Long Term Care Covid-19 Commission Mtg.

Meeting with the Association of Municipalities of Ontario
on Monday, October 26, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 26th day of October, 2020, 11:30 a.m. to 12:53 p.m.

BEFORE:

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

PRESENTERS:
Graydon Smith, President, Association of Municipalities of Ontario (AMO), and Mayor, Town of Bracebridge, and Chair of Health Task Force

Monika Turner, Chair of Working Group, Director of Policy, Association of Municipalities of Ontario (AMO)

Michael Jacek, Senior Advisor, Association of Municipalities of Ontario (AMO), alternate Chair

Cathy Granger, Director of Long-Term Care, Regional Municipality of Peel

Dr. Robert Kyle, Commissioner & Medical Officer of Health, Regional Municipality of Durham, and Past President, Association of Local Public Health Agencies (alPHa)

Dean Lett, Director, Long-Term Care, City of Ottawa

Lisa Levin, CEO, AdvantAge Ontario

Dan O'Mara, Mayor, Municipality of Temagami

Kelly James Pender, Chief Administrative Officer, County of Frontenac

Kevin Queen, CEO & District Administrator, District of Kenora Home for the Aged

Amber Crawford, Policy Advisor, Association of Municipalities of Ontario (AMO), staff resource

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Michael Finley, Gowling WLG (Canada) LLP

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

I N D E X

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 25, 71

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

-- Upon commencing at 11:30 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, good morning, everybody. My name's Frank Marrocco. I'm one of the commissioners. The other two commissioners that are with me are Commissioner Angela Coke --

COMMISSIONER ANGELA COKE: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): -- and Commissioner Dr. Jack Kitts. We'd like to thank you for meeting with us. We're kind of on to, you know, formulating some more permanent recommendations, and we felt the need to report, you know, relatively quickly and in a very informal way some observations we made. We did that on Friday, and this is particularly helpful to us because we think it will expand our understanding of the role of municipalities in this process, and we want to thank you for agreeing to do that.

So I don't know who's in -- there's a transcript. Ms. Belma, I think, is taking care of that, so you know, and we are in the practice of posting the transcripts on our website so the public have some idea of what we're up to here.

I don't know who's leading from your

end.

GRAYDON SMITH: Good morning, Mr. Chair, it's Graydon Smith. I'm the president of AMO, and I've got some opening comments for you and the other commissioners this morning, and then, of course, we've got many members of our long-term care task force with us this morning as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, nice to meet you, Mr. Smith. I think we're ready when you are --

GRAYDON SMITH: Okay. Well --

COMMISSIONER FRANK MARROCCO (CHAIR): -- unless you're waiting. Are you waiting for someone?

GRAYDON SMITH: I don't believe we're waiting for anybody.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Then we're ready to go.

GRAYDON SMITH: I think we are. So again, thank you and, again, thanks to all of the commissioners for letting us have this time with you today, and thank you for the opportunity to take a look at the interim report on Friday as well and the work that you've done so far with the Commission.

My name's, as I said, Graydon Smith. I'm here on behalf of the Association of Municipalities of Ontario as president. I'm also the mayor of Bracebridge, and I've been the Chair of AMO's Health Task Force as well for the last few years, so the issue of long-term care is one that we've discussed on multiple occasions around the AMO Health Task Force Table over the years.

Members that we have in attendance today are all volunteer members of our Health Task Force subworking group on long-term care. The group was formed to develop responses and provide input specifically to the Commission on behalf of AMO. And a list of our members was provided in advance of the secretariat, but we'd be happy to do -- happy to do a roundtable of introductions if you wish to formally record who's with us today.

COMMISSIONER FRANK MARROCCO (CHAIR): It might be a good idea, Mr. Smith.

GRAYDON SMITH: Okay. So if I can call on our members, perhaps, one at a time to introduce themselves, and we'll start with Dr. Kyle just to get things rolling.

DR. ROBERT KYLE: So, Commissioners, you've already heard from me, Dr. Robert Kyle

Commissioner and Medical Officer of Health for Durham region, and I'm a member of the AMO Health Task Force, so good morning, everybody.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning, Doctor.

DAN O'MARA: I'll go ahead. My name's Dan O'Mara. I'm the mayor of the Municipality of Temagami. Temagami is a little community north of North Bay, and we're known for our wilderness area, and we also have a very large senior population.

Prior to being mayor, I was -- I was involved in health care for 35 years. I started out as an orderly and -- at South Centennial Manor in Iroquois Falls, went to university, and became -- got involved in administration in a home for the aged and gradually worked my way up through the system; and when I retired, I was the CEO of the MICs Group of Health Services which is a group of -- a grouping that takes care of the healthcare services of three small communities, and so healthcare has been an interest, and long-term care has been an interest, and so I put my name forth.

And although I'm not involved in the industry on a day-by-day basis, I do have some

experience and have some outlook from the 35 years of work that I did and a lot of them dealing with long-term care.

GRAYDON SMITH: Thank you.

Cathy.

CATHY GRANGER: Thank you and good morning. My name is Cathy Granger. I'm the director of long-term care at the Region of Peel, and we have five homes in the Region of Peel, and I just came off 15 months as Interim Health Commissioner, so I have a good idea about how we handled the response with paramedics and Public Health as well, so welcome.

GRAYDON SMITH: Thank you.

Dean.

DEAN LETT: Morning. My name is Dean Lett. I'm the Director of long-term care with the City of Ottawa. We operate four homes in the area (INDISCERNIBLE). We currently have three homes that are on outbreak today, and I'm really thankful for the opportunity today to connect with the Commission.

GRAYDON SMITH: Thank you.

Lisa.

LISA LEVIN: Hi. Good morning,

Commissioners. I've met with you once before. I'm the CEO of AdvantAge Ontario. We represent 400 not-for-profit and municipal long-term care homes and seniors housing providers across Ontario, so because we have so many municipal members, I am on this task force as well.

And I have to just mention that a meeting with Minister Christine Elliott popped into my agenda on Thursday afternoon, and so unfortunately, I need to leave between 12 and 12:30 which I would normally never do, so I will be zooming in and out.

GRAYDON SMITH: Thank you.

Kelly.

KELLY JAMES PENDER: Hi. I'm Kelly Pender, Chief Administrative Officer for the County of Frontenac, and thank you for the opportunity today.

Frontenac is the area of north and south of the City of Kingston in Eastern Ontario, and we do both long-term care and paramedics, and pleased to be here to represent Eastern Ontario. Thank you.

GRAYDON SMITH: Thank you.

Kevin.

KEVIN QUEEN: Yes, I'm the CEO of the Kenora District Homes which is a home in Kenora, Dryden, and Red Lake. I guess I represent the far north rural area, and very pleased to be a part of this. Thank you.

GRAYDON SMITH: Thank you. And I just mentioned, Mr. Chair, we do have two others that couldn't join us today, Sandra Hollingsworth is a councillor from Sault Ste. Marie who was part of our working group as well as Jane Sinclair who's well known in the long-term care field and as a general manager of Health and Emergency Services for the County of Simcoe and also the chair for AdvantAge Ontario.

