Long Term Care Covid-19 Commission Mtg.

Meeting with Dr. Brian Hodges
on Thursday, November 5, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 5th day of November, 2020, 9:00 a.m. to 10:00 a.m.

BEFORE:

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

PRESENTERS:
Brian Hodges, MEd, PhD, MD, FRCPC,
Clinician Investigator, The Institute for Education Research (TIER)

Marnie Weber, Executive Director, Strategic Developments at University Health Network, Toronto

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Lynn Mahoney, Gowling LLP
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Dawn PalinRokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst for the Operations Branch, Long-Term Care COVID-19 Commission Secretariat

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: 48

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: 34

-- Upon commencing at 9:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So we're -- are you waiting for anybody else, Doctor? Or are you going to do this yourself?

BRIAN HODGES: I'm going to do most of it myself. A little later in the call, Marnie Weber is going to join. She was the co-lead on the PSW project with the Ministry of Health, and I can start briefing that, but she's going to join, when she's able, on that piece. And there's two other items before that I thought maybe, at your pleasure, I could talk to you about before she joins.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that would -- that would be great. We're -- as you know, we released a first preliminary report there.

BRIAN HODGES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): We haven't yet concluded whether there will be a second preliminary report or whether we'll just report at the end.

BRIAN HODGES: Fine.

COMMISSIONER FRANK MARROCCO (CHAIR): But we're working our way through it.

BRIAN HODGES: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): We tend to ask questions as we go along if that's okay?

BRIAN HODGES: Yes, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): And we do have a transcript which we post on the website so that people --

BRIAN HODGES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- have some idea of what we're up to.

BRIAN HODGES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): We're ready when you are, Doctor.

BRIAN HODGES: Okay. Fantastic. Well, thank you so much for inviting me. I just would say, on behalf of all of us in health care, and members of the public, myself with a family living in long-term care, that your work is greatly appreciated, and I have the greatest admiration for what you're doing.

I'm the Chief Medical Officer of the University Health Network and Executive Vice President of Education, so I come before you with two areas that may be of interest.

The first is UHN's own actions in regard to supporting 15 long-term care homes and 5 retirement homes during the first wave of the pandemic and, again, in the second wave.

I know that -- I believe that you've heard from a number of hospitals, so that part perhaps you want less about, but I'd be happy to describe that for a few minutes.

The second piece, though, is you may know, or not, that UHN is the only hospital in Canada fully integrated with a school. Ours is the Michener Institute of Education, and that provides us a very special opportunity to contribute to education in both precertification for health professionals and continuing education.

We're also the only school in Canada funded by a Ministry of Health. In this case, the Ontario Ministry of Health funds Michener, and so we've worked together on some important projects that I think you might find relevant. One was the creation of a second PSW Registry which is currently in a bit of limbo, but I can describe that process for you, and I offered to the Commission lawyers that you might wish to obtain the not-yet-published joint report from the

Ministry and ourselves.

And the second is the recently soft launch resident support aide program that we created over a period of two weeks with the Ministry. It was launched Friday, and we'll have a formal launch, we understand, on the 9th. It's scheduled for the 9th of November.

Marnie. Marnie, we hear you.

COURT REPORTER: I'll mute her.

COMMISSIONER FRANK MARROCCO (CHAIR): Janet, can you mute --

BRIAN HODGES: Yes.

COURT REPORTER: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- Ms. Weber --

BRIAN HODGES: Mute Marnie.

COMMISSIONER FRANK MARROCCO (CHAIR): -- before she says something that she regrets.

BRIAN HODGES: Yeah. Okay. So if you wish, I could give a few minutes on UHN's response and answer any questions, transition perhaps briefly to the RSA new program, and then we could spend a little time on the PSW Registry. Is that helpful?

COMMISSIONER FRANK MARROCCO (CHAIR):

That would all be helpful. I think I speak for the other two, yes.

BRIAN HODGES: Okay. Great.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes. Okay. It would be.

BRIAN HODGES: So let me begin, in the first instance, when the homes, the many long-term care homes were obviously in some distress, and the Ministry reached out to hospitals as lead agencies to participate, UHN was one of those. Kevin Smith is my boss, the CEO, and he asked me to lead this initiative for UHN. We put together an incident management team with all of the relevant players from infection prevention and control, the chief nurse, staffing, Environmental Services, et cetera, very much like other hospitals have done.

And we responded very rapidly, the same day, in fact. One of our homes was quickly going into crisis. I went there and walked the halls with the executive director.

And as you've heard, I'm sure, in many instances, in this home, we discovered units where perhaps a single PSW was caring for 50 patients or registered staff were very short and doing double shifts or even triple shifts, and there were acute

shortages of PPE and resources and a great deal of anxiety.

We maybe more aggressively than some other places sort of swooped in with a large group of people. We did everything from having portable showers installed in parking lots to sending truckloads of PPE, and we redeployed a lot of our staff. We urgently messaged across the organization for volunteers.

