Long Term Care Covid-19 Commission Mtg.

CanAge
on Tuesday, December 22, 2020

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7 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14 --- Held via Zoom, with all participants attending
15 remotely, on the 22nd day of December, 2020,
16 2:00 p.m. to 3:18 p.m.
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1 BEFORE:
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3 The Honourable Frank N. Marrocco, Lead Commissioner
4 Angela Coke, Commissioner
5 Dr. Jack Kitts, Commissioner
6
7 PRESENTERS:
8 Laura Tamblyn Watts, President and CEO, Canada's
9 National Seniors Advocacy Organization (CanAge)
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11 Diana Cable, Director, Policy and Advocacy,
12 Canada's National Seniors Advocacy Organization
13 (CanAge)
14
15 Sarah Pillersdorf, Policy Officer, Canada's
16 National Seniors Advocacy Organization (CanAge)
17
18 Vanessa Sparks, Policy Officer, Canada's National
19 Seniors Advocacy Organization (CanAge)
20
21 Brett Book, Policy Officer, Canada's National
22 Seniors Advocacy Organization (CanAge)
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1 Lawrence Ly, Design and Knowledge Mobilization,
2 Policy Officer, Canada's National Seniors Advocacy
3 Organization (CanAge)
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5 PARTICIPANTS:
6
7 Alison Drummond, Assistant Deputy Minister
8 Long-Term Care Commission Secretariat
9
10 Ida Bianchi, Counsel Long-Term Care Commission
11 Secretariat
12
13 Kate McGrann, Counsel Long-Term Care Commission
14 Secretariat
15
16 John, Callaghan, Counsel Long-Term Care Commission
17 Secretariat
18
19 Lynn Mahoney, Counsel Long-Term Care Commission
20 Secretariat
21
22 Derek Lett, Policy Director Long-Term Care
23 Commission Secretariat
24
25 Dawn Palin Rokosh, Director, Operations Long-Term

1 Care Commission Secretariat
2
3 Jessica Franklin, Policy Lead Long-Term Care
4 Commission Secretariat
5
6 Adriana Diaz Choconta, Senior Policy Analyst
7 Long-Term Care Commission Secretariat
8
9 ALSO PRESENT:
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11 Janet Belma, Stenographer/Transcriptionist
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1 I N D E X
2
3 **The following list of undertakings, advisements
4 and refusals is meant as a guide only for the
5 assistance of counsel and no other purpose**
6
7 INDEX OF UNDERTAKINGS
8 The questions/requests undertaken are noted by U/T
9 and appear on the following pages: 9, 17, 23, 26,
10 33, 42, 46, 49, 53, 54, 65, 66, 69
11
12 INDEX OF ADVISEMENTS
13 The questions/requests taken under advisement are
14 noted by U/A and appear on the following pages:
15 None
16
17 INDEX OF REFUSALS
18 The questions/requests refused are noted by R/F and
19 appear on the following pages: None
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21
22
23
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25

1 -- Upon commencing at 2:00 p.m.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Good afternoon.
4 LAURA TAMBLYN WATTS: Good afternoon,
5 Justice.
6 COMMISSIONER JACK KITTS: Good
7 afternoon.
8 COMMISSIONER ANGELA COKE: Good
9 afternoon, everyone.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Well, I don't know if -- but we're -- I'm
12 Frank Marrocco; the Commissioner Angela Coke; and
13 Commissioner Dr. Jack Kitts, so we are the
14 Commission.
15 Janet is the transcriptionist, the
16 court reporter, who will be keeping a transcript of
17 what goes on, and we'll put that transcript on the
18 website.
19 So, Ms. Tamblyn Watts, are you --
20 you're here or not? Is there someone missing?
21 LAURA TAMBLYN WATTS: No. It's a
22 pleasure to meet you, Justice Marrocco. My name is
23 Laura Tamblyn Watts.
24 Dr. Kitts, Ms. Coke, it's lovely to
25 meet you today.

1 Our team members, I think, are rolling
2 in. We have one or two who are going to be joining
3 us, but perhaps I'll just take this quick moment to
4 introduce to you two -- three of our team members
5 who are here: Diana Cable, who's our Director of
6 Policy and Advocacy; Sarah Pillersdorf, who is our
7 Policy Officer; and Lawrence Ly, who's also a
8 Policy Officer and Designer For Knowledge
9 Mobilization. We will be joined by Vanessa Sparks,
10 who -- and we will also be joined by Brett Book,
11 but they're not quite here yet, I imagine they will
12 be here in a minute, but we don't need to wait for
13 them.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Well, you can. You know, we're a bit early. We're
16 a minute early if you want to wait. I think
17 Ms. Sparks just showed up.
18 LAURA TAMBLYN WATTS: Vanessa's just
19 joining us now.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 We're ready when you are, so if you want to wait,
22 we'll wait. If you want to start, that's fine too.
23 LAURA TAMBLYN WATTS: We're fine to
24 start. I will just let Vanessa roll in. Thank
25 you.