We do have a number of staff members that have been guiding this process as well, and I'll just have them introduce themselves.

Monika.

MONIKA TURNER: Good morning, and thank you for having us. I'm Monika Turner. I'm the director of policy for AMO.

GRAYDON SMITH: Thank you.

Michael.

MICHAEL JACEK: And good morning, my name's Michael Jacek. I'm a senior advisor with

AMO for health and social policy issues.

GRAYDON SMITH: And Amber. I can't hear Amber, but she is with us this morning, and --

AMBER CRAWFORD: Oh, sorry about that.

GRAYDON SMITH: Oh, there you go.

AMBER CRAWFORD: I was on mute the whole time, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): You were on -- you were on mute.

AMBER CRAWFORD: Oh, my goodness. Well, at least that takes care of that for you. I'm Amber Crawford. I'm a policy advisor with AMO as well.

GRAYDON SMITH: So that's -- that's the gang this morning, and again, we're all pleased to be here, pleased to have input into the Commission outlining the recommendations.

First, I'll provide some brief information about our association. So AMO is a non-partisan, non-profit association representing municipal governments throughout Ontario. And we want to engage municipal governments and ensure that they work together to achieve our shared goals and meet common challenges.

One such cause is promoting healthy age

friendly communities which includes municipal long-term care homes operating in an efficient, safe, and effective manner. And while the Provincial government is responsible for legislation, regulation, and program requirements, municipal governments, as you know, are mandated under the Long-Term Care Act to operate homes. In fact, about 16% of homes in the Province are municipally operated and co-funded.

Municipal homes pride themselves on providing high-quality services and safe environments for their residents, and as we all know, COVID-19 has been a challenging time for long-term care.

From our perspective, the pandemic has exposed the structural weakness in the system especially chronic underfunding which has limited the ability to respond effectively during the first wave.

AMO acknowledges that the Provincial response to date and the support that has been provided and those other supports for long-term care specifically, and we thank them for it.

However, more action is needed in both the short-term to mitigate against future waves of

COVID-19 and the long-term to address persistent structural issues.

Last week we submitted to you our association's preliminary recommendation to inform the Commission's interim report and future reports, and AMO will also provide a more comprehensive submission to the Commission with mid and long-term recommendations before the end of the year.

So with that, I'll turn it over to Monika Turner who you met moments ago, AMO's director of policy. She's going to provide a brief overview of our recommendations, and then we'll open it up more broadly to our members to discuss some of the components of our recommendations and answer your questions. So, again, thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR): Just before you do that, Mr. Smith, we've tended to ask questions as we go along --

GRAYDON SMITH: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): -- rather than wait for it to be over, so as long as that's okay with everybody, that's what we do here.

GRAYDON SMITH: Yeah, absolutely. Not

a problem.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. All right.

MONIKA TURNER: So I'm Monika Turner, and thank you, President Smith. AMO is -- certainly appreciates the opportunity to provide our perspective on how municipally funded and operated long-term care homes have been impacted by COVID-19 thus far.

I am the chair of our working group and pleased to provide overview comments about our written submission provided to you last week. We know that you've provided an interim report to the government last week. We are very encouraged by what we've seen thus far and trust the government will carefully consider your interim recommendations.

Today, I'll touch upon our key themes but will not go into detail about our recommendations as you have our written report in hand, and we'd actually like to get to the discussion with you.

In our view, there are actions the Province can take in the short, mid, and long-term to improve and sustain the pandemic response be it

urban, rural, or northern. I'm pleased to be joined by our working group members. As you can see, they're a mix of elected officials and municipal staff working in long-term care, Public Health, and other municipal services. The members are available to answer questions today and will no doubt bring their unique and diverse perspectives from across all of the Province and municipal service sectors.

We're fortunate to have the CEO of AdvantAge Ontario represented on our working group, and as Lisa said, AMO works closely with AdvantAge Ontario, which, as you know, is an association that represents municipal and non-profit operators in long-term care homes.

As you've seen in our written submission, AMO is providing long -- high level recommendations about policy, planning, funding, and the provision of non-financial support to the sector. Our seniors and long-term care residents deserve high-quality care and utmost safety both during the COVID pandemic and beyond.

Our recommendations were grouped under the categories of planning and communications, staffing, resident care, funding, health and

safety, and mental health supports.

One general comment that we'd make is that we feel that data and analysis will demonstrate that municipal homes have fared well comparatively during the pandemic. We believe this is due to the commitment and investment that municipal governments have made to long-term care over and above the provincial subsidy.

In 2016, it was an -- it was estimated that municipal governments contributed an additional $350 million over and above the provincial funding subsidy, and this does not include capital expenditures.

Overall, municipal governments invested over $2 billion in seniors programs and other health services on an annual basis. This funding has an impact in our communities. It has enabled municipal homes to be leaders. Staff generally are paid higher wages with benefits that contribute to higher rates of attraction through recruitment and retention; we will say -- and we will get into staffing issues because there are major concerns that have been documented for years.

We also need to note that the funding that municipal governments contribute is not

sustainable over the long-term. Municipal governments cannot continue to fill in the gaps where provincial funding is lacking. It's healthcare which is an area of provincial jurisdiction. The municipal property tax base was never designed to pay for healthcare.

Many municipal governments and their residents wish to see more municipal homes built or expanded, but it's not currently affordable to do so. Funding, therefore, is a key issue we wish to highlight.

It's understood that today you'd like to hear the story of the pandemic response including what has happened, what worked well, and what could be improved from a municipal perspective. Our members can speak to these questions in general and specific terms.

And right now, I'll turn it back to you, Mr. Chair, to start the discussion, and we'll ask our members to identify themselves when they're speaking, so if I may. Thank you.

GRAYDON SMITH: Thank you, Monika.

And, Mr. Chair, we're happy to take any questions that you and the other commissioners may have this morning. Again, the submission is before

you, and Monika's given a great overview of what's contained within, so we're -- we're welcome to hear whatever you'd like more detail on.

COMMISSIONER FRANK MARROCCO (CHAIR): I guess I'll ask the first question. There's been a fair bit of public discussion about the for-profit homes and not-for-profit homes. How do -- and we've been told that there's a waiting list of 38,000 people in the Province.

Do you see a role for the private sector in the long-term care -- in the provision of long-term care services?

GRAYDON SMITH: Mr. Chair --

COMMISSIONER FRANK MARROCCO (CHAIR): And, Mr. Smith, please feel free if -- I'll direct the question to you, but if you think somebody else should answer it, just go right ahead.

GRAYDON SMITH: Yeah, and we do have speakers on certain sections of our presentation. You know, I would say it's a difficult question for us to answer. It's not something that we've contemplated through AMO.