The first night, 88 people from UHN volunteered, and among them -- and 18 physicians worked as PSWs, nurses, every category of worker. And we deployed, over the course of the first wave, more than 1,500 shifts of staff into our long-term care homes.

And then, as they began to stabilize, we also helped try to support leadership, staffing, connect them to organizations that could provide for their needs such as personal protective equipment and other things. And we have maintained quite good, strong relationships with these homes. Our legal department helped us create a template which I believe was used across the province in all the homes, an MOU that specified what our jurisdiction would be. We were -- we are aware,

continue to be aware of the sensitivity of hospitals, as one of my colleagues said, riding in on a white horse to save the day. And that is not our intention. We have always, in all our daily meetings with most homes, our -- keep articulating that this is a learning curve for both, that there's such a great depth of expertise in long-term care that the acute care hospitals can learn from, and similarly, that we would work together to help long-term care bolster areas where there was need such as infection prevention and control.

We also provided mental health support, and we extended our own staff wellness and mental health services to the homes we were supporting which had some uptake. And another thing we did was, for our own staff, we have used the Michener Institute residence for staff who are positive but not sick and who had difficulty going home or need to have isolation. And we extended that to our long-term care partners as well. There -- I don't know that there was a lot of uptake for that, but we did offer that.

So we spent three or four months in the Wave 1 stabilizing and settling our homes. Unlike

others, none of our homes received a management order, and none of our homes were engaged with the Canadian military.

Over the summer, when the valley came and we were able to return some of our attention back to our own patients with delayed care, which was very significant for UHN, we delayed many, many thousands of surgeries, and a lot of our populations, including our Princess Margaret cancer population, we fell behind in -- during the freeze. So we ramped back up to more than a hundred percent at UHN, and as we entered Wave 2, we realized that we would not be, again, able to do exactly what we did in Wave 1, so we have done our best to hardwire it in this time.

Rather than myself, the Chief Nurse, Chief Nursing Executive, Dr. Joy Richards, is leading the initiative, and there's a small dedicated staff to it. We realize, as well, we can't redeploy the kind of numbers of staff that we did last time because our operating rooms are running over a hundred percent to try to catch up, for example. So we have been relying on volunteers.

Yesterday, we sent out another request

as some of our homes are, once again, having some troubles asking for people, once again, to step forward to volunteer to work in long-term care. And we're trying to help them with staffing and link to the agencies that can help bolster and all of the other pieces as before, the helping with personal protective equipment and IPAC assessments and whatever we can extend to help them.

They know us this time, and this makes it -- life a little bit easier, and we wonder, parenthetically, if there will be a history or continuing relationship between hospital resource partners, long-term care and retirement homes in the future, and we feel favourable about that. Of course, that's a decision of other people, but we have built some excellent relationships between the hospital and our -- and our homes. So perhaps I'll have first --

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, if I can stop you for a minute.

BRIAN HODGES: Please.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there anybody that's opposed to a more permanent relationship of -- I have a sense, from what I've heard, that there is some resistance, but I can't

identify where it is.

BRIAN HODGES: Absolutely. It's -- yes. So there would -- it would come from a couple of sources. As I mentioned in the relational piece -- I'm a psychiatrist, I should add. In the relational piece, there's no question that there were homes who felt criticized, beaten up by the process, and now the bigwigs from the hospital were going to come and tell them what to do.

I believe this is effectively dealt with by really working hard on the relationship. You know, our CEO and their CEOs would speak regularly. I visited in person very often. We built relationships. You'd have to ask our homes, but I think that they would tell you that we've managed to foster a good relationship, but it does require care in the mutual respect. And the legal MOU helped us a lot to say this is what the UHN is going to do; this is what the long-term care home is going to do, and we could hold each other to account for that.

The second piece, I think, which I understand -- I mean, way back to medical school, I was steeped in the Lalonde Report and the idea that we have a sickness-care system and not a healthcare

system and that the acute care hospitals in the past have over-focused on acute care and not community issues, long-term care, social determinants of health. I think the community sectors, including long-term care, are a little bit frightened that too much control in the hands of hospitals takes us too far toward the highly technical, and they worry about that.

This will come back when we talk about the new resident support aide issue which the hospitals are going to play a significant role in.

So I think that would be my feeling about where some of this comes from. I would be remiss if I didn't tell you that UHN has its own long-term care homes. We are the owner of the Lakeside home, which is managed by Extendicare. We run a transitional care home, Hillcrest. We have complex care in Bickle.

So I think for us, it was -- it's not that foreign for us to have a part of our world connected to long-term care. There are definitely hospitals for whom the long-term care sector is another world where staff really have never thought about or seen how it works, and that creates, I think, some tensions.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts.

COMMISSIONER JACK KITTS: Brian, how many homes are you supporting? How many homes is UHN supporting at this time?

BRIAN HODGES: Yeah, two of our own with whom we have legal ownership or contracts; 13 long-term care homes that were assigned to us; and 5 retirement homes.

COMMISSIONER JACK KITTS: Okay. And can you comment briefly on the status of, I think, the big four, IPAC, PPE, staffing, and testing --

BRIAN HODGES: Yeah.

