the same as younger demographics as well, so the testing, you know, is really one of the best strategies we have to try and identify before we can hear it, smell it, you know, see it, that COVID actually exists.

Next slide, please.

So the next area, again, focussing on the testing, is really the methodology, and I just alluded to it, talking about some of the experiences our staff have had and families as well.

The current nasopharyngeal swabs are uncomfortable, and they can be, you know, more so for some individuals than others, and as I mentioned, you know, we actually have some staff that refuse that testing and then that really limits our ability to identify early.

So, you know, we are really recommending Public Health identify and implement less invasive testing options that we are hearing and seeing that are happening in other jurisdictions, and that long-term care, given the vulnerability of this population, be prioritized for this new testing equipment.

Less invasive tests, you know, will have better uptake, and then we can also, you know, do regular testing with our residents as well, you know, that is quick, quick results, easy to manage and, you know, really keep ahead of the COVID activity that is now ramping up in our communities.

Next slide, please.

The next area we wanted to talk about is personal protective equipment or PPE, and certainly there has been a number of issues that we experienced in wave one.

The universal masking is one of the most obvious. You know, the directive didn't come until April. We knew about asymptomatic transmission back in March, and, you know, the horse was kind of out of the gate at that point.

Earlier implementation would have been effective or more effective in helping us identify and prevent.

And there is a significant supply -- breakdown in the supply chain. April 13th, homes couldn't get PPE from the province unless they were in outbreak, and a big part of our prevention is wearing the PPE to prevent the outbreak. So it was only those prioritized during an outbreak.

And PPE was prioritized for hospitals, whereas the most vulnerable we identified was in long-term care homes.

So our recommendation is to establish, you know, sufficient and sustainable and appropriately priced supply of PPE to long-term

care and to prioritize our residents and staff and visitors for access.

And I give you a quick example. Pre-COVID, we were purchasing -- there was about a 500 percent markup here. We were purchasing the procedural surgical masks for our four long-term care homes, 20 cents a mask. We were paying -- we're up around a dollar or more than a dollar now per mask, exact same masks.

And that is just -- in our instance, we are going through -- our burn rate is about 1100 masks a day for our four long-term care homes and our seniors housing, so you can appreciate the significant cost implications for -- and that is just one category of PPE.

LISA LEVIN: If I can just add a late-breaking update that the Ministry is about to announce or maybe they just have, at 1 o'clock they were supposed to announce funding and including in that they are announcing 8 weeks of PPE for homes, which would be like an extra supply.

So we wanted to let you know that is happening and so that will help a lot.

COMMISSIONER JACK KITTS: Could I just ask before you move on, so I am just thinking of

the people in long-term care homes when an edict comes down from on high that says PPE must be prioritized for hospitals and PPE is not available because we are prioritizing hospitals.

What was the response by anyone in long-term care homes to the Ministry of that directive or recommendation?

LISA LEVIN: Well, what we said -- I don't know if we actually knew that that was officially a message, but we definitely said that we need to get the supplies in here. We were told there wasn't any. At first, I didn't realize that there were some going to hospitals, and I guess at that point we didn't know.

We saw what was going on in New York, and I think the Ministry felt that they needed to get the PPEs in the hospitals. But we asked early on that long-term care be in the mix for all forms of protection because we saw what was happening in BC and in Italy and in the U.S., and the first priority was acute care.

JANE SINCLAIR: And I can say from an operator's perspective, you know, we were scrambling to find any and all sources of PPE that we could.

We had -- and I am speaking on behalf of my homes specifically, but just to give you an example, we had calls out for volunteer groups to make cloth masks. We were investigating and purchasing equipment to resterilize masks. We were, you know, working with community groups, local businesses, organizations, you know, trying to solidify PPE supplies as best as possible because we knew it was such an important strategy in preventing COVID.

So, you know, not being prioritized initially, it really was very difficult, made it very difficult for long-term care homes, you know, to ensure the proper protection for our residents and to give our staff and to give our residents and our families the confidence they needed that we were doing everything to protect them, when we couldn't even guarantee that we would have the PPE supplies.

LISA LEVIN: And we deployed one of our staff who, you know, spent, I would say, part of his time looking for PPEs. We have a website -- like on our website we have a list of PPE suppliers so that we could help our members find things.

I was getting PPEs to members from

different places, and then homes were also conserving PPE. So, Jane, like some of the early directives talked about how often you could use a mask before you have to change it, which was conservation mode which really made the staff very nervous.

JANE SINCLAIR: It did, absolutely.

So looking at the next area of IPAC, infection prevention and control, is the need for resources, specific expertise in IPAC.

And during the initial wave, we really saw the relevance and the necessity to have dedicated IPAC support for long-term care homes across the province. However --

COMMISSIONER FRANK MARROCCO (CHAIR): Where do you see that support coming from?

JANE SINCLAIR: Well, I think during the first wave, you know, some homes had some expertise in-house. Some homes did not.

We did see some sharing from other types of health care organizations, like local hospitals, where their IPAC specialists were consulting with long-term care homes in outbreak situations, et cetera.

But ideally, you know, we would recommend that all long-term care homes have that expertise in-house as part of the regular resource management, so they on an ongoing basis can ensure that there is proper protocols and procedures in place. They can be surveilling and monitoring, and they can be an in-house resource when staff have questions and concerns that they need, you know, timely responses to.

And I can tell you there are scenarios that come up literally every day that we haven't thought of about a person becoming exposed or in a situation where a staff member's child was exposed, and now with school back in, the scenarios are popping up every day. And having that expertise in-house to guide our team to know when, you know, staff in this case should or should not be coming to work, to know what precautions they should be taking, to know, you know, when we need to isolate residents, et cetera, it is critical.

And that is something that can't be really effectively managed on a day-to-day basis from external resources. We need to build capacity in long-term care homes so that all homes have that expertise, and they will be on top of the IPAC

procedures and ensure, you know, effective prevention and containment.

LISA LEVIN: So part of the funding that also was, I think, just announced is $30 million for IPAC resources for homes, 10 million of that for education and training, 20 million for staffing.

We asked for 71.5 million in our pre-budget submission part two, which Lynette will send to you as part of our materials.

So the money that is announced is going to be very helpful, but it will not provide a dedicated person for every home, which we do need.

And I should mention that I am saying Lynette will send things. She is our Director of Public Policy, so she is not my EA. She is just here on the call and helping us, and her and Amit and Sarah have been very helpful throughout the whole pandemic.