As I said in our opening remarks, we're really an association that looks at the health and interests of 444 municipalities in Ontario. And,

of course, within that, we have a number of long-term care homes that are operated, and so that has been our focus, is the homes that municipalities and regions operate and how the service can be effectively delivered within those homes including pandemic response. So I guess that's a long way of saying that we really haven't scoped that out in what we've presented or discussed.

COMMISSIONER FRANK MARROCCO (CHAIR): The thought behind the question was Ms. Turner's statement that an increased role for municipalities is not sustainable under the current funding model, yet at the same time, municipalities have fared fairly -- have fared better in terms of providing -- coping with this pandemic than -- than other models.

So, you know, if they're performing better, you would say, well, that's a better -- maybe that's a better way of delivering the services. And then someone says, well, yes, but the current level funding model's just not sustainable for an expansion.

So that's what generated -- that's what generated the question. I'm trying to imagine

where the 38,000 beds come from.

GRAYDON SMITH: And I thank you for the clarification of your question, Mr. Chair, and maybe I'll let Monika expand a little bit more on the comments that she made in her opening remarks.

MONIKA TURNER: And if I may -- and I saw that Lisa also would like to follow. But that's exactly our point, is we, as municipal governments, are funding well above what the Province is providing, and with that, we are able to give higher salaries with benefits and such for those staff we have. We'll get into the shortages in a minute.

But -- so one can look at the municipal sector which is putting in an additional estimated $350 million, and so we do see it as a fundamental issue of funding and that if there is additional money that the Province can provide, that may encourage municipalities to expand, but right now, it is not a sustainable funding model, and that gets us into the division of the role of a municipal government with property tax base versus a province that has many other revenue sources, and who is accountable and responsible for healthcare of which long-term care is becoming more and more

the destination for those that have complex health needs right now, but all in there, so from an AMO perspective, we're looking at it very much on funding, who should fund it, who is responsible.

But I'll turn it to Lisa at this point.

LISA LEVIN: Thanks so much, Monika. So I would just add to the points that Monika made that I would say that it would be important for the government to consider how they can support the not-for-profit and municipal sector more to make sure it remains viable.

So, for example, there's new beds that will be built, and there are many beds that need to be redeveloped in the long-term care system, and, generally, the for-profits tend to be, you know, more efficient at doing that because they have a lot of large chains, and it's something that comes easier to them.

And we think that if more support could be given to the not-for-profit and municipal sector in terms of helping with capital development and redevelopment and also expertise in terms of looking at finances and operations of homes, then that can make a huge difference. And I think that the municipal homes can play a real leadership

role, and it has been -- it has gone somewhat unnoticed, and I think that, in terms of expanding the capacity of non-profit homes, the municipal sector could help by providing expertise.

And even during COVID, I know that hospitals have done a great job helping homes, but some municipal homes or even larger not-for-profit homes could help out and have helped out homes that have had outbreaks. So I think that we need to definitely look at empowering and enabling the not-for-profit and municipal sectors.

COMMISSIONER FRANK MARROCCO (CHAIR): I'll just check with the other commissioners. When you say "empowering" -- and I don't want to monopolize the questioning which is why I'm hesitating -- when you say "empowering," empowering in what way?

LISA LEVIN: So I guess in that case, I'm thinking more of a smaller county or a smaller not-for-profit home, in particular a smaller not-for-profit home that's not as sophisticated and they have to deal with the huge amount of regulations that come their way, and how do they meet all the expectations? How do they handle the sophisticated finance that's required for long-term

care? We have a full-day long course just on the introduction to long-term care funding, and so it's a complex sector, and it definitely could use supports to help these smaller players and also the not-for-profit players and small municipalities.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, Dr. Kitts?

COMMISSIONER JACK KITTS: Yeah, I just want to go back to see if I've heard correctly. The -- there's three types of homes: Not-for-profit, for profit, and municipal. And I think you said that there's -- I'm trying to clarify. Is there one type of home that is more successful in terms of performance for the residents and the staff? And I think, you know, there's -- there's -- some do well, some don't.

But is there an ideal model? Do we need three different types of homes? And is there an ideal model?

LISA LEVIN: Do you want me to answer that?

COMMISSIONER JACK KITTS: Sure.

U/T

LISA LEVIN: So I don't know if there's an ideal model, but, certainly, the research has

shown that not-for-profit and municipal homes have better outcomes and quality of care; and if you want, we can send you those studies.

That's not to say that -- you know, I'm hesitant to make a general comment about every home out there if they're not -- like, there are some for-profit homes that do very good jobs, I'm sure.

But the overall evidence does show municipal and not-for-profit do a better job, and in the case of COVID, the municipal homes, the evidence has shown, has done a better job in reducing the outbreaks. But that was Wave 1, and now we're in Wave 2, and who knows what will happen.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Granger, you were going to say something, and did you -- did you want to? I thought you were about to say something, and I think, then, we asked another question.

CATHY GRANGER: Yeah, I can just add on to what Lisa said. You asked -- you mentioned why we did well in the first wave. We also had staff in municipal homes, and because we're part of a community, we had staff we were able to redeploy.

We are also quite connected with our paramedics and Public Health groups, so they came in to support our homes as well.

And as a larger -- and to build on what Lisa said as well as -- in terms of larger municipal homes, we have five homes in the Region of Peel, and we certainly do train for other smaller homes. We have nurse practitioners focus on dementia that support all our homes across the sector and in our region, so certainly that model is being used in our area and other areas really well. We also partner with our local hospitals and provide feedback about long-term care in terms of the hospitals -- in terms of the homes that they are overseeing. So that model is out there for sure. Thank you.

DAN O'MARA: Yeah, it's Dan O'Mara. Also, being the mayor of a small community, I think -- I think one of the -- one of the aspects is accountability. When municipalities and that are involved in the homes, rightly or wrongly, I have to walk down that -- down the street one day, and if Mom's not getting the best care going, we're going to hear about it.

Now, whether that's the best model or

not, the big issue, though, is the funding. If -- I guess if everything was funded appropriately, then, yeah, probably, you know, the more local -- the more local kind of system that you have, probably the better because these are our residents and our community. And I guess that that's -- and that increases accountability as you get closer to the community, so that would be my comments on that.

GRAYDON SMITH: Okay. And I think the other thing, if I may just jump in, too, Commissioners, is to remember that, you know, municipalities, while on a day-to-day basis, their long-term care homes perform very well, in this particular situation of a pandemic, you know, we've got other places to draw resources from.

But, again, this is not a sustainable financial model, so the chronic underfunding that has been part of the system has made it difficult for us, and I think we've done an exceptional job at trying to make a lot out of a little.

But at the same time, if additional resources, financial or otherwise, have been put toward supporting long-term care facilities that are municipally owned during COVID or potentially

during another pandemic, that means something else is not getting done. That means those resources have been drawn from another pocket that will inevitably suffer in some way.

So, you know, again, it really comes back to a matter of sustainable funding as the -- kind of the underpinning of a system that can respond well on not only a day-to-day basis but also in a crisis such as this.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Commissioner Coke.