COMMISSIONER JACK KITTS: -- at this point in time versus how -- where you were at in Wave 1?

BRIAN HODGES: Right. So IPAC, I have to say this is still a struggle for us. The in-home IPAC supports are very, very rudimentary. So we're still relying quite heavily on our hospital IPAC team to do the virtual and then the in-person assessment.

UHN, as big as it is, 20,000 people, largest hospital -- well, I don't know if we're larger than Ottawa Hospital, but let's just -- we

like to say the largest in the country -- one of the largest in the country. We really just have two IPAC physicians in UHN, so our IPAC team, which is dealing with our own patients and outbreaks is doing a great job. We are awaiting the robust arrival of a hub-and-spoke system which purportedly will have a bolstered IPAC services in each of the homes who can link to us as a centre of expertise. Essentially, for the moment, we're still doing most of it directly ourselves.

In screening, in Wave 1, we used our -- we needed urgently to screen everybody, and we actually got a little bit out ahead of the Provincial initiatives. For safety reasons -- I'm quite open about this -- we asked our Department of Family Medicine to do it. The Department of Family Medicine had reduced its own services a bit, and they went into every home. They swabbed every staff and every patient in all of our homes in a -- in about a week period of time in Wave 1. And this was largely well-received, again, a few sensitivities about the swoop-in model.

In Wave 2, this is different. The testing has ramped up more effectively. They have more access to testing. There's still some of

this. Family Medicine's still doing some of it, but much, much less now, and the capacity for testing is improved.

Environmental Services was a highly variable practice in the homes, not familiar to what we would be used to in the hospital setting, and I understand that.

An example the Ontario Long-Term Care Home Association often uses is an urban myth, but a hospital team swooped in and said all the -- all the sofas need to be removed because you can't clean the fabric, not recognizing that this is not a hospital and that it's someone's home.

The challenges of Environmental Services are quite acute. We, in Wave 1, redeployed our Environmental Team to do an assessment, and then to help them -- the homes work with agencies to bolster and hire more Environmental Services staff. And this has also been less -- less acute.

A little note: When there's an actual outbreak, I mentioned that the needs go up, so the installation of showers for staff, which we did in at least one home, and the change in the PPE and the cohorting which needs to be done to contain an

outbreak at least at a hospital standard is a big challenge for some of the older homes, particularly those with multiple clients, patients in a room. I've missed one, IPE (sic), Environmental Services.

COMMISSIONER JACK KITTS: Staffing? The --

BRIAN HODGES: Oh, staffing.

COMMISSIONER JACK KITTS: Yes.

BRIAN HODGES: Staffing, of course. Yes, the big one, and that will lead us into PSW and RSA programs. Well, there's a few things that we find ongoing challenges slightly mystifying. There is a phenomena, seems to be a phenomena in long-term care where staff who are anxious or concerned just don't come to work. We don't ever have that in the hospital sector. It's intriguing for us.

It wouldn't be possible to work at UHN again if someone abdicated their duty to show up for work on a particular day. I'm not sure what's led to that, and it's an open question for many of us.

We know that in many of the homes up to a third or even a half of the staff maybe were not coming for shifts, and we saw widespread incidents

of people doing double or triple shifts and quite a lot of exhaustion which is why we extended the mental health supports that we did.

As I mentioned, we redeployed in the first wave, so we filled in with staffing. We have currently, in Wave 2, two -- three homes, different ones from Wave 1, that have had outbreaks and staffing challenges. And I think it also highlights a systems issue. There are not a lot of available PSWs. There appears to be a significant shortage of RNs and RPNS in the province, and I would just comment, at UHN itself, we have a shortage of 270 RNs today which is one of our breaks on our surgical services. So there are gaps in the health human resources that are available.

And I guess, finally, one of the things that we learned in Wave 1 was some of the homes asked us to help them with staffing with the process of staffing, so we used some of our HR -- we never thought we would redeploy HR team, but we did. We've sent people from the Human Resources Department to help with the onboarding, the hiring, the engagement, the process of staffing.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, before you go on, I'm having a little

difficulty with the sensitivity piece. Now, we've heard this statement over and over again that this is their home; it's not a hospital or a -- but it isn't really exactly like your home because, first of all, you can be moved to -- I don't know -- against your will. But you can be moved to a different room. You can't have visitors the way you -- I'm having a little difficulty with the analogy. It seems to me it's imprecise.

BRIAN HODGES: I would agree with the word imprecise. I think that IPAC -- I'm a, as I mentioned again, a psychiatrist, so my knowledge of infection prevention and control rests heavily on me consulting with our experts. And what I've learned from them is there's a lot of shades of gray in what are acceptable practices.

I think for all of us, including the acute-care hospitals, we recognize that a four-bed room is -- no matter where it is, is of such a high risk that it's really a problem.

I would say when you come to things like, you know, fabrics and chairs and fomites, there's debate in the field about how much that does or doesn't transmit.