COMMISSIONER JACK KITTS: When you say IPAC expertise in-house, you are not meaning an infectious disease specialist? You are meaning someone who is trained and tethered to the IPAC specialist perhaps in the hospital; is that what you are speaking to?

JANE SINCLAIR: No, I am actually talking about a staff member in long-term care having that expertise beyond, you know, the basic knowledge around infection prevention and control.

So I'll give you another example. In our four facilities, we have a number of leadership positions in the nursing and personal care department, Director of Care, Associate Director of Care, Resident Care Coordinator, et cetera.

And we have some expertise in one of those roles. It is not a full-time job as an infection control lead, but we have designated -- so at least one of our management team has additional training over and above. They attend, you know, rigorous education on infection prevention and control. They are an in-house resource or expert.

COMMISSIONER JACK KITTS: I agree with you.

JANE SINCLAIR: The other thing that I'll just quickly mention is about the nurse-led outreach teams, the NLOTs, as well, and, you know, really recommending funding to scale this program up.

So it is inconsistent. Where it

exists, you know, we have had, you know, observation and experience that has been really helpful. So in addition to the in-house expertise, to have that liaison with a nurse-led outreach leader from a local hospital is a fantastic partnership and can really help support the long-term care home to manage COVID as well.

So, you know, we would look for consideration for that as well.

Next slide, please.

Home design, the next area in terms of infection prevention and control, and, you know, really in long-term care there is an entire legacy of underinvestment in this area of capital development and re-development and even minor capital funding. There has been no minor capital funding until recently for long-term care homes.

And many of the homes are older and have the older, you know, design, and it is not consistent with, you know, recommended IPAC precautions in terms of design.

There is still many three- and four-bed wards that exist, and as you can see, you know, the results certainly play -- were a factor in rates of infection, as well as insufficient space to

isolate. And we chatted about that earlier. That is a really important consideration.

Ventilation systems is another factor, many of the older homes not having adequate ventilation systems or AC, air conditioning in their homes.

And then, you know, smaller homes, smaller design, more crowded spaces, again, you know, all contrary to what would be recommended to prevent infection and spread.

So we are really recommending the Ministry of Long-Term Care to provide funding for older homes to meet the current design. And I know they committed 1.7 billion -- and, Lisa, you can jump in there -- to re-develop 15,000 beds, but there is another 19,000 over and above that don't have funding for re-development, and the licences are expiring in the end of 2025.

So this whole issue around capital, you know, development and re-development and ensuring facilities are built to prevent, you know, this type of spread is a really critical component and a recommendation that we have for consideration.

Temporarily removing residents is the next area, again, under IPAC, and as I have

mentioned, again, you know, most homes lack the capacity for dedicated space. You know, even the newer homes don't -- you know, still have a number of rooms that have two residents that share washroom facilities, for example, and so our recommendation to the Ministry of Long-Term Care and the Chief Medical Officer of Health implement a directive to temporarily remove COVID-19 positive residents out of older homes and/or homes that just don't have the capacity to safely isolate those residents in an outbreak situation, and that they be moved to hospitals or other appropriate facilities during the outbreak.

And, you know, we can learn from other jurisdictions who have shown that their ability to transfer residents under these conditions has been really successful and critical in limiting the extent of spread in long-term care homes.

So, you know, hospitals have higher staffing. They have higher PPE levels. And so looking at that as a recommendation we feel will, you know, be a really effective strategy in future prevention now that we are in the second wave.

LISA LEVIN: And we are not talking about moving everyone. We are just saying when it

first hits the home, if the home can't isolate, especially if we even know that in the first wave they couldn't isolate even with everything, then take the first few residents, get them out. Otherwise, you just -- you see what just happened in Ottawa. Otherwise, it just rolls through the home, and it just -- you can't stop it.

JANE SINCLAIR: And some of the guidelines that came through Public Health and the Ministry of Long-Term Care earlier on talked about cohorting residents and moving residents so that they are in like areas.

And I have to tell you, from an operations perspective, that is not an easy feat either, you know, because there isn't ample space, vacant space, so we are talking about removing people from their rooms and moving them into other rooms. There is a whole disinfection process and, you know, moving personal effects, et cetera, you know, from other areas in the units.

And that can be really difficult for homes to manage as well. So it is not just, you know, where there is three- to four -bed units, et cetera. It impacts, you know, more homes that just don't have the ability to safely isolate once COVID

has been identified in their home.

So the next area, I am going to turn that back to Lisa. Thanks very much.

LISA LEVIN: Thanks, Jane.

So now I am going to talk about one of our biggest challenges. So long-term care has had historical health human resource challenges for many, many years.

First of all, the homes aren't funded for enough staff to begin with, which is why one of the things we asked for is at least four hours of care per resident, and then that sort of creates a catch-22 where staff are working with insufficient supports to handle residents who are much more complex than they used to be.

And the staff burn out, and then it is harder and harder to find staff and then it just sort of piles up and becomes like a snowball effect.

So as it is, homes don't have enough staff, and then they can't get staff because they are understaffed. Most homes are always working short, and this is before the pandemic.

When homes went into outbreak, many of them lost a lot of staff. In some cases, 80

percent of the staff left. We had one home that called over 1,000 people, and they couldn't find anyone to come in in the early days.

So even though this -- and so the Ministry of Health and the Ministry of Long-Term Care and Ontario Health, they only came in in mid-April to help homes with this. Prior to that, homes were on their own, and they felt very alone, and it was very, very scary.

So we tried to do what we could, which isn't our regular role. I spoke with the Registered Nurses' Association, and they agreed to put in place a program at first placing nursing students in homes and then they put in place a program to place nurses in homes, and that saved a lot of lives. It really saved a lot of lives.

And they placed thousands of staff in homes. They are not going to be doing that again in the second wave. The Ontario Personal Support Workers Association also helped with matching some PSWs, and even the dietitians of Canada, who we reached out to -- we reached out to all these associations -- were able to provide virtual assistance.

But in wave two -- also homes used

re-deployed staff that are not going to be available this time around because they are back at work.

But I have to tell you that homes were on their own, and we had some major outbreaks which were very awful. One in particular, one home in Toronto contacted me and asked if I could help them find staff, and I was able to find an agency who went into that home. And that agency told me they found dead bodies when they went into that home.

And I don't believe from what I could tell that the home was negligent. I believe that their staff walked out, and they didn't know what to do, and they couldn't find staff.

We reached out to Ontario Health. We reached out to the Ministry of Health. We told them that we had an agency in there when we got one in, and the agency was telling us that the people in the home, their first language wasn't English. They weren't wearing ID bracelets, so they didn't know what medication to give to whom, and they needed a translator.