1 Perfect. So we're just starting our
2 introductions as well. And I just wanted to get a
3 little sense of -- you wanted the format. We
4 certainly have a presentation to share with you and
5 welcome any questions and opportunities to chat and
6 to connect at any point therein. I think we're
7 just at 2 o'clock now.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Well, why don't we do that. Why don't you present
10 it, and then if we have questions, we'll interrupt
11 with the questions, and that way, we don't have to
12 circle back.
13 LAURA TAMBLYN WATTS: That's great.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay.
16 LAURA TAMBLYN WATTS: Perfect. I'll
17 just share my screen now. We're all getting so
18 good at the technology, aren't we? Ah, it's
19 perfect. We're also joined by Brett Book, one of
20 our Policy Officers, so we have our full team
21 that's presenting here today.
22 COMMISSIONER FRANK MARROCCO (CHAIR): I
23 can now see your presentation. I think probably we
24 all can.
25 LAURA TAMBLYN WATTS: Thank you very

1 much. So thank you so much for the opportunity to
2 present to you today. We had a great conversation
3 with the Secretariat in advance who helped to shape
4 some of the areas that we thought might be of
5 particular interest to you.
6 U/T I also wanted to note off the top that
7 we'll be providing some written submissions and
8 some materials that the Secretariat has also
9 requested as well.
10 So I thought as an agenda, just as a
11 recommendation, I would start with a brief
12 introduction of our team and the organization
13 itself, a very high level, then move to a couple of
14 the key activities that we've been engaged in
15 during the time of COVID-19, again, particularly
16 focused on issues related to long-term care.
17 We'd speak about some of the key
18 challenges that we've identified and how we
19 identified those challenges. And then we have some
20 recommendations for change including some that are
21 longer that I propose to just show at a very high
22 level and leave it for the Commissioners to delve
23 into at your convenience, and them a summary of
24 recommendations that we think might be a quick and
25 easy way, really welcome any chance to engage with

1 questions and feel free to stop at any point on the
2 way through, but if that suits you, that's the arc
3 that we would follow today.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 That's fine.
6 LAURA TAMBLYN WATTS: Thank you. So to
7 introduce our organization, we're a not-for-profit,
8 non-partisan, independent seniors advocacy
9 organization, and we really work to bring the voice
10 of older adults to the table. We have a team
11 across the country and head offices at the
12 University of Toronto in the Institute For Life
13 Course and Aging in the Department of Social Work.
14 So we work on a variety of different
15 levels, and I'll share a little bit of some of the
16 activities that we do, but for those of you just
17 joining us, I'm also pleased to introduce to you
18 Diana Cable our Director of Policy and Advocacy and
19 some of our team members who are joining us today,
20 Vanessa Sparks, Sarah Pillersdorf, Brett Book, and
21 Lawrence Ly. So we're so pleased for them to also
22 have the opportunity to present to you.
23 Just a quick note about our mission:
24 We're really engaged in problem solving. You know,
25 as a seniors organization, we are always looking to

1 ensure that older adults can live vibrant and
2 connected lives, and we work fairly tirelessly with
3 public, private not-for-profit organizations and
4 engage both as an academic research partner with a
5 wide variety of organizations. We have more than
6 30 established partnerships, and we work with all
7 of the networks and centres of excellence across
8 the country as sort of the designated seniors
9 organization.
10 Just a quick, sort of, set of examples:
11 So we have formal MOUs with, I would say, a wide
12 variety of organizations, and as you can see here,
13 they move from research to international to centres
14 on aging and to local issues as well.
15 So we thought that we would just start
16 off by saying in plain language what we do. You --
17 we can see our vision, our division, but actually
18 functionally speaking, what are we doing on a
19 day-to-day basis?
20 So we are actively engaged in advocacy,
21 and what that can look like can range from
22 government submissions to media to working
23 collaboratively to make positive change. We have a
24 public outreach component, and I'm going to share
25 with you some of the voices of people who've

1 reached out to us during the pandemic.
2 So we have phone lines and info at
3 canage.ca. We connect, and we call people back
4 personally. We spend time on the phone. We help
5 to do systems navigation. It's not the primary
6 goal of our organization to do individual response,
7 but we answer every email and every phone call that
8 we get, and we help on a white-glove approach to
9 get resources or answer questions for people in
10 their times of need.
11 We engage in a lot of tool development.
12 Here's one example that we put on the slide here,
13 you know, trying to create answers and system
14 navigation supports for people as they're trying to
15 make it through. This is particularly true in the
16 time of COVID-19 where we've been working, I think,
17 fairly tirelessly as so many of our other colleague
18 organizations have.
19 So we've been trying to be creative and
20 engaged and work extremely collaboratively to
21 leverage the best possible response. We'll talk a
22 bit more about what that looks like.
23 We engage in policy development,
24 research, and, again, we support people across the
25 country, but our head offices are in Ontario. And

