

Long-Term Care COVID-19 Commission

AdvantAge Ontario
on Tuesday, September 29, 2020



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom Videoconferencing, with all
15	participants attending remotely, on the 29th day of
16	September, 2020, 1:00 p.m. to 3:00 p.m.
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1 BEFORE:

2 The Honourable Frank N. Marrocco, Lead Commissioner

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5

6 PRESENTERS:

7 ADVANTAGE ONTARIO:

8 Lisa Levin, CEO

9 Lynette Katsivo, Director of Public Policy

10 Jane Sinclair, Board Chair

11 Sarah Le Monnier, Manager, Financial Policy

12 Sarah Boesveld, Policy Analyst

13 Amit Joshi, Director of Financial Policy

14

15 PARTICIPANTS:

16 Alison Drummond, Assistant Deputy Minister,

17 Long-Term Care Commission Secretariat

18 Ida Bianchi, Counsel, Long-Term Care Commission

19 Secretariat

20 John Callaghan, Counsel, Long-Term Care Commission

21 Secretariat

22 Lynn Mahoney, Counsel, Long-Term Care Commission

23 Secretariat

24 Derek Lett, Policy Director, Long-Term Care

25 Commission Secretariat

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ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

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

2
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Hello, everybody. I think the
5 Commissioners are here. Deana is here. And who is
6 speaking for -- oh, sorry.

7 (DISCUSSION OFF THE RECORD.)

8 Who is speaking for AdvantAge Ontario?

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

12 JANE SINCLAIR: Good afternoon.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 I want to thank you for coming. It is
15 very much appreciated. It is very helpful to us to
16 get this kind of perspective.

17 Does AdvantAge Ontario have a website?

18 LISA LEVIN: Oh, yes, we do.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Ms. Levin, would you mind if we had a
21 link on your website to our website so that
22 somebody who was interested in what we were doing
23 could very easily link to us?

24 LISA LEVIN: Absolutely, we can do
25 that.

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

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

14 We feel a pressure to make
15 recommendations.

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

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

25 So we are kind of doing it backwards in

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

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

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

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

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

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

1 And do the Commissioners have this
2 presentation?

3 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

9 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 All right.

16 LISA LEVIN: Okay.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Commissioner Coke, do you have it?

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

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

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

11 288 homes had been in outbreak as of
12 July 20th, which represented 46 percent of all
13 homes, and that number has likely gone up because
14 there is currently 40 homes in outbreak now, some
15 of whom have been in outbreak before and some of
16 whom haven't, and we haven't done that analysis yet
17 to determine how many new additional ones.

18 74 percent of the deaths reported in
19 the sector were from for-profit homes, 21 percent
20 from not-for-profit homes, and 5 percent from
21 municipal homes.

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

1 but they only had 5 percent of the deaths.

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

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

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 And so -- sorry. So how would the
6 table -- would the table take votes or make
7 decisions? How did it make decisions or did it
8 make decisions?

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

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

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

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

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

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

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

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

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

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

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

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

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

1 JANE SINCLAIR: Emergency services.

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

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

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 spread, yes, that is accurate.

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

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

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

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

5 LISA LEVIN: So if I can add --

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 So it is now taking -- still taking 6
8 to 8 days?

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

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 And why in your view is there a delay
16 in getting the results back? You said they had to
17 prioritize. Is it simply -- not simply, but is it
18 a question of not being high enough up the
19 priorities list, or is it something else?

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

1 supplies, but I don't know for sure.

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

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

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

1 We still have issues, unfortunately,
2 even with that process, although it tends to be
3 more efficient, but we have had scenarios where we
4 have had to call Public Health because it is 10,
5 12, 14 days we still are missing some resident
6 tests. And we have to, you know, stay the course
7 with all the additional precautions, not knowing
8 whether these, you know, lagging test results are
9 positive or negative.

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

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

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

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

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

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

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

1 and, you know, they didn't know.

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

8 Next slide, please.

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

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

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

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

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

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

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

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

15 30,000 of the 79,000 long-term care
16 beds have to be re-developed by 2025 because they
17 are older and many of those have three- to four-bed
18 wards, cramped common areas, cramped spaces for
19 staff as well.

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

1 hospital where they can be isolated.

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

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

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

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

1 prioritize long-term care would be a priority.

2 Next slide.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Do you have any sense of how long it
5 takes to put up a field hospital?

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

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

18 LISA LEVIN: There is also isolation
19 pods that can be erected. There is a vendor that
20 is selling these special quarantine units that are
21 \$200,000 a bed, and we did provide that information
22 to government.

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

25 JANE SINCLAIR: So if I move into the

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

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

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

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

1 Next slide, please.

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

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

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

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

1 Next slide, please.

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

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

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

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

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

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

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

3 And I give you a quick example.

4 Pre-COVID, we were purchasing -- there was about a
5 500 percent markup here. We were purchasing the
6 procedural surgical masks for our four long-term
7 care homes, 20 cents a mask. We were paying --
8 we're up around a dollar or more than a dollar now
9 per mask, exact same masks.

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

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

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

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

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

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

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

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

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

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

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

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

25 I was getting PPEs to members from

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

7 JANE SINCLAIR: It did, absolutely.

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Where do you see that support coming
17 from?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 COMMISSIONER JACK KITTS: I agree with
19 you.