We told Ontario Health. We told the Ministry we needed a hospital to assist. We needed a translator. Nothing happened. This went on for

weeks. Somehow the home got out of outbreak. If it wasn't for that agency, it would have been much worse. It was pretty bad as it was.

And we just cannot let that happen again. So when Deputy Minister Helen Angus was on a call in April with the Ministry of Long-Term Care and said that hospitals are going to help, I felt like this huge burden lifting off of my shoulders because until then we were very much on our own.

We can't let that happen again in the second wave, and the resources that we were able to access in the first wave won't be there, and I am very, very worried that this may happen again and be even worse because we also know and we have been told by the Deputy Minister of Long-Term care in a letter that hospital resources are scarce and hospitals will not be able to come into the same level and provide staff.

So we know that there was an announcement from Minister Elliot yesterday on human resource initiatives, and that is very good. We were happy to see it. We still need to get briefed on what that means exactly, but I can tell you it doesn't sound to me like COVID teams.

So that is an idea that we created with

the RNAO and with agencies, was to get them to bring COVID teams into the home. When you have staff walk out like that, you don't have time to go through resumés. You need people to come into your home.

So I don't know where the COVID teams are going to be for the next round, and I hope we don't need it, but if we do, there aren't any, except for potentially some agencies, and those are very expensive, and I don't know how homes are going to be able to afford that.

So I know that in BC they have taken hospitality -- people from the hospitality sector, and they have trained them to work in homes, and it would be great if they could do that in Ontario, but it is already September, almost October, and that hasn't happened.

Another thing that made it difficult was the one-site order, so when society was pretty much shut down, the government said, Okay, people can only work in one health care setting and that helped the virus transmitting from one home to another.

But now that things are open again, it actually has made it harder because half of the

staff in long-term care are part-time. That is a systemic issue and also a reality of shift work, and so these people need to make money. They need to make a living wage. So because they can't work in another health care setting, they are going to grocery stores, they are going to bars, they are going to Walmart, and in fact those settings might be even riskier now.

So what made sense in the first wave doesn't necessarily make sense in the second wave, and some of our members are suggesting creating HR resource bubbles where perhaps two homes share, or in Jane's case, she has four homes, maybe two of them could share staffing so that you could get the staff in and reduce the risk.

JANE SINCLAIR: If I can underscore the pressure on staffing that Lisa has alluded to. As she mentioned, we were in a staffing crisis pre-COVID across the province.

You know, there was workload issues, you know, higher acuity of the residents, et cetera, leading to the staffing shortages and just shortages of, you know, the qualified people that we need.

And then when COVID hit, all of the

precautions and preventive strategies added another layer of work. So the screening, everybody coming in and leaving, the screening of our residents, for example, the additional cleaning PPE requirements.

And in our case, Lisa mentioned, we have four long-term care homes. We are a regional level of government, and so we were fortunate to re-deploy staff from our other services that were, you know, slowing down because of COVID. We had at peak about 100 staff from -- you know, everywhere from roads and museums and libraries, other corporate services, that were working -- designated to a single site and working to help us with all these additional precautions over and above our basic care components.

And now with the services re-opening, we don't even have that amenity. We are actively trying to recruit for new positions just to do the basic COVID prevention strategies over and above the basic care.

So the human resource component in long-term care is a really, really critical piece and will be fundamental as we now have entered into wave two.

LISA LEVIN: I mean, I have to tell you

that, you know, I felt that if I didn't answer every email that came to me about staffing, that people would die.

Lynette and I were working around the clock, seven days a week for months, and many of our staff were working very hard as well, and I just cannot underscore enough how deeply disturbing this was and how we just can't let it happen again.

COMMISSIONER FRANK MARROCCO (CHAIR):

Did you see any examples of any attempt to recruit foreign-trained professionals to be public support workers?

LISA LEVIN: Jane, did you?

JANE SINCLAIR: Yeah, we have done it. So we have looked at every strategy that we can, and so we worked with our local college. We have some RN and RPN foreign students that we are just bringing into our facilities in the last month or two.

Lisa mentioned about hospitality students. We are, again, working with our local college to bring in those students to help with dietary needs, meal preparation, meal service, et cetera.

So, you know, we know other homes are

looking for any and all opportunities as well to get some additional resources.

So there is some of that happening, but even with that, the challenges are great.

LISA LEVIN: Yes. Like the homes cannot individually solve this problem, and I have to just mention that Jane is not a normal member of ours. I would say -- and I am not just saying this because you are my Board Chair, Jane. County of Simcoe is one of the leaders in COVID that has come out and emerged as being incredibly proactive and coming up with fantastic strategies that we have been able to share with other members.

A lot of our members don't have the resources that municipalities have. They are small, independent homes, and they need assistance from government to help them through these difficult times.

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Kitts?

COMMISSIONER JACK KITTS: Can I just come back? I have been quite intrigued by your bubble idea, because when I think back -- so when hospitals were providing care or staffing in really homes in severe distress with major outbreaks,

staff worked in two sites, right? They weren't PSWs, but they worked in two sites.

So if you had -- and in the hospital, the COVID patients were all cohorted in one ward, so if you weren't working in that ward, you were coming from a COVID-safe site to a COVID-safe site.

So I think that the idea of the bubbles can work if you break it down and spell it out a little bit.

LISA LEVIN: Absolutely.

COMMISSIONER JACK KITTS: Have you done that and has it gotten any traction?

LISA LEVIN: We have gotten interest from the Ministry, and it is one of the things that is on Lynette's very long list to work on, and we simply don't have the resources to do everything that we want to do as quickly as we can.

We have 17 staff. We are funded from our members. We took a huge hit to our budget this year because our convention was cancelled and our education sessions were mostly cancelled.

So we are just personally as an association struggling. At this point I wish I could hire more people so that I could have answered that question and told you that we have a

strategy ready to go, but we don't. And we could if we had the resources.

COMMISSIONER JACK KITTS: That is a good idea. Thank you.

LISA LEVIN: So the next one is financial incentives, so long-term care -- people who work in long-term care don't make as much money as those, for example, in acute care. So premium pay was really helpful to retain staff.

And we noticed that when it ended on August 13th -- and I don't know why it did -- a lot of absenteeism happened. We have a lot of absenteeism in our sector, and it seemed to have been alleviated to a great deal when pandemic pay came in.

Now, I do understand that the Ministry is supposed to be making an announcement about increasing pay, not as high as $4 an hour, and that will certainly help, but we do need even higher amounts than what I think might be announced that I am not supposed to say.