COMMISSIONER ANGELA COKE: Just with respect to your first two recommendations, you talk about planning and communications. And I'm just interested in what sort of challenges you've had with respect to representation on the planning tables or implementation tables.

GRAYDON SMITH: Monika, do you want to take that one?

MONIKA TURNER: So one of -- and Angela, I -- hi, a long time we haven't saw --

COMMISSIONER ANGELA COKE: It's a long time.

MONIKA TURNER: -- each other. But one of the challenges, if I can be very direct, is the

Ministry of Health, of which I had the joy of working for twice, unfortunately does not see municipal homes as an entity. They invite the for-profits and the not-for-profit associations of which that's one of the reasons we work so closely with AdvantAge, but they do not see the municipal long-term care homes as part of the planning, whereas Mayor Smith just said, we devote our resources that if we need to shore something up, we do, and we take it from another municipal service or such like that.

But I will say that the Province often has challenges in bringing or reaching out to the municipal side of something which is one of the reasons AMO is working so hard especially on health issues.

So if I may, they go to the physicians; they go to hospitals; they go to specific organizations, but we really have to -- and forgive me -- elbow our way in to have them recognize that the municipal sector provides these services as well, and we bring a different approach and ethos, if I may, than -- we do everything else as well as long-term care. We don't just do long-term care, and that is something that often they -- the

Province, when they approach, don't see the -- that in a systemic way.

COMMISSIONER ANGELA COKE: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR):

MONIKA TURNER: I hope that makes sense.

COMMISSIONER ANGELA COKE: Yes. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Does the municipality inspect the homes that it runs or homes -- or created, or does it rely on the Province to do the inspections?

GRAYDON SMITH: Which member of our group would like to take that?

Cathy, did you want to jump in?

CATHY GRANGER: Yeah, sure, I'll jump in. Yes, we do regular audits and inspections of our homes. We also go through accreditation every three years, so we do ongoing audits that supplement what the Province does, so our homes are in there quite frequently. And [indecipherable] --

COMMISSIONER FRANK MARROCCO (CHAIR): Would that be --

CATHY GRANGER: -- homes are similar. Sorry. Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): No. No. I'm sorry to cut you off. I'll wait until you're finished.

CATHY GRANGER: No. I'm good. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Is that -- is that the way it is with all the municipalities, or is it -- does it vary?

CATHY GRANGER: I think everybody would have their own process. I know that our majority of homes are -- do go through accreditation, and I would assume they all have a similar way to inspect their homes to supplement what's done by the Province, but I'll let my colleagues and friends jump in. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

Mr. Pender.

GRAYDON SMITH: Kelly.

KELLY JAMES PENDER: Yeah, certainly here in Frontenac, in a way of a quality improvement team that's led by Lean Blackbelt, we do accreditation. We do regular inspections. The medical officer of health and his staff are in the home on a regular basis.

I think what's being missed here is that there's a governance issue as well. You know, our -- our home reports to a council of eight, four mayors and four deputy mayors representing a significant geography who are responsible for make funding decisions, and as well, they are, for lack of a better word, the Board of Governors for our long-term care home, so there's that added layer of governance that I think the Province sometimes misses that, you know, a directive from the Province influencing a funding decision at our council table without recognizing that they are collecting tax dollars from our residents. So that's an important distinction.

I'd also suggest that on the not-for-profit front, you know, there are certainly well-funded not-for-profits that do an amazing job.

There are others like one in Eastern Ontario that a year ago had a bake sale to raise money to pay for replacement windows. It's just you can't just say the not-for-profit sector or the for-profit sector or, to a lesser extent, the municipal sector and picture it as a homogenous lot. There's distinctions within each one of those groups as well, so...

COMMISSIONER FRANK MARROCCO (CHAIR): Is there a relation -- a working relationship with the local medical officer of health in the municipalities?

DR. ROBERT KYLE: So, Commissioner, I can tackle this one. So we have excellent relationships with all of our long-term care homes and retirement homes including those in the municipal sector.

Dialing back to the previous comment, our involvement with respect to inspections of long-term care homes, retirement homes, focus on outbreak management, infection prevention and control, and if they have kitchens and onsite dining, food safety.

So we would be one of the -- I guess, we and the either Ministry of Long-Term Care Inspectors would be the two types of inspectors. Of course, there's building codes, fire codes, and all that type of stuff, so that's part of the inspection, that landscape, but in terms of COVID-19, we would certainly be involved as would the Ministry of Long-Term Care.

If I can, in AMO's submissions and in your first interim letter, you recommend a

collaboration and partnerships on the infection, prevention, and control, or IPAC front with hospitals and with the long-term care homes.

The words collaboration and partnership resonated with me, and indeed, that's a part of the AMO submission, and in particular, I think Public Health can play a role in kind of situationalising IPAC from a hospital perspective which may not necessarily fit in long-term care homes, retirement homes; and we can do that through our ongoing relationships with the sector. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I'll keep asking. You just -- if the other commissioners would just tell me to stop, then I'll stop, and I'll stop promptly.

There was a reference in the opening remarks to chronic underfunding in this sector. Can you give us a sense of, kind of, when that started and how it manifests itself from a municipal perspective?

MONIKA TURNER: If you will, I can start. So, again, for municipal long-term care, you also have to go back to why we were legislated to provide for long-term care. And it started back in the 1940s when it was basically housing for the

elderly and such like that, and what we have seen, and the experts amongst us can tell -- can talk us more, but it essentially started out as housing, and now it is moved into very, very complex healthcare. And the whole dynamics of those that are in a long-term care home has changed dramatically, so they're -- so the issue about local housing provided for the destitutes, to use 1940s terminology, made sense as a local government to do.

But as it's morphed, and as more and more dementia is there, more issues about complex illnesses, again, I'll look to the experts to talk about it. That's where the funding has gone is to deal with people with very complex medical care in what used to be for housing for the destitute.

So it's -- there's an arc of how municipalities have funded it but that it's taken on a different change of what it was intended to, and the issue about being legislated to do it, one of the things AMO has said is, if you would allow healthcare to be with the Province, it would allow the flexibility for municipalities to work on the local side of it.

So many municipalities right -- well,

all municipalities are very proud of their long-term care homes, but there is the fundamental question about is that the right thing for local government to do seeing that we're 16% of the beds, and that as Mayor O'Mara said, you walk down the street, and the mayor will be approached by the residents.

So the issue about when did it start, I will say is the funding deficit, which was your question, is probably when it morphed from a housing focus to a complex care focus which was probably -- and I'm not a health economist -- was probably about the mid-90s where it started to switch over, though I'll look to Cathy and perhaps Kevin to talk about as you started to see the change of the demographic of the residents in long-term care.

That's the best I can do at this point. We don't have a documented history of exactly where that pivot point was.

DR. ROBERT KYLE: I'm long enough in the tooth, Commissioner, to remember when, in fact --

COMMISSIONER FRANK MARROCCO (CHAIR): I have some sympathy with that, Mr. Kyle.

DR. ROBERT KYLE: Yeah. Yeah, when the homes themselves actually were responsible for placement.