But I would agree with you that homes

that I had the pleasure of seeing that have been built recently or in the past several years are constructed of materials and in ways that make it much easier to conform to the IPAC standards; whereas there are places where, I think -- and this would be true of hospitals including our own -- that were built to a different standard many years ago and that no one would recognize as ideal in terms of infection prevention and control. So in the hospital, we are pretty aggressive about that.

I'm going to just add that I mentioned that I'm also someone with parents of -- my mother just died a few weeks ago in long-term care, and my father is in a home.

On the other hand, we're all aware that there was a period of time before the essential visitor policy was elaborated where a very strict ruling meant that there was no family access. I experienced that for four months when I couldn't see my mother before she passed away.

So I think that some of this is couched in the terms of how extreme should the measures be and what is -- what is reasonable, and I would believe there's a lot of gray there.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right.

BRIAN HODGES: Would you like to talk about the resident support aide and the PSWs?

COMMISSIONER FRANK MARROCCO (CHAIR): I think so. I don't think we have any further questions up to this point.

BRIAN HODGES: I see Marnie's online, so maybe I will talk about the PSW Registry for you, very pleased to speak about this and just give you a little history. I think, for many reasons, the story of the Registry has had not very much visibility, and I think understanding it and all the work that went into the background is potentially helpful with one area that I know you're looking at which is the health human resources and the whole profession and specialty of personal support workers.

Without going into over length, I would preface by saying there is a final report of this project that was completed just as the calendar clicked into 2020. Right as COVID was hitting, Marnie Weber and Allison Henry in the Ministry were the operational leads with Sydney Redpath from the Michener Institute. The original sponsors were myself and Denise Cole; then she was the Assistant

Deputy Minister; and then this passed on when the government changed to a new group that continued to support it.

Long story made short, there was an earlier attempt to create a PSW Registry. It was not successful for a number of reasons including privacy and the rigor of the Registry. The ministry, at the time, under the Wynne Government, commissioned an expert from England from something called the Professional Services Association to do an extensive report of -- and examination of the Registry and make recommendations.

In the United Kingdom, there are many areas of work that are part of a registry. Ontario has very few or no registries. There are few examples in Canada. In British Columbia, there is a registry now for personal support workers.

So the government was interested in exploring whether there was a model a bit short of a college. The College structure is very elaborate and also very expensive and based on membership fees. There was a recognition that it would be unlikely that PSWs would be able to pay the membership fees necessary to sustain a full college. So the report suggested a registry, and

the -- first the Wynne Government and then the Ford Government engaged with us at Michener, and we spent two-and-a-half years building a prototype of a Personal Support Worker Registry, a very large advisory committee -- and Marnie can speak to this -- a very large advisory committee with members from all over the province, the sector, the unions, the personal support workers themselves, the organizations, et cetera, participated. It was co-chaired by Marnie and Ministry colleagues, and it created a model which exists. The Registry was created. It was pilot tested. It had a lot of features built into it, and it was then prepared -- ready to be transitioned. This was always the plan that, after it was built, it would be transitioned to the care of probably one of the large colleges to oversee and regulate and operate.

And that process was to happen in the spring, but when COVID happened, it was paused. So the Registry sits -- sits bare, dormant, and the report is available, and the report makes some recommendations from the advisory committee that were jointly derived by our team and the Ministry.

COMMISSIONER FRANK MARROCCO (CHAIR): So is the idea, Doctor, that if you get into

difficulty, they can strike your name off the Registry, and then you can't --

BRIAN HODGES: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): -- work as a PSW anymore?

BRIAN HODGES: Yes. There's a number of features to it.

And, again, Marnie, if you're there, maybe this might be a moment to invite you to say something if the Commission would like that.

The structure -- a registry is less than a college, so some similar features, not all the same. So a registry is rigorous in that there's credentials required to be on it. You improve things like the vulnerable sector check. You're training. There was a standardization of access to it. It was built originally with a model whereby the relationship was with employers.

One of the challenges of a registry in contradistinction to a college is the disciplinary piece. So just as you've said the idea would be that if a PSW was reported to the Registry to have been disciplined or let go, they could be struck from the Registry, and this would be public facing that.

COMMISSIONER FRANK MARROCCO (CHAIR): Who would conduct a hearing?

BRIAN HODGES: Well, that was the issue. The model was based on a memorandum of understanding with each employer that the employer would be responsible for ascertaining good standing of the employee and that they would report to the Registry if that was not the case. There was a lot of discussion about this, and the -- there's a model built into the report that suggests a more rigorous disciplinary model, should it be transferred to a major college, that they could use some of their disciplinary mechanisms to do that.

I should say that one of the things that's always been believed by us and by the Ministry, that this would only -- any of this would only work if it was mandatory.

In the absence of it being mandatory to join the Registry, there's not very much hope that --

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

BRIAN HODGES: -- it would be a robust process to guarantee the safety to the public which is one of the main reasons to --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, most professional disciplinary or regulatory authorities --

BRIAN HODGES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- your obligation is mandatory.