In addition to that, pandemic pay did not include supervisory staff or management, and many of them were working on the front lines flat out. Like, Jane was working every hour of every

day practically. I don't think she sleeps. And the fact that the management did not get any form of recognition or incentive was very demoralizing, and I am concerned that we are going to have a lot of people quit in our sector at all levels if they haven't already.

So we have asked that the Ministry reinstate pandemic pay and then over a longer term increase compensation, and we think that something is coming.

And we also wanted there to be incentives for PSWs and nursing graduates who recently graduated to keep working, and we know that since we wrote this, the PSW grant came out for six months. However, it is only limited to full-time work and that means that we are not sure how the take-up is going to be because most new staff cannot get full-time roles. There is Collective Agreements that would prohibit that.

And there were other announcements made, but we don't know the impact yet because we still have yet to be briefed but clearly financial incentives are important.

JANE SINCLAIR: If I can just echo Lisa's comments about the leadership piece, and not

about myself but about the teams that are in the homes.

For months, almost the first three months, our teams were meeting -- not only were they jumping in and providing care because of the shortages and the increased pressures, but we were having meetings, a group of 40 or 50 just in my facilities alone, every single day, seven days a week, rain or shine, holidays, it did not matter, and lengthy meetings, and we'll talk about communications in a bit, but to try and understand the copious amount of information coming down the pipe and ensure we had everything in place and were quarterbacking on scenarios that were happening every day to ensure that we were applying the, you know, consistent and proper procedures.

So there is not just a significant crisis in frontline staff in long-term care. There is a management and supervisory, a leadership issue that has been in place pre-COVID as well. It is a very challenging sector, and there is a significant turnover of leadership.

And if you don't have good leadership and consistent leadership in these long-term care homes, that is going to be a huge problem as well.

So I would just underscore, you know, that component.

Thanks, Lisa.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you just help me with this. You are obviously in the area. As this was unfolding, when did you -- when did the light go on for you that you were a prime candidate to have a problem?

JANE SINCLAIR: I think I have got it -- it was about March 9th when I started to see -- the first meetings start to happen, and in my particular case, I started to call the meetings, daily meetings, I think, March 11th.

And we actually -- right, wrong or indifferent, we implemented many or most of the protocols before they were actually directed by the province.

So we started to do burn rates to see how quickly we were going through PPE, for example, in our four long-term care homes and our retirement home, which were the most vulnerable, to see how long we could sustain our supply for me to turn on the light to say, I want universal masking. We know it is a protective barrier. It has worked. We have seen what has happened in other

jurisdictions.

And so as soon as we could confirm that we had a, you know, secure enough supply, we weren't going to do it for two weeks and then run out and I would have to tell staff, sorry, we have run out, we did it. We implemented.

So we -- you know, I think we were all on alert across the province. I can only speak to our personal experience at the County. We started to meet immediately when the teams started to convene in Ontario, anticipating, and knowing what had happened globally and the vulnerability of our sector we are caring for, we had to be a step ahead.

And, you know, to date -- and I am touching wood -- we have not lost a resident in any of our four long-term care homes. We have had very limited COVID-positive tests. We have only -- we have lost one in our retirement home, unfortunately, after a lengthy stay in hospital, but, you know, we have just tried to be ahead of the curve, no pun intended.

LISA LEVIN: We started ringing the alarm bells in early February when we saw what was happening internationally and we saw that long-term

care was going to be very vulnerable.

JANE SINCLAIR: And few --

COMMISSIONER FRANK MARROCCO (CHAIR):

I'm sorry, Ms. Sinclair, I interrupted. Please finish what you were saying.

JANE SINCLAIR: My apologies. I was just going to say, AdvantAge Ontario was a huge resource for our sector. They have been communicating every single day since this started. They do daily webinars. They have been trying to, you know, grab the information as it is coming out, and you know, make sense of it and give guidance to our long-term care operators as well.

And I have to say that has been a critical asset to all of us, I can speak for all of our members, having that additional set of eyes to analyze, you know, the changing landscape as it unfolds and the new directives are coming at us fast and furious. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR):

Ms. Levin, what I was starting to ask is, so it is early February -- if I understood you correctly, it is early February, and you are sounding the alarm bell. How do you sound the alarm bell?

LISA LEVIN: So I sit on the collaboration table, which is led by the Ministry of Health and has the Chief Medical Officer of Health and the Deputy Minister on it, as well as many associations.

And in our early meetings, they were actually in person because we weren't quarantined yet, and I said -- you know, they were talking about the plans to, you know, get testing ready and get acute care ready and how they were setting up local tables in the different Ontario Health regions.

And I said, Oh, is there going to be long-term care representation on these tables because we see that long-term care is one of the hardest hit areas internationally and in BC and in Italy and in the U.S. And the answer was, No, we are starting with acute care.

So I actually didn't take no for an answer, and I asked my members -- we have a regional structure for volunteers for the different regions, and I sent them the names of people because I knew it was just a matter of time before they would need them.

And I don't have the chronology in

front of me. I still haven't put that together yet, but I would say maybe three weeks later or two weeks later they started asking for that.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thanks.

Normally we would take a break around now. So I think what I will do is I'll take 10 minutes and then we'll come back and receive the balance of the presentation.

JANE SINCLAIR: Thank you.

LISA LEVIN: Thank you.

-- RECESSED AT 2:11 P.M.

-- RESUMED AT 2:21 P.M.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, Ms. Levin, are we ready?

LISA LEVIN: Yes, I am ready.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Go ahead. We are ready when you are.

LISA LEVIN: Okay. Great. Thank you.

So the pandemic left many homes even more short-staffed, and then as Jane was saying, additional staff had to be hired to take on the new tasks of screening, supporting visits, and cleaning.

And so an Emergency Order had been put in place and is still in place to allow redeployment of staff from other health care settings and also to allow homes to use other staff to provide care.

And so this order is temporary, and so far it has continued, and we have told government we would like it to keep going because it is very important that homes have that flexibility.

Also, PSW students cannot do on-the-job training and work as apprentices, and that is something that we think should be a more longer term solution that would help, as well as funding to cross-train staff for different roles.

So we can go on to the next slide.

And also organizational culture is very important because there is a lot of -- some homes have very challenging cultures where PSWs are seen in a negative light by nursing staff or others, and we just think that homes could -- that the Ministry should undertake a review to identify the role of organization and management culture and how it made an impact on staff retention and look at strategies to help spread and scale to all homes.

The next slide.