So the other thing that happened in the early to mid-90s is placement to municipal homes for the aged, as they were called back then, transferred to home-care programs. They were called placement coordination programs. They eventually merged with home-care programs to really form the basis of what we have right now with respect to case coordination under the LHINs.

That all happened in the '90s, and the result was municipalities really lost the ability to mitigate the cost risks associated with more complex care because they lost the leverage and ability to choose who could come into the homes. And I think that was around 1992. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Commissioner Kitts.

COMMISSIONER JACK KITTS: Is the issue, then, more like we're continuing to call them long-term care homes for residents who this is -- this is their -- where they live. But in the '90s and into the 2000s, that whole dynamic shifted because now they're -- you're saying that they need

continuing complex care which is not the idea of a long-term care home, at least from what we've heard so far.

So is that confusion contributing to the funding and staffing challenges, do you think?

DR. ROBERT KYLE: If you're directing it at me, and I'm not an expert, the brand changed from home from (sic) the aged where it was a place for those who were indigent to get housing to now one of several types of long-term care homes which really provide far more than housing, but medical and other care and treatment for a population that has had increasing complexity of care needs.

I would say certainly starting in but certainly carrying on and accelerating in the early '90s to the present today, if your question was directed at me. But I'm going to shut up because I'm not the expert. I'm the Public Health guy here.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

Ms. Granger.

CATHY GRANGER: Yeah, so I'm not the expert in terms of the dates and timing, but certainly we have become -- the people who come

into our homes, their needs are quite acute now. So they've changed significantly. Our rates of dementia, just over the last ten years, have risen significantly which are -- is impacting the care as well we provide.

The numbers of people who come and live in our homes, also, the comorbidities that they have, so the mental health issues, when we lost some of the mental health housing -- and, again, I don't know the dates -- have really increased care as well, so -- and our staffing has not, you know, kept up the pace with all these changes, so it's really become a challenge.

So to Monika's point, the increase on our tax base has risen consistently because we care about these people in our communities, but it's not sustainable, so it -- and, you know, we've tried to support as much as we can with increased training, but again, it's not sustainable, so a very different type of person if you'd -- if we do the general profile for someone in our long-term care home is extremely different from what it was ten years ago even. Thank you.

DAN O'MARA: It's Dan O'Mara. One of the -- I've been -- I've been involved -- I started

in the home for the aged -- this is Thunder Bay -- years and years ago, and the debate as to municipalities getting involved and the question between long-term care, I mean -- I mean, extend -- nursing home and municipal homes has been debated for years.

And I guess one of the shortfall comes in is very early on it became -- if the government didn't provide it, the municipalities ended up providing it, so the whole issue of municipalities paying above and beyond the care has been going on for years.

GRAYDON SMITH: And just to supplement Dan's comment, you know, the $2 billion that Monika referenced in terms of healthcare spending that municipalities contribute, a lot of that was created by vacuums forming and municipalities stepping in to fill that vacuum, not just in long-term care but in other matters as well.

You know, quite simply, I don't think that any municipal official or employee is willing to be the one that was accused of being asleep at the switch, you know, when a service stopped being provided.

So by necessity, the money gets put

into the system, but again, that has impacts on the other functions that municipalities are required to perform. So we have seen over the years in long-term care and in other facets that this number continues to climb, and our involvement and investment in the healthcare sector as a whole continues to climb.

But it wasn't by design by municipalities. It was somewhat systemic in the system, and I'm not pointing the finger at any one government because, again, this has happened over decades that this vacuum was created and municipalities stepped in and filled it.

COMMISSIONER FRANK MARROCCO (CHAIR): Correct me if I'm wrong --

Oh, go ahead, Mr. Pender. You're on mute.

KELLY JAMES PENDER: Oh, thank you. Just to point out that, you know, in 2008 when the Sharkey report came out, the average length of stay in our home was just under five years. It's now under two years. And what's changed in that time was the provincial aging-in-place strategy, and with -- somebody with aging parents, I fully endorse and support an aging-in-place strategy, but

where that pressure shows up is in our long-term care facility, and one of our consultants is fond of saying that you can tell the age of a long-term care facility by the size of the resident parking lot.

You know, we have an aging home which is scheduled to be replaced. There's nobody driving here anymore. Ten years ago, we had residents that were still driving. When they arrive on our doorstep, this is their last home, and that's how we like to treat it. And I think it's important to separate the political desire to do the right thing as President Smith said, know our politicians are fully invested. Our home is 20% of our budget, but it's a big part of the heart of our community from the funding portion which, you know, the circumstances around us have changed fundamentally with the aging-in-place strategy.

And people are arriving sicker and in more need than they ever have, and we welcome that, but we do not have the resources to deal with it. And the answer can't be going back to the municipal taxpayer to ask for more funding. It just isn't sustainable.

COMMISSIONER FRANK MARROCCO (CHAIR):

So, then, do I have it right --

Oh, Commissioner Coke?

COMMISSIONER ANGELA COKE: No. Sorry. If you want to continue with this, I have a completely different question.

COMMISSIONER FRANK MARROCCO (CHAIR): Do I have it right that the problem has its origins in -- in the idea that -- in the home care model that this is a part of the home-care model that wasn't thought through?

KELLY JAMES PENDER: I think that's fair to say, and it's not -- I wouldn't just take a long-term care perspective. Like, the community care centres, you know, providing meals on wheels and some of these programs, that they're stretched to the -- they're stretched to the ends of the rope, and, you know, we saw the problem first in hospitals, but it's long-term care and community support programs as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Mr. Lett.

DEAN LETT: Thank you. I just want to add a few more comments that my colleagues have brought up. Definitely, the increased acuity levels having a significant impact.

The way our case-mix index is calculated is also, I believe, a concern for our sector. It does not capture dementia, the behaviours of dementia, the reasonable require [indecipherable] or the activities of [indecipherable]. And -- [indecipherable] for long-term --

COURT REPORTER: I'm sorry, sir. You're cutting out quite a bit --

DEAN LETT: Sorry.

COURT REPORTER: I'm sorry, Mr. Lett. You're cutting out a bit. If you could --

DEAN LETT: Yeah. I'm sorry. I'll try again.

The other thing I wanted to say was there's a readjustment factor that's applied to the CMI each year as well. So while we're seeing the increased acuity level, the adjustment factor will bring down the CMIs, so we're not truly getting the funding that's associated with the care levels that we're having to provide in the homes. Thanks.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, you were going to ask a question on a different topic, you said, or a different -- slightly different direction.

COMMISSIONER ANGELA COKE: Just on the staffing issues, and we've heard a lot of the challenges that people have: I'm just curious to hear -- elaborate a little bit more about particular challenges for the rural and northern areas. I just want to hear a bit more about that.

KEVIN QUEEN: Yeah, Kevin Queen. When you say you want to hear a little bit more about that, in what context? In the level of staffing generally? Or --

COMMISSIONER ANGELA COKE: Yeah, I'm assuming you have some of the same issues as everybody else, but I'm trying to figure out if there are any nuances or particular issues in your rural areas and northern areas other than it just might be more difficult. I don't know.