BRIAN HODGES: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): There's usually a charge with it, and you pay for it, and --

BRIAN HODGES: That's right. I might invite Marnie to -- Marnie Weber is with us at UHN, and Michener was the lead of this together with the Ministry, and has a great deal of expertise.

Marnie, did you want to -- would you like to make comments about this?

MARNIE WEBER: Yes, I'd love to. Thank you, and my apologies for my rather unceremonious entrance.

When the Ministry looked at PSWs, they found that it's the second largest workforce in Ontario, and it's the largest unregulated workforce in Ontario. So there are, as you probably know, 122,000 PSWs; 8,000 graduate each year; 70% work in home and community; that's some 86,000 PSWs work in

the home; and about 36,000 work in long-term care.

So it's a very significant touch points with clients and residents. And when the Ministry looked at this, it's an entirely unregulated profession, sometimes very isolated and not visible in home practice, little more visible in long-term care homes.

The types of activities around client care that they do: bathing, feeding, dressing, toileting, walking, nutrition. They do client assessments, clinical assessments, blood pressure, temperature, continence. They do delegated acts, suppositories, enemas, medications, wound care, dialysis support.

And so the Ministry came back, as Brian was describing, to say, what would a PSW Registry look like for the Province of Ontario to help assure the safety of practice in the home and in long-term care homes.

And when we looked at other jurisdictions, England, B.C. has moved to now recommend that their PSW Registry be moved under the College of Nursing, and that's something that we think is probably the right model for Ontario because the interrelationship between PSWs and

nursing is quite significant.

When we developed the Registry -- and as Brian says the reports with the Ministry, it's not been publicly released -- we went about looking at the core elements for a registry, Code of Ethics -- and these are all very defined in the report -- core competency, profiles, roles and responsibilities none of which exists, so perhaps to Brian's comments about why would a PSW walk away? There is no Code of Ethics, core competencies, responsibilities.

The Registry also recommended the fair processes as you've just commented on, around complaints, a risk-based complaint process with all of the same checks and balances as would be under the RHPA; disclosure of status, registration process that both includes new grads. There is a standardized provincial curriculum for PSWs. Having the Registry would help continue to refresh that in a way that --

COMMISSIONER FRANK MARROCCO (CHAIR): If I can interrupt for a second. How would -- I mean, if the home -- if the employer had responsibilities as far as a registry's concerned, there's a staffing shortage, so would the employer

not be, kind of, conflicted in the sense that if you strike a person off the Registry, it's one less person working for you? Would that -- was that -- is that just theoretical, or is that real?

MARNIE WEBER: That was actually why we moved way from an employer-based model and we went under an existing college where the obligations of the employer to report practice would be similar to nursing.

So we were trying to make sure that the focus was on the safety of the clients, the residents as opposed to perhaps an employment model.

The Registry would actually also give a window into the human resources planning. Where do people -- where do the PSWs practice? Where are their shortages? What is the mobility throughout Ontario or people leaving the profession of PSWs, quickly after they graduate, for instance?

So we were definitely moving away from -- and, in fact, that model did not get support. The employer-based model had neither support from the employers nor from the PSWs themselves.

COMMISSIONER FRANK MARROCCO (CHAIR):

The College of Nurses, let's say, if that was the overarching body, would experience costs in terms of this registry, investigating complaints, paying people to adjudicate the complaints, and so on, and there may even be an appellate that you may even create --

MARNIE WEBER: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- an internal appellate procedure --

MARNIE WEBER: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- because sometimes you do that. How does that get paid for? Because I thought earlier the idea was that the PSWs would likely not be able to afford at least their own college which -- I mean, which I can sort of understand from the perspective that you just don't create these self-regulating bodies because you pass a law. That is not nearly the problem.

But how -- who would pay the College? How would that work?

MARNIE WEBER: So we did look at all of the College fees that exist currently. The size of a PSW Registry allows for the fees that we actually recommended to be about $50 a year because if it's

mandatory at 122,000 people, and also being able to have the opportunity for the efficiencies of another college -- the IT systems are there; the web links are there. Some of that startup is actually lower, and we did look at that.

So, for instance, in Ontario, there's 175,000 nurses. Their college fees are $270 a year. PSW at 122,000, we suggested 50, so we dropped as low as we could get it. Some people suggested zero, that there be no fees, but we felt 50 was reasonable.

So we think we've got a low barrier, and what we heard a lot from the PSWs was this would elevate their practice into the interdisciplinary team, so the work they do, the safety of understanding the client from day to day from shift to shift, by having a registry would say it matters. What we do matters. We have a clinical role to play. We're not a contract provider like a porter or like someone who is not as integral to the client care. And so we had very positive reception from the PSWs to say, this is what we're missing.

COMMISSIONER FRANK MARROCCO (CHAIR): What was the attitude of the College of Nurses?

MARNIE WEBER: At the time, they had been receptive and understood that it was a match to the practice of nursing and PSW. They're very linked, and so we had a bit of a touch point at the beginning of the process, and we left it back to the Ministry where the report now is at on whether they wanted to pursue that particular college. It resonated with the Ministry. It's how B.C. is doing it, but, again, the report is a recommendation to the Ministry at this point.