And then this section is funding, and --

COMMISSIONER ANGELA COKE: Can I ask a question?

LISA LEVIN: Oh, yes.

COMMISSIONER ANGELA COKE: Sorry, you are just talking about management and organizational culture, and I am just curious, in terms of your role, is there training and that type of support that is provided for your leadership folks?

LISA LEVIN: So we actually provide the administrator/leadership course. We are one of the main providers of it. I would say we're probably the primary provider that is required under the Long-Term Care Homes Act, and off the top of my head, I don't know what we have in there about organizational culture. We can find out.

And I am not sure if we have done training on that or not recently.

Lynette, do you know offhand if we have?

LYNETTE KATSIVO: No, not recently, Lisa.

LISA LEVIN: So that is an area that we

could definitely look into, but all the training that we provide until this recent time, homes have to pay for it, and so right now, with the financial constraints and time constraints, that is a barrier for sure.

But we would be opening to providing that kind of training, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR):

I take it there is no mandatory continuing education for people in leadership roles?

LISA LEVIN: No, and that is something that we have been thinking of doing, an administrator/leadership part two. We have also been thinking of doing clinical leadership training, but there is nothing mandatory, no, unless it is part of their regulated health professional college.

COMMISSIONER FRANK MARROCCO (CHAIR):

If a PSW student --

LISA LEVIN: Sorry, I am having a fire alarm.

Okay. Lynette is going to answer the next question or Jane, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, Ms. Levin, we don't want the building to burn down while you are trying to answer our question. Perhaps you should look into that.

LISA LEVIN: No, it is a drill, and it was supposed to happen earlier. I deeply apologize.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, I am relieved to hear that because it has been quite informative so far, and we wouldn't want to have any premature end put to it with your room burning down.

LISA LEVIN: This won't take long.

COMMISSIONER FRANK MARROCCO (CHAIR):

We'll wait a minute.

LISA LEVIN: Okay. Well, it is quiet for now. They'll start talking again in a minute and then hopefully they'll be done. I am so sorry.

Anyhow, what was your question?

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, I don't remember. No, I was just saying that if a student works in -- you know, some professions at one point in time that was how you learned. You went to school part of the time, and you worked part of the time in an office where you

were trying to learn the profession, you know.

It was on-the-job education, I'd say.

LISA LEVIN: Yes. So that is really important to have experiential training, especially when you are working with a challenging population, and it is hands-on. So we have been asking for a couple of years now for PSW apprenticeships, and I know the PSW association is interested in doing something as well, and it also shouldn't be a novel idea to government.

And another thing that has been happening is living classrooms, and I don't know if Jane has that in her homes, but a number of homes have started having living classrooms where they open up a space in their home if they have space for -- and then they have a partnership with a community college where PSWs come in and get their training in the home and then can go out and be with residents wherever possible as part of their placement.

So it is sort of like an informal apprenticeship, but they don't get paid, which is a barrier, especially in a lower-wage role, because people have to put their income on hold while they are in school.

COMMISSIONER FRANK MARROCCO (CHAIR):

If you have been advocating for this change for the last couple of years, who has to make the decision for this to happen?

LISA LEVIN: I think it is the Ministry training colleges and universities, but it might be the Ministry of Labour because they seem to have gone back and forth. In fact the last -- yeah, so, Lynette, did we land on which Ministry it was?

LYNETTE KATSIVO: We landed on Ministry of Labour. This was about five months ago is we heard who would be responsible for this, yes.

LISA LEVIN: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR):

So it is even confusing to try to figure out who to ask.

LISA LEVIN: Well, I think there was some shifting portfolios, and this sort of fell in the middle. Well, at first it didn't exist, and then it sort of fell in the middle. So yes, it was confusing.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

JANE SINCLAIR: And right now, from an operator's perspective, we do have a partnership

with our local college, Georgian College, and they actually will bring an educator on-site, and we have the practical nurse -- registered practical nurse program. We offer it on-site in one of our long-term care homes on a part-time basis, and so they have the training on-site. They get exposed to the long-term care world ahead of the curve, you know, before they are actually engaged as an employee.

It has been a great, great partnership, but it is a one-off. If you happen to have a local college, you know, a good relationship, and they are, you know, open and amenable to these different types of partnerships or arrangements, then it is excellent, but it is not mandated and there is nothing -- there is no consistency with it.

And the apprenticeship side, what we find -- one of the we think -- or we believe one of the critical factors in the shortage is the PSW program, for example, which is the largest group of staff in long-term care homes. When they train, they don't have that apprenticeship model, and they get a resident assignment of one-to-one or two residents maximum, and then they complete their schooling. They get a job in a long-term care

home. And it is extremely overwhelming because now they are assigned eight, nine, ten or more residents to provide the same care they have only learned about one or two.

The volume of work shifts dramatically, and I know Lisa can probably rhyme off the stats, but, you know, there is a huge turnover of new PSW graduates that, you know, don't stay a full year before leaving the industry after graduating.

So an apprenticeship model would really be welcome to the industry, and again, we are starting to do relationships with our local college where, when they do their placement in long-term care, say two or three shifts a week, we are paying them as students for the balance of that week so they have got paid employment while they are a student. We can't pay them for their actual placement. And they are getting a feel of what it is to work in long-term care, and it is fulfilling our needs because of the shortages.

So there are some significant opportunities, but we need it, you know, approached at a provincial level so it is consistent and the opportunities are for all long-term care homes.

LISA LEVIN: And not every municipality

can pay for that, so Simcoe has made a commitment to do that.

COMMISSIONER FRANK MARROCCO (CHAIR):

In Simcoe, I take it each one of the long-term care homes would be -- you tell me, would be within the area of a hospital, would be within the catchment area of a hospital?

JANE SINCLAIR: Yes, that's correct. The four homes all have a local hospital in the -- you know, in the near proximity.

COMMISSIONER FRANK MARROCCO (CHAIR):

Did the hospital provide any training or assistance with the long-term care homes?

JANE SINCLAIR: We did have -- during COVID wave one, I'm assuming.

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes, sorry, that is what I meant.

JANE SINCLAIR: We did have our local hospitals reach out to us and the partnership, because we had some really solid expertise and some systems in place. They absolutely did reach out and provide support, but, you know, it was more collaborating around testing, et cetera, because we were fortunate to have that expertise.

But in all instances, in all four of

our locations, the hospitals did connect with us.