1 certainly, we spend a lot of time thinking about
2 the Ontario context.
3 I know from our colleague organizations
4 and from the excellent reports that you have put
5 out that you care a lot about the voices of
6 individual older adults, residents, family
7 caregivers. So I thought we would start off by
8 telling you a little bit of what we heard.
9 So these are all outreach to us by
10 email, and we all had permission to share. I have
11 taken out the names of the organizations and the
12 locations from where they came. An example:
13 "My mother is in assisted
14 living at this location."
15 In fact, it wasn't assisted living. It
16 was, in fact, a long-term care facility.
17 "She moved there after hip
18 surgery. She's not been allowed to
19 leave. We're desperate, confused,
20 and totally out of the loop."
21 On the right is an older adult in -- is
22 a resident of long-term care that we've been in
23 communication with supporting him through the
24 process. He's talking about being left in soaking
25 diapers. He's talking about how personal support

1 workers are run off the feet. They're worried.
2 He's expressing that he's very worried that the
3 managers are sitting around. I don't know. I
4 guess that's his experience. In our -- in our
5 experience, managers have been very, very busy, but
6 I wanted to give voice.
7 Here are two others:
8 "I'm wondering if you could
9 assist me with advocating for visits
10 for my mother who is in a long-term
11 care facility in Ontario. She's 97
12 and has several comorbidities.
13 Currently, Ontario families are
14 permitted one supervised visit a
15 week."
16 And then she goes on to really plea
17 because she can't get into those visits, and that's
18 a -- that's a -- certainly, a theme that we've
19 heard where there may have been established
20 policies, but people can't actually access the
21 policies.
22 You see here on the right-hand side,
23 concern at a broader level about where money is
24 being invested. And in this particular
25 circumstance, we are going to be talking about why

1 money is being sent into acute and long-term care
2 with a lack of investment at home support.
3 She says here:
4 "As you point out, home care is
5 the cheapest, most effective, and
6 most desirable form of senior care.
7 How do we get government to
8 rearrange its priorities?"
9 And then the one that spoke so
10 poignantly to me, I wanted to leave with you.
11 There's this one where we have from a caregiver
12 herself; she's speaking about the rapid decline and
13 that she's speaking about the fact that her mother
14 keeps asking to see for the family. They talk
15 about Skyping and outdoor visits, but it's not
16 enough. We say -- we have a little bit of a vision
17 into how her world was before with supports for
18 toileting and supper and washing down. And since
19 then, she has really deteriorated.
20 And the corollary is this is a voice
21 that we were supporting a resident in long-term
22 care. And I will just read it. It says:
23 "Please help me. They have
24 locked me in my room. I am alone.
25 I am scared. Help."

1 These voices have been resonating
2 through the work that we've been doing. Our
3 colleague Brett who's on this particular call today
4 has been the point person navigating through the
5 hundreds and hundreds and hundreds of outreach
6 responses we've had from people as we've been
7 trying to support them, family members, and care
8 providers.
9 We've had outreach from CEOs, outreach
10 from individual residents, and everyone in between.
11 I will never forget the day where I sat in this
12 particular office and answered the phone. It was
13 the end of March. It was a CEO of a long-term care
14 home south of Ottawa, and she was crying, and she
15 said, Laura, can you help? We have almost 90
16 residents, and I have no staff. And I said, what
17 do you mean you have no staff? She said I showed
18 up, and my administrative assistant showed up, and
19 we have to provide care for nearly 90 people. I
20 don't know what to do.
21 Those stories and those voices
22 encapsulate the experience from CanAge and really
23 drove our focus on trying to provide positive
24 change.
25 So I wanted to start off with a few

1 high-level observations. I think it's the lawyer
2 in me. I want to give the answer first, and then I
3 thought I would, kind of, take us through some of
4 the ways that we learned some of these key issues.
5 Compared to other jurisdictions, in
6 particular, I will use the jurisdiction of
7 British Columbia as a comparison, but we are a
8 Pan-Canadian organization, and we can speak to you
9 about jurisdictional response in each of our 13
10 Provinces and Territories.
11 U/T We also work at an international level
12 through our colleague organizations, and I'm
13 pleased to provide with you additional information
14 about how Canada has compared to some other
15 jurisdictions.
16 But Ontario stubbornly refused to
17 prioritise long-term care in the face of
18 all evidence. And when I say evidence, I don't
19 just mean evidence, but also, please -- please, to
20 look at what was happening in Asia, what was
21 looking at happening in Italy, then France, then
22 Spain. We knew what was coming, and yet the
23 Ontario Government, quite unlike the
24 British Columbia Government decided to exclusively
25 prioritise acute care, stockpile personal