So we think it's a positive fit. It certainly was well understood why the College of Nurses would be the appropriate place to link in the PSW Registry.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, do you have a question?

COMMISSIONER ANGELA COKE: I was going to ask about the reaction, obviously, of the PSWs, and from what I'm understanding from you, they're seeing this as more professionalization and so a good thing.

I'm curious about what were any concerns from the Unions' perspective.

MARNIE WEBER: The Unions were extremely positive. Where they felt it absolutely

had to have very clear complaints processes, actions that the Registry would take, we defined certain behaviours around elder abuse and some of the abuses as an immediate suspension. They wanted, exactly as you've described, processes that followed judicial standards. Currently, PSWs do have responsibilities to their employer, but they felt that having that transparency at the Registry level actually was very positive. The Unions felt it was extremely important to elevate, and that was one of the reasons why recruitment was so difficult.

So we had very positive -- we had positive response from advocacy groups for seniors, so I think we've got a good place to actually move this forward.

COMMISSIONER JACK KITTS: So I don't know if this is for Brian or Marnie, but we've talked a bit about the risk-benefit analysis. Are you able to share the report with us, the report that you made --

R/F MARNIE WEBER: Unfortunately, Jack, we can't because we've submitted the report to the Ministry and even as early as this morning because I, sort of, anticipated you might ask that. They

said please let the Commissioners know that, if they would like the report, to request it directly to the Ministry.

COMMISSIONER JACK KITTS: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): We have numerous outstanding requests for documents.

MARNIE WEBER: Oh, do you.

COMMISSIONER FRANK MARROCCO (CHAIR): We'll add this to the list.

MARNIE WEBER: I think they know you're going to ask.

BRIAN HODGES: Yes.

MARNIE WEBER: So I think the other part that is so crucial is public trust, and so by having the visibility of the Registry, we recommended that residents and family be on the various committees, and so I think that's important about safety and quality.

We looked at pathways to registration, both our existing education processes in Ontario which are quite varied from college to night school, as we used to call it, to reciprocal pathways to registration with other provinces whose

curriculum is very similar to Ontario, and as well, the measure of competency for practicing PSWs who maybe just because of experience have become very good PSWs.

So we developed competency assessment tools. We developed mentorship processes. We developed equivalency of hours of work to be an equivalency to one of the indicators around competency. We looked at mentorship that if skills perhaps needed to be buffed up a bit, how would mentorship fit into a PSW. PSWs very much wanted that the Registry itself provide a value to them as practitioners.

And so -- and I'm sure Brian will talk about this -- things like palliative care, things like clients with responsive behaviour, dementia, the increasing complexity of clients in long-term care homes and at home. PSWs said part of what the Registry can give them is a sense of what are their standards of practice but also continuing education, validity, and even directional to say, listen, you know, we've got a whole bunch of things happening around care, and the Registry can be that resource to them.

So it was -- it was a really, really

rich experience. We had focus groups. We made presentations to conferences. People could provide input. The website at Michener was open for input. We had PSWs on our committees. We had associations and employers on the committees, practicing managers.

COMMISSIONER FRANK MARROCCO (CHAIR): Was there a discussion with the College about participation by the PSWs in the governance structure? If you're going to be -- if you're regulating me, I should -- I should be able to elect somebody to the governing body.

MARNIE WEBER: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): Were they -- was the College okay with that?

MARNIE WEBER: Yes. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Or was that not suggested?

MARNIE WEBER: Oh, no. No. It's totally suggested, and, yes, there -- all of the colleges have that as some of the principles under the RHPA.

So it would -- so totally accepted, totally understood that part of a complaints review, and you could imagine, I'm sure, with

dementia, so clients often lose things or accuse: Somebody took my watch. So there was very much a sense that those complaints in populations had to have -- had to have a family member's -- and processes that understood a complaint versus something that might be a part of the disease processes. No, it was very, very supportive.

COMMISSIONER FRANK MARROCCO (CHAIR): But I guess -- I don't know. Maybe we're talking about the same thing. I just want to make sure we are.

You have 122,000 members, then, suddenly. If you're the College, you're now supervising 122,000 people. They're paying a sum of money for you to engage in that supervision, but it would stand to reason, perhaps, to them, anyway, that the body imposing the discipline, that they should have some participation in the governance structure of the regulator because that's certainly not unheard of in the province.

And I was just wondering how the -- the regulatory body, the College of Nurses reacted to the idea that they were going to get some more help governing --

BRIAN HODGES: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- the College.

BRIAN HODGES: Perhaps I could just suggest --

And, Marnie, correct me if I'm wrong.

The Ministry always ask us -- and I would underscore how terrific the partnership has been -- that this -- what's called Novation (phonetic), I think, is the legal term of the Registry to a college would be an activity of the Ministry.

And so the degree to which we discussed or connected with the various colleges was quite limited. The original PSA Report actually recommended four or five different colleges that could potentially host a registry.