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

25 So it is inconsistent. Where it

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

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

10 Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 has been identified in their home.

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

4 LISA LEVIN: Thanks, Jane.

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

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

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

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

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

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

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

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

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

25 But in wave two -- also homes used

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

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

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

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

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

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

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

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

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

25 So that is an idea that we created with

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

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

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

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

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

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

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

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

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

25 And then when COVID hit, all of the

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

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

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

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

25 LISA LEVIN: I mean, I have to tell you

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

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

9 COMMISSIONER FRANK MARROCCO (CHAIR):

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

13 LISA LEVIN: Jane, did you?

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

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

25 So, you know, we know other homes are

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

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

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

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Commissioner Kitts?

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

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

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

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

10 LISA LEVIN: Absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Thanks, Lisa.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Can you just help me with this. You
6 are obviously in the area. As this was unfolding,
7 when did you -- when did the light go on for you
8 that you were a prime candidate to have a problem?

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

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

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

1 jurisdictions.

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

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

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

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

1 care was going to be very vulnerable.

2 JANE SINCLAIR: And few --

3 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

25 And I don't have the chronology in

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay. Thanks.

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

10 JANE SINCLAIR: Thank you.

11 LISA LEVIN: Thank you.

12 -- RECESSED AT 2:11 P.M.

13 -- RESUMED AT 2:21 P.M.

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

16 LISA LEVIN: Yes, I am ready.

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

20 LISA LEVIN: Okay. Great. Thank you.

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

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

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

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

15 So we can go on to the next slide.

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

25 The next slide.

1 And then this section is funding,
2 and --

3 COMMISSIONER ANGELA COKE: Can I ask a
4 question?

5 LISA LEVIN: Oh, yes.

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

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

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

21 Lynette, do you know offhand if we
22 have?

23 LYNETTE KATSIVO: No, not recently,
24 Lisa.

25 LISA LEVIN: So that is an area that we

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 If a PSW student --

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

13 LISA LEVIN: This won't take long.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 We'll wait a minute.

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

19 Anyhow, what was your question?

20 COMMISSIONER FRANK MARROCCO (CHAIR):

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

1 were trying to learn the profession, you know.

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

13 LISA LEVIN: Okay.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Okay.

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

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

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

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

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

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

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

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

25 LISA LEVIN: And not every municipality

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

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

8 JANE SINCLAIR: Yes, that's correct.

9 The four homes all have a local hospital in the --
10 you know, in the near proximity.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 Yes, sorry, that is what I meant.

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

25 But in all instances, in all four of

1 our locations, the hospitals did connect with us.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

1 settings are very different.

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

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

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

24 So there is a bit of a disconnect
25 there.

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

8 JANE SINCLAIR: I believe so,
9 absolutely.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Okay.

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

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay.

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

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

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

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

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

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

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

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

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

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

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

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

20 SARAH LE MONNIER: Yes, there was some
21 40 million announced for occupancy support, which
22 would have covered the three- and four-bed wards.

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

1 help.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 How does the money in the context of
4 wave two, which is like right this second, more or
5 less, how does the money compensate for the bed
6 shortage in that -- the loss of 4300 beds in that
7 period, or is this a more long-term improvement?

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

16 Sarah, do you have something to add to
17 that?

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

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

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

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

13 Okay, so next slide.

14 I don't know if you are aware, but in
15 2019, the government decided to reduce long-term
16 care pharmacy funding. So every long-term care
17 home has a contract with a long-term care pharmacy
18 provider and that funding was cut, and the cuts are
19 going to occur over four years and keep going down.

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

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

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

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

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

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

25 So they really -- you know, they do

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

7 LISA LEVIN: Okay. Thanks, Jane.

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

17 LISA LEVIN: Absolutely, yeah.

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

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

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

1 LISA LEVIN: Uhm-hmm.

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

4 JANE SINCLAIR: Thanks very much, Lisa.
5 So next slide, there we are.

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

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

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

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

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

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

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

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

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

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

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

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

25 Which takes precedence? So after, I

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

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

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

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

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

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

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

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

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

25 So, you know, the communications

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

3 Next slide, please.

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

11 So a really, really important
12 component.

13 Next slide, please.

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

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

1 identifies trigger points when future directives
2 should come into effect.

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

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

20 The next slide, please.

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

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 So I appreciate that that's what it is.

14 JANE SINCLAIR: Opinion only.

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

25 And I think when we began to engage in

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

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

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

1 the non-profit or municipal sector.

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

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

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

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

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

1 Health level.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Okay.

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Well, we should because we perhaps
8 mistakenly but scheduled another interview at 3:00,
9 so we would be keeping them waiting, so go ahead.

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

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

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

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

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

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

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

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

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

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Okay.

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

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

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

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

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Well, thank you very much.

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

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

23 And so thank you, thank you all.

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

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

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

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

12 JANE SINCLAIR: Thanks again. Bye for
13 now.

14 LISA LEVIN: Thank you very much, take
15 care.

16
17 -- Adjourned at 3:02 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

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

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

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

13
14
15
16 Dated this 30th day of September, 2020.

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