1 protective equipment, and really turn its back on
2 older adults who were the most frail in a most
3 risky setting. I'm sure this is nothing that you
4 haven't heard before, but I wanted to share with
5 you that we were part of those pleas, and we were
6 part of the letter writing, and we were part of the
7 phone calls to say the prioritisation must be into
8 long-term care.
9 The lack of action by the Ontario
10 Government was, in fact, a critical failure, and if
11 we look at the comparison just even between the
12 British Columbia and the Ontario response, we see
13 the difference between implementing key measures in
14 the middle of March versus five, in fact, more like
15 six or seven weeks, and I'll speak about those
16 measures in a minute, but including things like
17 single-site staffing, prioritising of testing and
18 PPE, et cetera.
19 Because we didn't do that, we lost
20 hundreds and thousands of lives with a 10X loss of
21 life compared to jurisdictions, and we were able to
22 trace back the fact that so many of those, over
23 more than 90%, according to recent studies, can be
24 traced to that period of delay.
25 So the lack of action by the Ontario

1 Government in mid-March with clear warnings has led
2 to the loss of lives of thousands of older adults
3 in long-term care.
4 Another high-level key theme is that
5 the sector was, in fact, left alone. It was an
6 abandoned sector. It felt like there was a sense
7 of acceptable losses, and I'm not one prone to
8 hyperbole. It's not my mandate, and it's not,
9 certainly, the way that our organization functions.
10 But I do want to share with you the
11 urgency that organizations who are working in this
12 space felt to actually mobilise, and the dissonance
13 between the urgency felt on the ground and the
14 response led by Government.
15 I want to give one example: The CEOs
16 of most of the major organizations -- and I'll just
17 share with you some of those organizations on the
18 screen -- started coming together. I was having
19 bilateral conversations with many of them and
20 decided that we as a sector needed to get together
21 for weekly and sometimes daily meetings.
22 So the CEOs would get together, and we
23 would problem solve. We would share slices of
24 information that each of us might have or try to
25 problem solve cases and concerns like the CEO who

1 called me for whom I was able to connect with some
2 other resources, but it was just because she
3 happened to reach out to us that I was able to
4 reach into our resource group.
5 This should not be left up to
6 organizations. This should be led by Government in
7 a coordinated pandemic response. And one key
8 example is this: Because of the fairly remarkable
9 and stubborn refusal to prioritise personal
10 protective equipment and testing in long-term care,
11 we worked as a large group for the Ontario
12 Caregiver Organization to lead the charge in
13 calling for nail salons and hair salons to donate
14 masks and gloves because we could not keep staff
15 safe. We could not keep residents safe.
16 An actual public call for nail salons
17 and hair salons to step up and provide inadequate
18 but basic personal protective equipment, I think,
19 has been endemic and has been really a shocking
20 example of how the sector was abandoned.
21 A few more high-level observations:
22 That poor Government communication led to real
23 inconsistencies amongst staff and residents and
24 families. Again, I'm sure the Commission has heard
25 this before, but it's been our experience as well

1 what very poorly worded communication that came out
2 was interpreted broadly by different long-term care
3 homes, broadly by different staff members. It led
4 to frustration and confusion at a time where
5 clarity and Christmas was needed.
6 This was especially true around
7 visitation rules where we were working sometimes on
8 a one-on-one basis trying to support caregivers and
9 talk to administrators where we couldn't actually
10 get support more directly to help people get in by
11 saying no essential caregivers have been allowed.
12 The tales that we heard have been reflected in your
13 work as well, but our members spoke to us about not
14 being able to say good-bye, about having the
15 body -- and that's how it was described, not the
16 remains or the deceased or the loved ones, the body
17 pushed out the door, not being able to have the
18 most basic connection about even electronic
19 supports like Zoom calls or digital visits not
20 being supported. And we have great empathy for the
21 staff who are trying to provide care in a very,
22 very pressured circumstance, but the coordination
23 was not there, and many of the answers were
24 available, but they were not implemented.
25 We know that prior to COVID-19, we had