So our report recommends the -- what Marnie has described for you, but -- and there was -- there is a sense that that would be an appropriate way to go, but I think the Ministry was quite clear with us that the detailed discussions of how this would work with the College once we've turned over the Registry, as we have, would be a discussion between the Minister of Health and that college.

COMMISSIONER FRANK MARROCCO (CHAIR): So your perspective was there should be a registry, and it should be administered by a college, an established college, example, the College of Nurses, and then that was the end of the --

BRIAN HODGES: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I understand.

BRIAN HODGES: Yeah. Yeah.

MARNIE WEBER: We did look at governance in the sense of a director, so we went to build a little bit of what that might look like. So we designed a position called the Director of the Registry that would report to the governing counsel. The governing counsel's membership would include PSWs.

We did anchor the inquiries committees, discipline and registration committees into College of Nurses which was our recommended college. We had -- we created a PSW advisory committee where, again, complaints, registration, and practice would have PSW input and also help increase the adoption of the registration over a certain time period.

COMMISSIONER FRANK MARROCCO (CHAIR): It would be interesting to be a fly on the wall

when they're having discussions about who can do what. What can a nurse do? What can a PSW --

BRIAN HODGES: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): -- do?

MARNIE WEBER: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, you know, internal to the College, there will be somebody --

MARNIE WEBER: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- pulling out their hair. But that doesn't really matter. It's still -- it's still somebody's got to regulate. I mean, I want to -- don't want to come to a conclusion prematurely, but --

BRIAN HODGES: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- you would think if you're providing services to the public, that somebody should regulate you --

BRIAN HODGES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- in some fashion.

BRIAN HODGES: Yes. And when -- and when you're ready, we can transition, as soon as this topic's exhausted, to the part Marnie's

alluding to which is the development of additional competencies and new roles in the -- in the sector to --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

BRIAN HODGES: -- bolster health human resources because I think that's one of the issues that arises immediately when people start to look at scope of practice, and is the distribution of scope and the number and competencies of professionals in the system appropriate and adapted for what needs to happen in long-term care.

COMMISSIONER JACK KITTS: Brian or Marnie, do you know, at the present time, the College of Nurses includes both RNs and RPNs; is that correct?

BRIAN HODGES: That's correct.

MARNIE WEBER: Correct.

COMMISSIONER JACK KITTS: So all three workers would be in the same College?

BRIAN HODGES: Yes. And at a national level, the Canadian Nursing Association has reunited with the leadership in the RPN world. And I was at their national conference, and they are messaging very clearly the continuum of care and

the importance of drawing people in across the whole spectrum including RPNs, RNs, and nurse practitioners.

COMMISSIONER JACK KITTS: Thank you.

BRIAN HODGES: Perhaps if it's appropriate, I could share a few minutes on both the new program that the Ministry has created with us in the last two weeks for residents or aides for long-term care and also the available provincial eLearning platform to -- for advanced skills to work in long-term care, just very briefly. Is that appropriate?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. That would be fine.

BRIAN HODGES: Yeah. Okay. So just very briefly, on the first note, the homes collectively in the Ontario Long-Term Care Association and others have spoken very much about the range of health professionals and workers available and the shortage in many areas. And it was noted by the Ministry that many homes were engaging nonclinical staff to pick up some of the burden from the registered staff and the PSWs.

So, for example, the -- I -- we've spoken about the visitor policies, the need to

connect through iPads to families, the portering functions that -- so there has -- there has been quite a shortage of helping hands beyond the professional group.

The Ministry approached the Michener Institute and the UHN and the Ottawa Hospital, and now two other hospitals in Mackenzie Health and Trillium to create a provincial program for those who are currently underemployed either in student programs or the hospitality industry to rapidly retrain to be deployed as a workforce into the long-term care sector in a role that has been approved as an RSA or a resident support aide which was launched on Friday.

The curriculum was built quite rapidly. There's a screening process through a provincial portal which was established in Wave 1, but now they're streamed to a 15-hour training program and then matched through the human resource departments currently of the University Health Network, the Ottawa Hospital, Trillium, and Mackenzie, and the intention is to roll it out to the province and then matched through any home that has a shortage of hands, of help to add a support role, again, to say not in the professional ranks, not as a PSW or

an RN or RPN, but to bolster them.

The Ministry has done groundwork to try to understand what the demand is for this, and the belief is that several hundreds or even thousands of people could potentially be available through this program to add extra help into homes that are either green, no outbreaks, or yellow, which is teetering, not into homes that are in active outbreak which is a totally different story.

So just to tell you that this was soft-launched on Friday. Communication went to all the colleges and universities in Ontario and a number of other stakeholders, and the -- and we have a trickle of people coming through the program. And the intention is, I believe, that there is to be a Ministry announcement of this around the 9th of November.

There have been many, many stakeholder meetings with long-term care sector and many other sectors including colleges and universities, so I just thought I would let you know because that's a very recent development.

And I don't know if there's questions about that, but related would be one other thing that I do think was helpful and important. You'll

wonder why I'm going to start with critical care, but you'll understand in one minute.