KEVIN QUEEN: Well, yeah, we've had chronic staffing shortages in our smaller homes in the North, and the problem is when you try to have an education system or develop new personal support workers, for example, you have to have a certain threshold of students. If they don't have enough in the class, they don't have the class.

But the Act requires you to have PSWs, so you're stuck without -- you might have people

who want to work, but they can't get into the class because there's not enough people to take the course, which then ends up you can't hire them, so you're overworking the people that you do have.

So that end -- that results in burnout, mistakes, stress in the workplace which you don't need. And then one of the big things in the staffing study was the culture of the homes, and this all contributes to an unfortunate culture where people are overworked and stressed.

And so what we're looking at in the North and smaller areas is more flexibility in the hiring practices, allow us to bring in students that we can train in-house.

I worry more about, when you're talking about culture, the characteristics of the individual you're hiring is equally as important as their -- whether or not they have their PSW. They have to be in a -- be able to provide care compassionately and effectively.

So what we do -- I mean, even with the additional funding for more staff, if the staff aren't available, it's great to have the funding. I totally support it, but we still have to have mechanisms in which to attract them. And again,

like I said, we have to improve the culture, have the flexibility to bring people in and train them, give them a certain time period to learn -- to learn the skills.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you mean training on the job?

KEVIN QUEEN: Absolutely. Actually, training on the job would be -- would be really, really advantageous for smaller homes. I think it would work well in larger homes as well. We have a buddy system. It's like -- almost like an apprentice.

The benefits to that is the staff -- the new people get to learn the job to see whether they're suited for it. We get -- also get to see whether they're suited for it as well before investing a lot of money into getting the training.

Just having the PSW certificate does not necessarily make a proper staff person or an RPN or an RN for that matter. They have to be -- I'm not saying an RPN and an RN has to have their regular -- their certificate, but the -- but the PSW, we certainly could be putting them on the floor with the -- with the -- as a buddy -- in a buddy system.

COMMISSIONER FRANK MARROCCO (CHAIR): And I guess that addresses, in part, what happens when they decide -- community college decides not to have the class because there aren't enough people who want to take it, but you still want to hire somebody.

KEVIN QUEEN: Absolutely. We've had several years where we were not able to do a course because there's only three or four people. They wouldn't have it for that many, so -- but we -- but in the past when we were going through the development of the Act when it first came into play, we had several people that didn't have their certificate. It was just a misinterpretation, but we were able to get them all trained through a fast program within -- with the college within three months.

So we actually tried different models that work really well. It's just that there is no flexibility in the Act right now, so in a way, the Act is intended to protect the care, but in -- by enforcing it, it's actually making it more dangerous for the residents in the home because you can't get the people to work. And not having enough staff is just as unsafe as not having

somebody with a PSW, so it's kind of a which is worse.

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. O'Mara. You're on mute.

DAN O'MARA: Yeah, I'm involved in -- I'm involved in a home in West Nipissing as being part of a municipal rep on a Board. They've come up with what they call a helping-hands program where they do bring people in and to assist. I don't know how necessarily they do it under the Legislation, but I guess, worse come to worse, if you need somebody in your home and you need someone to take care of you, you have to -- you have to do different things.

But, you know, the whole aspect of, you know, getting younger people involved early on, like myself, I had a choice of working in a papermill or becoming an orderly. I started as an orderly, got interested in the healthcare field. It wasn't cool in those days to be -- for a male to become a nurse, so I ended up eventually getting back in healthcare through the fact that I got a job as an assistant to administrator, got -- got it, and I worked my way through the system.

The trades do it all the time. You

know, they bring people in. They train them. They have work program. At least in the North, that would at least allow the homes to start educating, and it can just start -- PSW could work towards the RPN, and one of the concepts there, it's not new. It can be used if it was -- if it was organized appropriately. And I think it's -- at least that's -- that's something, I think, that would at least start producing some of the people that we need in healthcare.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Mr. Pender.

KELLY JAMES PENDER: I think what -- you can't separate the staffing issue from the labour relations issue, too, and this may be a tad bit outside the scope, but the current collective bargaining and arbitration process in Ontario means that -- and we deal with CUPE, ONA, OPSEU. They're all the same. They know perfectly well that as long as they drag their feet and throw enough spaghetti on the wall, they can pretty much stalemate anything or take it -- take it to the end of the process and delay change.

And there is no incentive for any union working in long-term care to bargain freely in

Ontario because they just end up going to an arbitrator, putting 23 issues on the table, and the arbitrator picks 6 of them and tries to normalize things across the spectrum. And they know that as long as they can keep this process going through freeze periods, that there is no way for management to make any effective changes like introducing a resident aide or another position.

In our home, we have been in a perpetual freeze period for almost six years because the union, and it's CUPE, and it's not the local people -- it's CUPE Provincial -- knows that they just need to keep dragging their feet and change won't happen, and to a lesser extent, the colleges, too, and I've dealt with the colleges enough to know, you know, for the most part, they're well-intentioned, but there is no incentive for any of the colleges to change. And that is a big piece of the resistance puzzle that you're going to face any time we look at changing the system.

And I can assure you that, you know, I fully support the four hours of care, although I question whether it's enough. But as soon as that's announced and as soon as you start talking

about PSWs or full-time hours, the expectation with our unions is going to be that that's going to happen over night, and there just aren't the staff to make that happen.

So it's a double-edged sword, but we can't ignore that the labour-relations process in Ontario does not -- does not provide for change. In fact, it works against any change that may happen, so...

COMMISSIONER FRANK MARROCCO (CHAIR): And it strikes me, though, that there's -- you could really run into some headwinds in terms of making change if you managed to unify a group of people against what you're recommending. I take the point, but I worry that you don't end up biting off more than you can chew kind of thing.

KELLY JAMES PENDER: Yeah, I don't disagree, and, I mean, I look to the hospital amalgamations, the same kind of thing. I mean, it -- there were the amalgamations, and I worked in Muskoka Algonquin Healthcare during parts of this. There was no incentive for any staff or any union to be a part of the change process.
If it isn't mandated, it won't happen. And I recognize that that would result in significant

headwinds, but if you're looking for systemic change, if you ignore the union process and the current labour-relations process, you're just going to get that headwind anyway. So -- and I think there's enough in what you're saying to say, okay, here's some carrot, but here's a little bit of stick. And it could be an 18-month window while it gets implemented or a pause in maybe negotiation process or a speeding up of the arbitration process or a one-year extension of current collective agreements.

There's all kinds of mechanisms that could allow change to happen, and I think you would have the ear of a lot of the unions on that change if it was thoughtful and well thought out because they support four hours of care, and they support -- they support more full-time hours, but they'll resist with the -- their dying breath if that change means that -- you know, that they're going to lose some control over the process, so -- and I recognize there is no simple answer to that, but...