1 endemic staff shortages and ratio problems. We
2 know that we did not have integrated staffing at
3 different levels in the way that we've needed, but
4 that's been exacerbated to the point where we're --
5 been more concerned with the second wave in some
6 cases than the first wave because the existing
7 staff are exhausted.
8 We know that staffing and safety and
9 quality of care has significantly suffered and that
10 isolation and mental health has been combined with
11 a physical health deterioration due to the closed
12 doors.
13 I want to pull upon two key pieces as
14 well before we launch into a few other more
15 detailed aspects of our submissions, and that's
16 around vaccines. CanAge has a key priority around
17 vaccinations, and as we are looking towards a very
18 hopeful roll out of COVID-19 vaccine, we want to
19 say both that we have done a poor job of vaccine
20 rollouts on ones that we already know and already
21 have, and the corollary is that there's still an
22 opportunity to keep older adults, particularly
23 those in long-term care, but community-dwelling
24 older adults as well, safer right now by
25 implementing the viral pneumonia vaccine

1 Prevnar 13, which is currently only available for
2 people who are designated immunocompromised. One
3 of our key recommendations is to -- following
4 Theresa Tam's recommendations, consider everyone
5 over the age of 60 immunocompromised but certainly
6 those in long-term care.
7 And this would be analogous to how
8 we've prioritised the high-dose flu in long-term
9 care. But, of course, viral pneumonia has an even
10 poorer outcome than people who have had the flu.
11 Similarly, this is an opportunity to
12 implement a further level to Ontario's new Shingrix
13 program to reduce this -- shingles, and we could do
14 that as well. So I just wanted to point out our
15 concern about the flu vaccine roll-out this year
16 and the opportunity right now to still vaccinate
17 people for viral pneumonia and to implement the new
18 Shingrix program in long-term care.
19 One of the pieces I want to flag before
20 I move on is the great concern that we had when we
21 heard the Premier say that he had ordered enough
22 flu vaccine for everyone who wanted one. And that
23 was said many times during a number of press
24 conferences.
25 U/T And yet, the recommended NACI vaccine

1 rates are about 80%, and it is our understanding
2 that only enough flu vaccine was ordered for about
3 40% of the population, and we can provide you with
4 further information and supports as secondary
5 documentation on that. And so as we were trying to
6 get flu vaccine into people, we knew that there was
7 a critical shortage before we even started.
8 I was asked to write for the American
9 Bar Association's Commission on Law and Aging, an
10 article talking about Canada's response to the
11 coronavirus, and I was pulling upon different
12 aspects of how response was done in B.C. and
13 Alberta and Quebec and Ontario and the Atlantic
14 Provinces and so on. And I was very sorry to say
15 that I think Ontario had one of the poorest
16 responses and not for any particularly good reason.
17 The key differentiators that we were
18 able to identify for why we had such a poor
19 response is that we did not implement some of these
20 changes until much later, which I spoke about in my
21 introduction.
22 So by contrast, our CanAge Fellow,
23 Kerry Baisley, was in charge of the Lynn Valley
24 response in British Columbia in North Vancouver,
25 and our CanAge Fellow, who was working with

1 Dr. Bonnie Henry and others, moved very quickly to
2 a single site for staff restriction, moved to
3 create availability and prioritisation of long-term
4 care PPE including a 1-800 number that you could
5 call.
6 Now, I understand it wasn't perfect,
7 but compared to the Ontario system which sometimes
8 took three or four different levels to get PPE in,
9 this was a much more streamlined approach. They
10 never locked down in quite the same away and had, I
11 would say, a better version of essential caregivers
12 than we did in Ontario. That, again, wasn't
13 perfect, but it was better.
14 They moved earlier to create an
15 additional new level of staff to allow healthcare
16 providers to provide the hands-on care while
17 backfilling non-hands-on processes like
18 administration roles, cleaning, and so on.
19 They also had newer buildings on the
20 whole. As you know, of course, Ontario's building
21 stock is some of the oldest in the country, and we
22 certainly can see that it was difficult to cohort.
23 And I hate the term decanting, but it was -- it was
24 very difficult to cohort and move people around,
25 and there was a general reticence in Ontario to

1 move people who were sick with COVID-19 out of
2 long-term care into acute care. This underscores
3 the key theme of prioritising acute care and
4 leaving long-term care a little bit alone to suffer
5 and to spread.
6 U/T We were part of that OSCAR letter in
7 the summer, and, again, we'll provide those
8 materials to you. We have submitted letters that
9 have been sent out by CanAge and other OSCAR
10 members to the Government over the course of these
11 many months asking for residents of long-term care
12 to be moved into hospital setting, and that was
13 refused on many instances leading to both a
14 deterioration of that individual older adult, but
15 also to increased infectious spread, again, that
16 preservation of acute care over long-term care; we
17 believed it was agism in action.
18 We were pleased that there was the
19 connection with the LHINs eventually and with
20 hospitals eventually to support resident flow. It
21 has not been without its challenges, however,
22 because there has been a real clash of cultures
23 when the acute care supports came in. Grateful, of
24 course, happy to have the help and support, but we
25 would like to offer that there was a real cultural