So in the first wave, and Jack would know this as Kevin, what happened was we were very terrified watching reports from Italy and the United States about critical care units be overwhelmed and running out of ventilators. So the Ministry of Health asked the Michener Institute to rapidly create an eLearning training program for health professionals who might have to go work in critical care that had never worked in critical care.

So we did. We have something. It was built called criticalcarelearning.ca, and it was made available to 192 hospitals in Ontario, and a lot of people signed up for this. It turned out that not that many redeployments were necessary into critical care.

So in the first wave, they came back and they said, could you do something with this interesting platform for long-term care? You and others seem to be sending a lot of nurses and doctors and others to long-term care, and our feeling is that they may not know that context. So it would be really important before they go that

they have something to provide knowledge for them and safety.

So modules were created with a collaborative that included Baycrest and George Brown College and others largely built on the PSW curriculum from several schools.

And so the long-term care curriculum online is now very robust, and it's available to all hospital resource partners and all 660 home -- I think there's 660 long-term care institutions. And it's very widely used. More than 10,000 people are using this regularly to learn about and to understand the context of long-term care.

My own CEO, Kevin Smith, volunteered for a shift as a PSW to rally the troops, and he did the learning modules on COVID care learning before he went to learn about long-term care, care and feeding, et cetera.

So that platform has proven very useful. It's free. I can give you the information on how to look at it. It's had much more added to it now like ethics and models of care and team-based care and wellness, et cetera. And now we're using that same platform for this, resident support a program which will allow folks going into

long-term care to do their eLearning. And one other group which is we've discovered that every home has or should have an education coordinator who onboards new staff and teaches them safety, like personal protective equipment. So we've created a mentoring and support program for the education leads in each long-term care home, and that's a section of the website as well. So I --

COMMISSIONER FRANK MARROCCO (CHAIR): That would be very helpful if we could get access to that. Thank you.

U/T BRIAN HODGES: Definitely give you access. It has a password access, but only once, and that's just to set up an account so we can actually track who has used the platform so we can communicate with them. I'll arrange for you to get that information.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

BRIAN HODGES: Any questions? Yes?

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

COMMISSIONER ANGELA COKE: Just on the resident aides, I'm just -- I understand the concept totally. I'm trying to figure out how you

avoid some of the issues that the PSWs experience now that you have another layer lower than that.

BRIAN HODGES: Yes.

COMMISSIONER ANGELA COKE: I use that term in that way.

BRIAN HODGES: Yes.

COMMISSIONER ANGELA COKE: And just also curious about what the Union's response was to this new, sort of, category --

BRIAN HODGES: Yes.

COMMISSIONER ANGELA COKE: -- and how that fits into the scheme of things.

BRIAN HODGES: Yes. Great questions. So I should just tell you the leadership structure of this. So it's come from Ministry of Health, and Michael Hillmer and David Lamb are the leads on the Ministry side reporting to Helen Angus.

And on our side, Kevin Smith, in his role as the incident management chair for the Province is the sponsor, so the day-to-day work is done by myself and Maria Tassone who is our Director of Interprofessional Education at the Michener.

The -- definitely those issues have arisen, and there are -- have -- every day, there's

four or five stakeholder calls and discussions. The unions, in particular, have been largely supportive of the role with a few important caveats, obviously. This is a temporary workforce. The -- I mentioned that it's the human resources departments of the large hospitals that are employing these folks, and the reason for that is to provide the WSIB support and the robust onboarding that a hospital can provide.

However, the first appointment is -- has got an eight-week timeframe, and at any point during that time, the home can hire the person permanently if they wish. And at that point, any rules or regulations or union affiliation that is normal in the home can apply if it applies in that home. If it doesn't, it doesn't.

I believe that they've -- they have messaged that most people feel comfortable if this is a short-term Wave 2 phenomena and that it's built such that the intention is not that the hospital will be the long-term employer of resident support aides, only that we use the mechanism of the hospital to rapidly deploy them, and then they will be picked up into the employment context of each home as totally under the jurisdiction and in

the hands of the homes that wish to have them.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, there are no other questions. Doctor, thank you. Thank you very much. It was very informative. We've been struggling with how you would -- about -- at different times in our discussions with how would you effectively regulate the staffing model, whatever it may be. And this is extremely helpful from our perspective, and thank you very much.

And thank you, Ms. Weber, for your assistance. And we may be back. We, kind of, never go away permanently. So you may hear from us again.

BRIAN HODGES: It's our pleasure.

MARNIE WEBER: It is a pleasure.

BRIAN HODGES: And we'll make ourselves available at any point as -- yeah -- [indecipherable].

MARNIE WEBER: Absolutely. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you both.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 9:52 a.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 6th day of November, 2020.

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NEESONS, A VERITEXT COMPANY
PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Page 10, line 18 should read “residence” not “residents”

Page 32.... line 19..... Should be " play "..... not " pay"

Page 33 ....line 4 .... Should be " a bit of a touch point"..... rather than " bid.... put"