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

Yes, Ms. Turner, I guess.

MONIKA TURNER: Just to say, and, again, just building on this, I think it's well documented that there's been long-term staffing shortages, and one of the challenges is the -- is movement to better paying jobs with benefits and such like that.

And I think one of the things we're looking at is we're not going to solve this long-standing issue by using the same old, and we're looking to you, and we're probably trying to encourage you with all the -- our staffing suggestions of looking for something that we haven't tried before and even -- and bringing in the unions, bringing in all those folks that care desperately that residents in long-term care are well looked after and that the staff are safe, the residents are safe.

But there needs to be some different ways to do things, and -- that you don't get perverse consequences such as, you know, the changes in the regulation has prevented folks that would like to work in place if they're already living in Kenora or Ir Falls or Red Lake, but that they train up and with the ideas about new virtual learning, there's got to be some new opportunities

we can do to grow staff in place so that everybody benefits.

And if I may, to Kelly's point, the unions are looking for innovative ways as long as they're part of it. So, again, I think you're seeing that everybody wants positive change, but doing the same old, same old hasn't worked well and especially not in the northern and rural communities where you get people pulled from long-term care to work in hospitals, and so you constantly get movement of health staff who are just looking for good, stable employment as well.

So it -- to use negotiating parlance, it needs to be in everyone's interest as you're moving it forward so that they are part of the change as opposed to resisting the change.

And we're happy to help you with some ideas of that, but that's what we're looking at, and even things such as we were asking you to keep the redeployment orders in and things like that just says that we have a -- we all have a staffing shortage issue, and we're finding ways to do band-aids when you really need a systemic approach.

And that was our question of -- our recommendation for a province-wide health human

resources strategy to address the long-standing staffing issues and that we want to be part of that solution. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Ms. Granger.

CATHY GRANGER: Yeah. Yeah, I agree with that, Monika.

We're not asking just for more money, right? It does require a whole new strategy, different ways to recruit people, different ways to grow your own.

For one small example, what we've had quite success at is we train all our staff to provide care, so our housekeepers are some of the best people who do provide emotional care to the people in our homes. So that doesn't -- won't cost the Province a lot more money, but we need to invest in everybody; it's all hands on deck. It's someone's home.

Yes, our -- the people living in our home are much more complex in terms of their needs, but in terms of basic needs, helping people get to -- to their meals, making them feel less lonely, we need to invest in all our staff because there aren't that many staff to go around, so we need to

support our staff as well if we want to provide the best care for the people living in our homes.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: So I just -- I notice your recommendation about the pharmacy funding, and I'm just trying to understand a bit more from your view what the on-the-ground, sort of, impact has been with respect to changes to the pharmacy funding.

MONIKA TURNER: Michael, is that something you can speak to? Or I'll look at -- to the other members.

MICHAEL JACEK: I think for the on-the-ground impact, perhaps one of the administrators or directors or perhaps Lisa might be better placed to answer that question.

LISA LEVIN: I apologize. I was interrupted. Can -- would you be able to repeat that question again, Commissioner Coke?

COMMISSIONER ANGELA COKE: I just want to understand a bit more about the, sort of, on-the-ground impact of the changes to the pharmacy funding.

LISA LEVIN: Oh, yes. Yes. Okay. So

the on-the-ground impact, it's somewhat hard to assess because of the pandemic because things have been in such chaos in general, but there's a significant -- so first of all, the funding changed to a capitation model from a fee for service which we actually agree with because it didn't make sense.

But it also -- the funding levels reduced significantly, and they're supposed to continue reducing over the next three years start -- the next one being in January.

So things like pharmacy -- like medication destruction is no longer being done by many pharmacy companies, so instead, it has to be done by the clinical staff.

There's no one change that's across the whole sector necessarily because every home has a different pharmacist, but medication reconciliation may not be done as often. Pharmacy audits may not be done as often. There's just a lot less involvement.

Another thing that pharmacy companies typically do is they take what's called government stock which is, like, vitamins and laxatives, and they package them in the strips that go out to --

for each resident, so many companies are no longer doing that which means that the nurses have to do it.

So the general impact has been, firstly, more of a workload for existing staff, typically nursing staff; and secondly, somewhat less oversight. So it's very concerning, and we are hoping that the continued cuts do not happen or at least are delayed until we get through the pandemic.

COMMISSIONER ANGELA COKE: And, sorry, did you know what the rationale for those were, for the cuts were in the first place?

LISA LEVIN: So first of all, it was a move away from a current model which was not a great model to a capitation model. So the way it was working before, pharmacies were paid a certain amount per resident, and there was a lot of competition between the pharmacy providers, so then they were throwing in stuff to homes, and so some of the stuff that was provided are things like medication carts which are very expensive for homes to be able to purchase on their own, and probably the government should formally pay for that as opposed to it being something that the pharmacies

provide.

There's also a number of homes that received financial incentives from pharmacy companies beforehand which was not seen necessarily as the best way to do things.

So move to capitation makes a lot more sense, and I think the government had the feeling that there was too much money going to pharmacies if they were able to give financial incentives to some homes, but the level of the cuts has been quite significant, and it's very hard to determine the exact impact because every pharmacy provider's doing things differently.

So it's been hard for us to advocate for this, and we did surveys of our members to see what would be cut, and some of the things I mentioned to you are things that were indeed cut, and further cuts will happen because it's a three-year phase in in January if these continue to occur.

There's also less education for staff, and other members can talk to you about -- I think Cathy has had some impact in her homes. Maybe she can talk to how it's impacted her home, or maybe she stepped away for a minute.

CATHY GRANGER: No. It's Cathy. Yeah, I typed it in. Certainly, we've had a significant decrease, so it really has impacted staff training, their participation in care conferences, overall support to families, supplies, just regular training they would provide. As you're probably aware, the complexity of medications that we give to the people in our homes is very complex, so just ongoing training, it's just decreased significantly.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we've exhausted our questions. I don't know --

Oh, Ms. Turner.

MONIKA TURNER: I just wanted to -- thank you very much, Commissioner. I just wanted to add something, and we'll probably capture it in our next series of recommendations, but it's actually a real need right now which is how there can be rapid deployment of staff to those homes that are encountering an outbreak.

Again, especially in rural and Northern Ontario, you can't always depend on the Red Cross, but I just wanted to say that this is something that we're hearing of, and I don't know if it's --

if there can be teams that can be available on a regional basis or such, but it is -- I -- a need that we're hearing of.

We have heard of there's less staff now than there were especially as those that were redeployed are going back to their home positions.

But it is something that we are aware of, and we wanted to bring it to your attention. And I don't know if any of those that are running long-term care want to speak to the -- and have either have an outbreak or have had an outbreak, want to speak to the human staffing needs that you're encountering.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just -- while they're thinking about that, can I just ask you about this deployment? If you have five -- if you have more than one home that's a municipal home, can you redeploy under the current directive from one home to the other?