COMMISSIONER FRANK MARROCCO (CHAIR):

Yeah, I wasn't thinking, you know, so much as that as I was thinking about, you know explaining to people how to put on protective equipment, how to take it off, how to -- the importance of isolating people who are infected or who may be infectious. That is the kind of training and education, practical tips for dealing with the problem, that sort of thing, because I would have thought that expertise would be at a hospital in some form or other.

JANE SINCLAIR: Yes, so we did not have that training offered to us by the local hospitals. They did come in and do IPAC assessments in most of our locations and made recommendations, you know, where they thought we could, you know, add additional procedures or protocols that would be helpful.

But in terms of the ongoing training and support, no, we have managed that ourselves.

And I would, you know, caution there is a difference between the acute care sector and the long-term care sector, so albeit there is great expertise in IPAC in acute care settings, the

settings are very different.

And so even with the assessments that we had done, we noticed some recommendations around hand wash facilities, et cetera, that were recommended in the long-term care environment that were not appropriate because it was a resident's living environment. It is their home. There are additional risks in caring for this population about accessing different products, et cetera.

So there is a lot of provisions that are very unique and specialized in long-term care that acute care would not understand the environment itself.

So that is why earlier I stated about, you know, developing that expertise in long-term care specifically because the environment is very, very different than acute care, as it is very different than home and community care and mental health, et cetera, and you really -- to appropriately apply the prevention -- you know, the infection prevention and control strategies, you have to understand the working environment to which you are applying these.

So there is a bit of a disconnect there.

COMMISSIONER FRANK MARROCCO (CHAIR): So that it would have to be -- if you were going to try to access that expertise in the acute care sector, there would have to be some collaboration between the home and the hospital in order for the appropriate modifications to take place in what people were being told?

JANE SINCLAIR: I believe so, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LISA LEVIN: I also think that, you know, hospitals have been very, very helpful, and we wouldn't have gotten through the first wave without them, but there hasn't been enough focus on looking at leaders in long-term care to help one another.

So, for example, Jane has been unofficially helping all of our members through her great strategies and approaches, and we have been disseminating that information, but we think that a greater role can be played by homes such as Jane's in helping others.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER JACK KITTS: Just to clarify, Jane, because I think we spoke earlier, so I am not sure what you are saying about the hospital involvement in long-term care. Are you saying that it is best if long-term care homes band together to learn from each other, share best practices, and the hospitals not?

Or what do you see the hospital role is in maybe preventing wave two from becoming like wave one?

JANE SINCLAIR: I think -- I believe that the hospitals are a very important partner, no question in my mind, and having a collaborative relationship with our local hospitals, whether that be around as a resource for infection prevention and control strategies and, you know, consulting around different situations or whether it be around testing strategies, because the homes have needed some help as well through this, just to complete the testing requirements.

So I think there is definitely, you know, an important relationship that needs to continue and maybe strengthen between acute care, hospital sector, and long-term care, but I also believe very strongly that the long-term care homes

themselves need to build that important infection prevention and control expertise. They need to build that capacity so that they have that core knowledge that they can manage every single day and that they are, you know, checking their line lists and checking their various infection control measures as an in-house expert to ensure, you know, people are following the right protocols, et cetera.

Not to have that on a day-to-day basis, not to have that expertise, is not going to provide the leadership that the long-term care homes desperately need, in my opinion.

COMMISSIONER JACK KITTS: Thank you. That makes total sense to me. Thank you.

LISA LEVIN: Okay. So as we have said before, our sector has been historically underfunded, and then with the pandemic, that has created the financial pressure.

So this is where we have asked the Ministry to provide more funding, which was just announced, half a billion dollars in funding has just been announced for long-term care, and so that will take us a long way towards meeting this recommendation.

I believe that the amount that will be provided will be around 45 million per month. We have asked for 57 million a month, so it is close, not exact. And so we are urging the Ministry to, you know, look at homes' actual expenses and see where things land.

There are some homes that even with this funding are having issues and will continue to have issues, and the government has been open to hearing these concerns and providing some short-term relief funding for some, and so this issue is something that we need to carefully continue to monitor, but today's announcement is definitely going to make a big difference.

And then in terms of lost revenue as well, that is something that was supposed to be announced today as well, and Sarah, was it announced, the three- and four-bed ward dollars? I think Sarah is --

SARAH LE MONNIER: Yes, there was some 40 million announced for occupancy support, which would have covered the three- and four-bed wards.

LISA LEVIN: Okay. That is something that -- I mean, we have to analyze everything because it just came out, but it definitely will

help.

COMMISSIONER FRANK MARROCCO (CHAIR): How does the money in the context of wave two, which is like right this second, more or less, how does the money compensate for the bed shortage in that -- the loss of 4300 beds in that period, or is this a more long-term improvement?

LISA LEVIN: Well, so this money will help compensate for the lost revenue that homes have -- revenue that homes have lost because the rooms have been left empty, and then the government will need to decide and make a long-term decision on if these rooms will remain empty or not, and if so, will they continue to provide funding to the homes.

Sarah, do you have something to add to that?

SARAH LE MONNIER: Yes. It is primarily a combination of a cash flow issue, so the Ministry provide funding on a monthly basis, and they have continued to provide funding for beds at 100 percent occupancy, which is great, but what they continue to deduct from that is the same estimated resident revenue that they predicted at the beginning of the year, and that is based on the

same number of beds being occupied and the same amount of money that they anticipated to come in, and obviously for homes there is less beds because they would have to close some of them and also less contribution from the residents.

So it will be mopped up to some extent, but it won't happen until probably the end of quarter one next year, so it just compounds the cash flow issue for homes in the short term.

LISA LEVIN: Sarah is our manager of financial policy. Welcome Sarah. We have two Sarahs.

Okay, so next slide.

I don't know if you are aware, but in 2019, the government decided to reduce long-term care pharmacy funding. So every long-term care home has a contract with a long-term care pharmacy provider and that funding was cut, and the cuts are going to occur over four years and keep going down.

And so things such as narcotic destruction will no longer be done by long-term care pharmacies. They also provided homes with very important medication carts. Something called government stock was allocated by them, and those are non-prescription items such as vitamins and

laxatives. They were putting them in the strips along with the other medication for the homes.

So at the time we asked that this not happen because the sector could not afford any further funding loss, and it went ahead, and we are asking that it be reversed and not continue.

JANE SINCLAIR: If I can add just an anecdotal -- you know, the relevance around pharmacy.

For example, you know, there used to be a greater presence before this and support in our long-term care homes before the funding shift, and with COVID, an example of how they could assist with that greater presence is testing. You know, we are hearing about the Shoppers Drug Mart is, you know, offering testing to the public, and I have approached our contracted pharmacy provider -- and I am waiting to hear -- about helping us doing testing for our residents, you know, once every two weeks to be on-site to do regular testing with our residents to help because it is a workload issue.