1 dissonance between acute care supports particularly
2 having -- we were getting calls from people where
3 folks were coming into their rooms and wrapping up
4 all of their items and moving them out of the way,
5 concerned, confused, and crying.
6 We also know that in Ontario, with the
7 reduction of inspections, which, again, I know has
8 been a key theme that have been informing your
9 considerations, that the lack of comprehensive and
10 surprise inspections has been a challenge.
11 I would like to go further. I think
12 that we need to think about what we are actually
13 inspecting. You know, Ontario has no shortage of
14 things that it's inspecting. It is our submission
15 that we may be inspecting some of the wrong things
16 and setting up long-term care homes to fail,
17 prioritising tick boxes over quality of care.
18 In short, the civil rights of residents
19 were at either great risk or, in many cases,
20 violated. We saw the connection between the COVID
21 infectious spread, and we saw that this shared
22 experience for COVID-19 gave us, I think, to a
23 moment where we had the whistleblower report in
24 long-term care from the military. And this was
25 entirely consistent of what we were hearing from

1 our outreach.
2 One of the things that we do is policy,
3 and so we actually had these team members that join
4 us and many others work about five months around
5 the clock to create a National plan for aging for
6 Canada, something that we have been unique in the
7 OECD for not having and which speaks very
8 specifically to the issues that we share. And it's
9 called the Voices of Canada's Seniors. It's a
10 roadmap to an age-inclusive company, an
11 age-inclusive Canada.
12 There are 6 compass points, 40 issues,
13 and 135 very specific evidence-based
14 recommendations. We spoke with thousands of a --
15 key informants and policymakers across the country.
16 We analysed the literature. We reviewed the
17 systemic purviews. We had expert committees. We
18 spoke to the Archbishop of the Anglican Church of
19 Canada. We spoke to the guy next door.
20 And we were really also very interested
21 in hearing about other models of care. You'll see
22 that we talk about the Nordic models or the
23 Australians models of care include COVID response
24 and care at home. The roadmap is a flexible and
25 ongoing document. It speaks not just to COVID-19,

1 but has some specific recommendations about it
2 within.
3 I propose just at this very high level
4 to orient you to some of the key recommendations
5 and then conclude with a summary slide, and then I
6 would love to be able to engage in whatever
7 questions you have and happy, of course, to speak
8 more specifically to the key recommendations, if
9 that suits.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 That's fine.
12 LAURA TAMBLYN WATTS: So in our 'I',
13 the Voices of Canada's Seniors, we talk about
14 infection prevention and disaster response. And I
15 will just, again, go through this at a very high
16 level and then provide that summary piece.
17 You know, vaccines, which we're hoping
18 for, has been the hope and prayers of so many, have
19 been, in many cases, the most overlooked issue that
20 we could be engaging in for infection prevention
21 and disaster response. And one of those pieces is,
22 you know, we just need to cover the best in-class
23 seniors vaccines. We have, at this point, the
24 NACI, N-A-C-I, recommendations from the
25 Federal Government, and the implementation for

1 vaccines is at the Provincial level. But, of
2 course, then it's downloaded to local Public
3 Health. And by the time it ends up at local health
4 departments, it's a huge portion of the budget;
5 whereas if all NACI-recommended vaccines were
6 implemented for Canada at a Federal level or even
7 just at a Provincial level that was paid for the
8 Federal levels, it would cost about 1.5% of the
9 annual drug budget of Canada.
10 But when you're actually asking the
11 municipal local Public Health authorities to cost
12 out the vaccines, it's a huge proportion of the
13 budget. But at a minimum, the high-dose or
14 enhanced flu vaccine, the viral pneumonia vaccine,
15 and the shingles vaccine, there's only about 3% of
16 all Canadian seniors that are up to date on
17 vaccines. We could -- I'm happy to speak more,
18 but, again, a key recommendation that we have right
19 now is to implement an immunocompromised status for
20 all older adults in Ontario, and most specifically
21 and urgently, the viral pneumonia vaccine for all
22 residents of long-term care.
23 And to do that, it would be quite
24 simple. You would just simply have to say, yes,
25 those people are designated immunocompromised. If

1 one wanted to walk it back later, you could reverse
2 that designation of immunocompromised, although I
3 would respectfully submit that there's no reason to
4 do so. We could save lives right now. We could
5 keep people healthier right now by prioritising
6 viral pneumonia as well as shingles vaccines.
7 We know that caregivers will be one of
8 the key areas of prioritisation for vaccination,
9 and we wanted to offer that it should not just be,
10 again, with COVID-19 vaccinations but also for the
11 other three.
12 We know that we have not done a good
13 job with disaster response, and some of the
14 learnings around upgrading infection prevention
15 protocols in long-term care means that they need
16 supports in-house, not brought in after, not as an
17 afterthought from acute care, but in-house
18 supports. They call it seasons for vaccines and
19 illnesses for a reason. While the pandemic was
20 unforeseen in its breadth, it is not unforeseen in
21 its planning, and the planning was very poor. We
22 can do better, and we must make sure that there are
23 requirements on site that also then is connected to
24 regular unannounced inspections as well as upgraded
25 infection control protocol review.