LISA LEVIN: You can redeploy from one home to another, but that -- that -- or those individuals cannot return back to the other home because of the one-site order, so --

COMMISSIONER FRANK MARROCCO (CHAIR): Do you think it would be better, then, if you had

the flexibility to move your own staff around?

LISA LEVIN: We have asked for the Ministry to consider what we're calling staffing bubbles, which would be exactly what you're talking about, Commissioner, where either a home that has more than one homes, like a municipality, for example, or if it's an independent home that they partner with another local independent home so that they can work together on infection, prevention, control and have their staff share because when the one-site order came in, we were all shut down.

Now, we're not all shut down, so staff that are working in long-term care and, as you've noted, there needs to be more full-time work, many -- half of them are not working full time, and many of them, but not all, want to be full-time, so they go seek employment elsewhere.

And now they're ending up in Walmart. They're ending up in grocery stores because they can't go to healthcare, and one might say that the risk in those environments is actually higher than if they worked in another home.

MONIKA TURNER: If -- it's Monika. I might take it a different way as well. What I understand from a number of municipal commissioners

and such, and Cathy and Robert may want to speak to it, is having a municipal structure where you're not necessarily moving long-term care staff around but rather folks that are not long-term care but can come in and do some of the nonclinical work so you're redeploying municipal staff to do things that will free up those that already work in the long-term care to focus on the resident care items. And that has helped especially when you have a number of staff across a municipal corporation.

And I know Peel has done that very effectively. I don't know if Robert wants to talk about what Durham or what you've done in the counties, but it's those redeployment orders that we're asking you to keep in place that allow flexibility of municipal staff not just long-term care municipal staff.

Cathy, did you want to comment?

CATHY GRANGER: Yeah, thank you, Monika. Yeah, that was -- that significantly helped us, and I think I mentioned that briefly in my first comments, manage the first wave.

However, as we enter the second wave, as you can understand, we, as a regional government, we do want to support all services,

so -- and the economy, so we probably won't have as many staff available to support us this time around because everybody's trying to open up their own business.

And when we were in the first emergency, certainly, we did have lots of support, but to Lisa's point, when it -- when it comes into our homes, it happens fast, and the need for staff is urgently needed.

And while the hospitals had said that they would provide staff, they really, the majority of time, they couldn't, and the IPAC support that they tried to provide was not necessarily the IPAC support that we needed in long-term care, so that wasn't exactly what we needed. We need on the body -- on-the-ground bodies to help support.

DR. ROBERT KYLE: What I would say, Commissioner -- thanks for the question -- is for boards of health to work effectively in the COVID-19 response including responding to outbreaks in long-term care homes and retirement homes, we have relied on the emergency order specific to boards of health to allow us to optimize staff within the health department.

In addition, the emergency order with

respect to municipalities allows us to import, if you will, staff from other parts of the municipality depending on their skillset and so forth and allows us to redeploy to long-term care homes. I think we're a net importer of redeployed staff versus an exporter. But both emergency orders have been crucial not only for the long-term care home response, but the Public Health response that, among other things, has assisted with outbreak management in affected long-term care homes, retirement homes, including municipal long-term care homes. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Somebody else. Well, oh, yes, Mr. Pender. I knew there was someone else.

KELLY JAMES PENDER: Thank you. And I just want to end with one single thought: There seems to be a push of long-term care to become hospital-like, and having worked in both the hospital sector and the long-term care sector, I think that that is completely the wrong direction.

We have to remember that the people in our long-term care homes, as my director of care likes to remind me, it's their last rocking chair, and to push long-term care closer to the hospital

model will only increase costs.

I think what we need to do is do a better job of providing that last rocking chair. And one of the problems with the Case Mix Index is (a) it's two years old, and the people that we're measuring by the time it amounts to funding have passed way, so it's a retrospective work.

Plus in our small home of 130 beds, it's 1.8 FTEs of RPNs collecting data, meaningless, meaningless data. Those RPNs are much more valuable on the floor than they are in front of their computers translating data that goes into a formula that's basically an estimate times a guess divided by an assumption. It's a meaningless process, and to move long-term care closer to the hospital sector, in my mind, is completely the wrong direction because that will just impose far more regulation and far more data collection that frankly is meaningless to my mother's last 18 months on this earth, so if that makes any sense.

LISA LEVIN: If I can -- if I can add to what you said, Kelly, and what Cathy alluded to before, I agree with you.

And I wanted to thank the Commission for their comment about the relationship between

long-term care homes, hospitals, and Public Health units must be based on trust, collaboration, and respect for all sides. I think that's really important.

But above that, you talk about how a collaborative model should be mandated, and what we're seeing in some cases, and certainly not all cases, is that the hospitals that come in do not understand the long-term care environment, and they're going into a home that's in outbreak, and it becomes, in some cases, a bit of -- it becomes a situation where the hospital is telling the home what to do in an authoritative way which isn't always appropriate for the environment of long-term care. And that's something that we need to really take a look at and determine how to improve that.

And one of the side effects of that has been demoralization of the staff in long-term care, and this is an area where I understand you've already been speaking about staffing where it's so hard to find staff to work in long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just follow up on that? Do you agree, though, that in an emergency, sometimes, you just have to -- somebody has to show some leadership and

give some direction and have the authority to give direction that you don't often in an -- you may not in an emergency have too much time for consensus?

LISA LEVIN: Yes, I hear you, and that's an excellent point, and I think that you do need that, but I think what's happening in some cases, and once again, I reiterate not all, the voice of the home is completely lost. And so we need to figure out a way to have that quick response that you're referring to, Commissioner, but not completely lose the voice of the home.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, I mean --

Sorry. Commissioner Coke, did you --

COMMISSIONER ANGELA COKE: No. It's fine.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I want to thank you, Mr. Smith, and all of the rest of you that came here. This has been extremely helpful, and we do really appreciate the opportunity to just ask the questions and get -- and get your answers. It's extremely helpful for us.

You're so connected on the ground to what's really happening that it's very important

for us not to -- to remember that and not get caught in an entirely policy-driven analysis, or we will have some -- we might miss the point of it.

So thank you very much for -- for the time, and thank you for the presentation. And we --

GRAYDON SMITH: And thank you --

COMMISSIONER FRANK MARROCCO (CHAIR): -- might be back.

GRAYDON SMITH: We'll definitely have more for you, and we'd be happy to come back and talk about our next submission. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): There's one request: Just, you have a website, and -- I think -- and I was wondering if we could link -- we could put a link on your website to ours so that anybody -- any of your members who were curious about what we're up to could have an easy way of getting to us. It helps us be a little more transparent, and -- if you wouldn't mind?

U/T GRAYDON SMITH: We'll take that with us and find a way to make that happen.

Monika.

U/T MONIKA TURNER: If I can, Mr. Commissioner, just to say that to contact me or

Michael which your staff already know our contact information, we have on our website a section on health and long-term care, and we can put your link right in there.

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

Well, thank you all, and have a good day.

GRAYDON SMITH: You too. Thank you.

-- Adjourned at 12:53 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 27th day of October, 2020.

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