And families are really struggling with going to the assessment centres right now with huge delays, et cetera, et cetera.

So they really -- you know, they do

provide a pretty critical role in long-term care, and, you know, a missed opportunity here with the recent changes where they might be able to help us in the second wave if there is, you know, more support to the homes around things as basic as testing.

LISA LEVIN: Okay. Thanks, Jane.

So the next one is virtual technologies. So because of visitor restrictions, residents were physically isolated and that was very challenging, and technology was a great way to help assist with that.

And so a lot of the non-essential medical visits were switched to virtual visits through iPads and phones, but many homes lacked the infrastructure and resources to support this. Some have been able to get some, and there was a recent donation from Clorox actually that we helped provide tablets to 25 homes.

But the Ministry should provide dedicated funding to spread and scale the use of these technologies because it looks like we are going to be in this pandemic mode for awhile and this is a safe way for people to have visits.

COMMISSIONER FRANK MARROCCO (CHAIR):

But, you know, in terms of internet connection and speed, do they have that, do you know?

LISA LEVIN: So most of them do, but in the north, especially in the remote north --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, there is problems with the internet.

LISA LEVIN: -- and in some rural areas there would be problems, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): So the only other thing -- I mean, correct me if I'm wrong, but what you would need then perhaps so that the visit could be a little more real is a larger screen, you know, as opposed to a little tablet screen.

LISA LEVIN: Absolutely, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): A larger screen so that everybody is on it in a reasonable size.

LISA LEVIN: Right, yes, a larger one would help with the vision, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): That's right too. I hadn't thought of that. That's right.

LISA LEVIN: Uhm-hmm.

Okay. So Jane is going to take us through the next few slides.

JANE SINCLAIR: Thanks very much, Lisa.

So next slide, there we are.

So I alluded to this earlier, communication, consistency of communication in particular has been a real challenge through the first wave.

Right from the get-go we were hearing from the Ministry of Long-Term Care, Public Health Ontario, we were hearing federally, you know, watching directives and recommendations come from the Chief Medical Officer of Health of Canada, Theresa Tam, and we were trying to pull all this information together and determine, you know, what applies, what doesn't apply, and then work our way through some of the inconsistencies.

And even, you know, an example on this slide, the Ministry of Health, the variances that the Provincial Emergency Operations Centre giving directions that were different than the Ministry of Health or Ministry of Long-Term Care. So we have seen some huge amount of inconsistency throughout this.

And even the ability to ensure that long-term care operators understand, you know, all the information coming at them has been -- certainly been a challenge, and I can give you one example that comes to mind very quickly.

Within one of the directives, I think it was number three, there was some extensive guidelines about PPE and isolation, you know, a whole list, and within that, embedded within that very comprehensive document, there was guidelines around meal service that actually recommended that all long-term care homes provide dual service, dual shifts for meal service.

And operationally, A, that is really, really challenging to do when you don't have additional staff, when you are dealing with shortages, but B, when this was communicated, you know, with many of our homes, there was many homes that weren't even aware of that particular requirement.

So that the extent of information coming out and coming out from so many different stakeholders, instead of one constant, you know, information coming from one source, that the duplicity or, you know, the multiple entities

communicating to the sector has, you know, added a layer of challenge, no question.

LISA LEVIN: If I could add to that, Jane, we would be willing to share access to our members only side of the website -- I am probably going to get in trouble for saying this -- so that you can see all of the resources we offer this sector, which is all of the slide decks for our daily webinars that we had until the end of wave one and our daily bulletins, as well as you'll see the myriad of resources that we provided to our members. It is carefully curated with all the different directives.

So if you would be interested in that, let us know, and we can get you access.

And I wanted to give you another example of a conflict of inconsistent messages.

Right now, the visitor policy put out by the Ministry of Long-Term Care says that all essential caregivers and visitors in long-term care must attest to having a COVID test that is negative. But directive three, which is put out by the Chief Medical Officer of Health, only requires screening.

Which takes precedence? So after, I

don't know how long, how many, two months maybe, we finally got an answer from the Ministry of Long-Term Care that theirs would take precedence. However, in directive three it says that theirs should take precedence.

So this is an example of a very important yet confusing situation that our members are trying to deal with.

JANE SINCLAIR: And if I can just elaborate on that whole -- the visitor policy is a great one to illustrate some of the concerns.

It came out on a Friday, a Friday afternoon, and it was twofold. It was about outings, short-stay outings, and overnight absences and then the essential caregiver guidelines.

And the one half was to be implemented immediately, and the other half, there was a very short time frame for homes to prep.

And I can tell you, you know, in our instance we didn't implement -- we didn't implement right away because there are so many considerations before you start to allow residents to go out, for example, in terms of getting the paperwork in place for screening purposes, for -- information packages were required to be provided to families, to ensure

that we have resources at the door, manning the doors, ready to greet these people and go through all of the rigour that is required to ensure that, you know, they are not symptomatic and they understand the need to wear a mask, et cetera, et cetera.

And to turn on a dime and implement immediately would pose risk, and so it is a balance for long-term care homes to implement these directives so quickly and risk not having all the provisions in place versus having more time to really understand all the implications related to these, these provisions, and do it right and get things in place in a safe manner so that when we do proceed, we can do it safely.

So, you know, that visitor guideline is a great example of something that is still, you know, causing great consternation with long-term care operators because of the -- particularly in the second wave, trying to have, you know, additional provisions in place to protect the residents if they are exposed on these outings, how do we mitigate it when they come back into the facility.

So, you know, the communications

consistency in timing, you know, were not adequate during the first wave.

Next slide, please.

Yeah, and this is really a repeat of what I have spoken about. You know, the outcomes, people will make mistakes. If there isn't good communication and people aren't clear or understand what is happening, things will not be fully engaged as required, and that is when you are going to ultimately see infections and spread.

So a really, really important component.

Next slide, please.

So, again, I mentioned about the timing of the directives. Important policies and processes like testing and restricting visitors and stopping admissions came later. Some of us may have implemented earlier, but the directives came after the fact. So the timeliness was not conducive to preventing infection and spread.

In our recommendation, the province, including the Ministry of Long-Term Care and the Office of the Chief Medical Officer of Health should review the timing of directives issued during wave one and develop strategy that

identifies trigger points when future directives should come into effect.