1 We can't forget home care, and this is
2 a key theme that we want to talk about. We know
3 that about 20% of older people who are in long-term
4 care right now could go home with adequate
5 supports. And we're suggesting that the home care
6 infection prevention and control needs to be
7 supported right now so that people don't end up in
8 long-term care as well. So we take a health and
9 housing continuum approach. So don't forget that
10 we need home care infection prevention and control
11 and screening as well.
12 We need to do better with the
13 Pan-Canadian seniors disaster plan. We don't have
14 one. We are working with the Public Health Agency
15 of Canada and the NIA and the Red Cross right now
16 to support improvements in that area, but we know
17 that there's significant gaps.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Were you able to figure out why there's no plan? I
20 mean what -- the way -- how somebody reasoned to
21 the conclusion that that was a good idea?
22 LAURA TAMBLYN WATTS: Justice Marrocco,
23 no. The answer is, like so much in the field of
24 aged care and long-term care specifically, it is
25 often overlooked, underfunded, and

1 under-prioritised. There's -- absolutely
2 unconscionable that we haven't had a proper
3 pandemic plan or even just a plan for disasters for
4 seniors.
5 The last, really, note of any kind is
6 with the Public Health Agency of Canada, and I was
7 part of that program in 2008. It's not accessible.
8 It's not practical, and it doesn't help people on a
9 community orientation or a long-term care. So, no,
10 I think it's a gap, not a managed response.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 M-hm.
13 LAURA TAMBLYN WATTS: We talk about
14 changing to home care, and we know that home care
15 workers like all care workers need to be paid by
16 where the work they're doing is requiring them as
17 opposed to the location of the work. So again, pay
18 staff based on the work done, not where they do the
19 work. In many cases, as you know, acute care
20 workers can get paid and sometimes twice as much as
21 home care or long-term care workers. So in order
22 to create a proper system of supports, we need to
23 make sure that remuneration is possible.
24 U/T We would love to talk about
25 transforming our home care worker model into an

1 integrated multidisciplinary team model of care at
2 home. This is an area we've done significant work
3 on. It really shouldn't matter where you live.
4 You should be able get the same care wherever that
5 is, whether you are in your own community dwelling
6 home, whether you're in long-term care, or some
7 type of supports in between. So again, really
8 happy to share more information and more research
9 about the care-at-home model.
10 We know an essential caregiver program
11 needs to be created. We know that we need to work
12 with the FPT on long-term care stakeholders, and
13 that different kinds of care need to be provided.
14 And I just wanted to conclude my
15 substantive remarks with this kind of recipe. We
16 know that we need to fix the funding model, and
17 we're working at the Federal as well as Provincial
18 and Territorial levels to try to support dedicated
19 transfers of funds.
20 We believe that a regulatory authority
21 arm's length is a key component of that like the
22 Australian model which also has a similar division
23 of powers. In our respectful view, Commissioners,
24 it is far too long that fingers have been pointed
25 at the division of powers as an excuse not to

1 provide the needed care that older people need, and
2 there's a way through. And Australian provides an
3 analogous division of powers with an analogous
4 public and private split; again, really happy to
5 share more information the Commissioners if you'd
6 like to talk about that model.
7 The staffing pieces, we've talked
8 about, but we know that we need to change the
9 triangle. Right now, as you, I'm sure, have heard,
10 it's extremely rare to find a physician in
11 long-term care, and the requirement of one nurse
12 per site is not adequate. We need an integrated
13 care support model where we don't just have more
14 staff, but we have more differentiated staff. And
15 we have very specific recommendations here about
16 that.
17 The upgrading to buildings, we know
18 we're going to lose about 30,000 long-term care
19 home beds within five years, now four and a half
20 years, out of our 78,000 long-term care beds just
21 because of fire safety alone.
22 We also know that the liability piece
23 is real, and coming from an insurance liability
24 background, I can tell you that it feels like we
25 are ignoring one of the most pressing issues which

