

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)

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

3

4 PARTICIPANTS:

5 Alison Drummond, Assistant Deputy Minister,
6 Long-Term Care Commission Secretariat

7 John Callaghan, Counsel, Long-Term Care Commission
8 Secretariat

9 Derek Lett, Policy Director, Long-Term Care
10 Commission Secretariat

11 Lynn Mahoney, Gowling LLP

12 Ida Bianchi, Counsel, Long-Term Care Commission
13 Secretariat

14 Dawn PalinRokosh, Director, Operations, Long-Term
15 Care Commission Secretariat

16 Jessica Franklin, Policy Lead, Long-Term
17 Care Commission Secretariat

18 Adriana Diaz Choconta, Senior Policy Analyst for
19 the Operations Branch, Long-Term Care COVID-19
20 Commission Secretariat

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22 ALSO PRESENT:

23 Janet Belma, Stenographer/Transcriptionist

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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

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 So we're -- are you waiting for anybody else,

4 Doctor? Or are you going to do this yourself?

5 BRIAN HODGES: I'm going to do most of

6 it myself. A little later in the call,

7 Marnie Weber is going to join. She was the co-lead

8 on the PSW project with the Ministry of Health, and

9 I can start briefing that, but she's going to join,

10 when she's able, on that piece. And there's two

11 other items before that I thought maybe, at your

12 pleasure, I could talk to you about before she

13 joins.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Well, that would -- that would be great. We're --

16 as you know, we released a first preliminary report

17 there.

18 BRIAN HODGES: Yes.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 We haven't yet concluded whether there will be a

21 second preliminary report or whether we'll just

22 report at the end.

23 BRIAN HODGES: Fine.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 But we're working our way through it.

1 BRIAN HODGES: Right.

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

5 BRIAN HODGES: Yes, absolutely.

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

9 BRIAN HODGES: Yes.

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

12 BRIAN HODGES: Yes.

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

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

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

1 The first is UHN's own actions in
2 regard to supporting 15 long-term care homes and
3 5 retirement homes during the first wave of the
4 pandemic and, again, in the second wave.

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

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

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

1 Ministry and ourselves.

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

8 Marnie. Marnie, we hear you.

9 COURT REPORTER: I'll mute her.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Janet, can you mute --

12 BRIAN HODGES: Yes.

13 COURT REPORTER: Yeah.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 -- Ms. Weber --

16 BRIAN HODGES: Mute Marnie.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 -- before she says something that she regrets.

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

3 BRIAN HODGES: Okay. Great.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Yesterday, we sent out another request

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

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

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

21 BRIAN HODGES: Please.

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

1 identify where it is.

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

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

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

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Commissioner Kitts.

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

6 BRIAN HODGES: Yeah, two of our own
7 with whom we have legal ownership or contracts; 13
8 long-term care homes that were assigned to us; and
9 5 retirement homes.

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

13 BRIAN HODGES: Yeah.

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

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

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

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

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

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

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

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

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

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

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

1 outbreak at least at a hospital standard is a big
2 challenge for some of the older homes, particularly
3 those with multiple clients, patients in a room.

4 I've missed one, IPE (sic), Environmental Services.

5 COMMISSIONER JACK KITTS: Staffing?

6 The --

7 BRIAN HODGES: Oh, staffing.

8 COMMISSIONER JACK KITTS: Yes.

9 BRIAN HODGES: Staffing, of course.

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

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

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

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

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

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

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

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

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

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

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

25 But I would agree with you that homes

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

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 All right.

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

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

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

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

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

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

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

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

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

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

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

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

3 BRIAN HODGES: Right.

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

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Who would conduct a hearing?

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

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

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

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Right.

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

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

4 BRIAN HODGES: Yes.

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

7 BRIAN HODGES: That's right.

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

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

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

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

20 When the Ministry looked at PSWs, they
21 found that it's the second largest workforce in
22 Ontario, and it's the largest unregulated workforce
23 in Ontario. So there are, as you probably know,
24 122,000 PSWs; 8,000 graduate each year; 70% work in
25 home and community; that's some 86,000 PSWs work in

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

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

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

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

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

1 nursing is quite significant.

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

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

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

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

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

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

7 MARNIE WEBER: Yes.

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

10 MARNIE WEBER: Yes. Yes.

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

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

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

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

6 So, for instance, in Ontario, there's
7 175,000 nurses. Their college fees are \$270 a
8 year. PSW at 122,000, we suggested 50, so we
9 dropped as low as we could get it. Some people
10 suggested zero, that there be no fees, but we felt
11 50 was reasonable.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 COMMISSIONER JACK KITTS: Okay. Thank
5 you.

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

9 MARNIE WEBER: Oh, do you.

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

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

14 BRIAN HODGES: Yes.

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

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

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

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

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

25 So it was -- it was a really, really

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

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

13 MARNIE WEBER: M-hm.

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

16 MARNIE WEBER: Yes. Yeah.

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 But I guess -- I don't know. Maybe we're talking
10 about the same thing. I just want to make sure we
11 are.

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

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

25 BRIAN HODGES: Yeah.

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

3 BRIAN HODGES: Perhaps I could just
4 suggest --

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

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

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

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

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

6 BRIAN HODGES: That's correct.

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

9 BRIAN HODGES: Yeah. Yeah.

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

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

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

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

3 BRIAN HODGES: Right.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 -- do?

6 MARNIE WEBER: Yeah.

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

10 MARNIE WEBER: Yes.

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

16 BRIAN HODGES: Yeah.

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

20 BRIAN HODGES: Yes.

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

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

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Yeah.

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

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

17 BRIAN HODGES: That's correct.

18 MARNIE WEBER: Correct.

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

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

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

4 COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

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

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

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

1 an RN or RPN, but to bolster them.

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

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

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

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

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

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

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

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

1 they have something to provide knowledge for them
2 and safety.

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

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

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

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

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

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

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

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Thank you.

20 BRIAN HODGES: Any questions? Yes?

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

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

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

3 BRIAN HODGES: Yes.

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

6 BRIAN HODGES: Yes.

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

10 BRIAN HODGES: Yes.

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

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

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

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

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

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

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

1 the hands of the homes that wish to have them.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, there are no other questions. Doctor, thank
4 you. Thank you very much. It was very
5 informative. We've been struggling with how you
6 would -- about -- at different times in our
7 discussions with how would you effectively regulate
8 the staffing model, whatever it may be. And this
9 is extremely helpful from our perspective, and
10 thank you very much.

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

15 BRIAN HODGES: It's our pleasure.

16 MARNIE WEBER: It is a pleasure.

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

20 MARNIE WEBER: Absolutely. Thank you.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Thank you both.

23 COMMISSIONER ANGELA COKE: Thank you.

24 -- Adjourned at 9:52 a.m.

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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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PER: JANET BELMA, CSR

CHARTERED SHORTHAND REPORTER

1 Page 10, line 18 should read "residence" not
2 "residents"

3
4 Page 32.... line 19..... Should be " play ".....
5 not " pay"

6
7 Page 33line 4 Should be " a bit of a
8 touch point"..... rather than " bid.... put"

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