And would really emphasize collaborating with the sector to understand, you know, what those timing needs are. Lisa talked about a number of different planning committees. I currently participate in a recovery and planning table with the Deputy Minister of Long-Term Care and a number of other stakeholders and that is a great opportunity to provide some ongoing input.

But again, the amount of information that is being shared quickly and the time frame for implementation continues to be fast and furious, and not allowing for, you know, a really good consultative process to understand all the possible implications of those changes and ensuring that long-term care homes, you know, have adequate time and resources to get the precautions in place to move forward with the next directives.

The next slide, please.

Representation in the system, and again, Lisa did speak to that. You know, initially long-term care homes weren't even at the table, and when they are such a vulnerable stakeholder in this COVID pandemic, that was a real miss in terms of

ensuring there was an understanding of this environment and how we could work collaboratively to prevent transmission and spread.

COMMISSIONER FRANK MARROCCO (CHAIR):

I am not sure you would have the answer, but if it is obvious back in February that you have vulnerability, did you have any sense of why long-term care wouldn't have been at these tables?

JANE SINCLAIR: I can give you my opinion, and Lisa can add.

COMMISSIONER FRANK MARROCCO (CHAIR):

So I appreciate that that's what it is.

JANE SINCLAIR: Opinion only.

But I think our health care system tends to still be somewhat acute care-centric, and although we are seeing shifts to be focussed more on, you know, other aspects of health care, the entire continuum, I think there is some key stakeholders that have -- there is a legacy of being, you know, primary stakeholders in health care and tend to be the go-to by government in terms of, you know, changes, directives, consultations, et cetera.

And I think when we began to engage in

this COVID pandemic, this was no exception. And so some of the larger stakeholders were, you know, at the table, obviously needed to be at the table but were at the table, and there tended to be, you know, a focus on more acute care needs than the actual area that was most vulnerable and had been shown over months and months in other countries and other jurisdictions to have been, you know, the worst impacted by this particular pandemic.

So, you know, we have said it throughout, almost, you know, like a broken record, but long-term care is, you know, the most vulnerable, and seniors housing and services, and they need to be prioritized, whether it is testing or surveillance or communications or other types of planning. We know they are the most vulnerable, and that is where, you know, we have the potential to have the worst outcomes.

LISA LEVIN: The other thing that I would like to add is that there is currently an IMC table, Incident Management Committee I think it stands for, that was put in place in wave one, and then, again, it is in place in wave two, and in wave one there was only one long-term care home on it, and that was a for-profit home. So no one from

the non-profit or municipal sector.

And now in wave two, it has been reconstituted without any long-term care home representation. However, there is hospital representation.

So we think there is definitely a huge gap there in that the long-term care sector leaders, such as Jane, are not being asked what can the sector do to improve, how can the sector improve itself, and that is an opportunity that has been missed.

JANE SINCLAIR: If I can give a quick analogy, a person wouldn't go to a long-term care operator to ask for insight into, you know, how to implement something that was an acute care policy or procedure.

And on that same vein, similarly, to go to an acute care setting to ask how to operationalize something in a long-term care sector is kind of the same scenario.

The expertise and the care provisions are both critically important, but they are extremely different, very different environments, and I don't know that that is, you know, truly understood at a government and perhaps at a Public

Health level.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LISA LEVIN: Are we on a strict time until 3:00? We have two more slides left.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we should because we perhaps mistakenly but scheduled another interview at 3:00, so we would be keeping them waiting, so go ahead.

JANE SINCLAIR: So I'll very quickly say, you know, the emotional needs of our residents were a huge factor during wave one, and, you know, we would recommend a greater investment in technology by the Ministry to support long-term care homes. We have seen some tremendous changes with COVID that we think are here to stay in terms of connecting residents safely with their loved ones through FaceTime and Skype and other types of, you know, technological means.

So, you know, we really would promote that going forward.

And, Lisa, I'll turn it to you to wrap up the last couple of slides.

LISA LEVIN: Okay. So although your mandate is long-term care, there was a very large

seniors population that has not -- that has been missed, and we just wanted to bring it to your attention.

So there is something called Assisted Living and Supportive Housing, and what that is is it's seniors apartments typically that are usually funded by the province and sometimes as well by the municipality.

The populations in these buildings are the same as those in retirement homes except they do not typically have the same income levels. These are people who cannot afford retirement homes. So an example of this, there is around 150 of these across the province, and Jane, for example, has at least one on one of her campuses of care.

The government did not provide any directives to these settings until late April, and we actually wrote the directive for them and even then it turned into the congregate care setting directive and then we got a special covering memo.

Those homes did get pandemic pay, and they did get -- and they just got free PPE from the government as part of congregate care, but they have never been recognized specifically. They are

not monitored for outbreaks, so -- I mean, I think obviously Public Health monitors them, but there is no special list for this group.

So if any of our members had an outbreak in their assisted living, I wouldn't know, and I think it is a huge vulnerability for the second wave, and I was, you know, happy to see there was no huge outbreaks in wave one, but they are really no different than retirement housing in terms of the population, and they have just been ignored.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LISA LEVIN: They haven't received a cent of money or anything, even though they still -- even though they are doing screening and cleaning and all of that.

So I think that we don't need to reiterate what we have already said. This is sort of like just a summary of our health human resources concerns, which I believe we conveyed, and then the financial concerns and the concern about spread in older homes.

So basically, you know, we are happy to work with the Commission to provide whatever

information you need and happy to have another conversation, if you have other questions afterwards and, you know, just let us know.

JANE SINCLAIR: We really appreciate this opportunity. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, thank you very much.

We probably will take you up on it. As we are developing interim recommendations, we might come back to you and ask you to take a look at them just to get your impression, and we would do that obviously with the drafting stage before we would finalize what we were going to say and reserving the right to completely deep six something that we had in there.

But I think it would be very helpful. This has been very informative. I'm sure all of us feel the same way. It was very thorough and very helpful and very interesting to find a region or whatever the appropriate geographical description is where there has been some success, and it helps us with certain issues we have around leadership.

And so thank you, thank you all.

LISA LEVIN: Thank you very much. We are happy to review your interim recommendations.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I sort of sprung that on you without having consulted the others, so I'm a little ahead of myself, but it did occur to me that it might be a good idea as I was listening to you, and thank you for offering to do that.

LISA LEVIN: We can even draft them if you would like.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no, we have to draw the line somewhere, Ms. Levin.

JANE SINCLAIR: Thanks again. Bye for now.

LISA LEVIN: Thank you very much, take care.

-- Adjourned at 3:02 p.m.

REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 30th day of September, 2020.

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