1 is the confusion people have about what insurance
2 means to long-term care. I know, Commissioners,
3 that there was significant pushback about the
4 concern of having legislation brought into bear
5 that would protect for liability for reasonable
6 spread while there was not gross negligence, but
7 the broader insurance question is not that.
8 With respect, it's about the fact that
9 long-term care has become essentially uninsurable,
10 and that as insurance policies, commercial
11 insurance policies come up for renewal without a
12 backstop, long-term care will simply cease to
13 function probably by March or April. Almost all
14 insurance renewals are coming up in January, and
15 with the binding of insurance, you can buy a little
16 bit of a time. This is perhaps, with respect,
17 Commissioners, one of the most urgent issues we
18 have before us.
19 We talked about infection control, and
20 I would like to just conclude with talking about
21 the Institutional Model and why it should not any
22 longer be where we move forward. CanAge has heard
23 with some concern the announcements of this
24 Government about building new large long-term care,
25 and with great respect, Commissioners, we disagree

1 about that being the answer. We need more care at
2 home, and we need smaller models of care, 10 to 25
3 people.
4 In one of the transformative
5 emotion-focused models of care, whether it's the
6 Butterfly Model or the Eden Alternative, the
7 Green House Model or others, it's about small homes
8 where people are not medicalized. It doesn't just
9 create better dignity. It doesn't just create
10 better health outcomes. It also helps to create
11 better infection prevention and controls, and where
12 we have seen the lack of infectious spread has been
13 in limited homes where they can control it.
14 That concludes our formal part of the
15 presentation. We look forward to any questions you
16 may have.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Have you looked -- I think the answer is yes, but
19 I'm curious what you observed. Have you looked at
20 long-term care facilities that performed quite well
21 in Wave 1, and did you form some general
22 conclusions around why that was?
23 LAURA TAMBLYN WATTS: Yes, we have. It
24 has been a real recipe of the following items: The
25 first is typically a smaller, more modern

1 infrastructure building, like an actual -- you
2 can't actually do infection prevention and control
3 when you have hundreds of people sharing bathrooms,
4 sometimes 20 and 30 people sharing bathing
5 facilities with ward rooms of three to four people.
6 So where the opposite was small homes
7 able to be cleaned, individual suites with an
8 ensuite bathroom and bathing facilities, homes
9 perform better. And if we look at comparative
10 jurisdictions in Europe and Australia, you will see
11 as well, Commissioners, that that has been a
12 consistent outcome. It also just makes sense. I
13 mean, you don't, in fact, need to be an
14 epidemiologist to understand if you have fewer
15 people, modern facilities, and lack of infectious
16 spread, you'll do better.
17 Where homes were overfull, cohorting
18 was a challenge, and we saw that, you know, where
19 you didn't have swing space, there was nowhere to
20 put anybody. So homes that had spaces where people
21 could be kept away from other people in a cohorting
22 or decanting type of basis, were able to do better.
23 Where there was leadership -- and this
24 is early information, Commissioners, and I would
25 offer that it's not evidence with a capital 'E',

1 but it's certainly -- it's certainly important
2 information. Where we saw leadership from
3 administrators and a long -- a significant
4 commitment to communication and clarity, homes did
5 better. And what we saw as well is that where
6 there was not clarity in communication from
7 Government, that the synthesis amongst
8 organizations like the ones I shared providing
9 tools and resources that were then implemented
10 helped outcomes.
11 We also saw -- and this is anecdotal
12 because we haven't had a proper study of it yet,
13 but we certainly saw that where there were active
14 residents councils and active family councils,
15 outcomes seem to be better. And I would include,
16 Commissioners, when I say outcomes, mental health
17 outcomes, physical outcomes, not just infectious
18 spread outcomes.
19 Essential caregiver visits were
20 critically important, and where testing was made
21 available or clear sense of testings, it, again,
22 was preferred.
23 The failure of this Government to
24 implement robust and engaged testing protocols is
25 going to be a story that we tell as a cautionary

1 tale in future, and we can see other jurisdictions
2 that did not have that failure to act who also did
3 better.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay.
6 LAURA TAMBLYN WATTS: I want to say
7 first off that --
8 COMMISSIONER FRANK MARROCCO (CHAIR): I
9 should say, you know, we're in the same position in
10 the sense that our Commission is functioning in the
11 middle of these events, so we understand when you
12 say this is not evidence with a capital 'E'. We
13 are both experiencing the same reality that way.
14 LAURA TAMBLYN WATTS: Yeah. I would
15 offer that we certainly have, you know, strong
16 information and reliable information and promising
17 approaches and perhaps, in some cases, best
18 practices. But there is information with a capital
19 'E' on some aspects, and those we wanted to bring
20 forward in particular.
21 You know, we know the infrastructure is
22 an issue. We know the lack of testing is a key
23 issue. We know the health and housing continuum is
24 not being serviced in a way that allows people to
25 stay in their homes longer. We have no end of

1 evidence about that.
2 And we also know that vaccines work,
3 and the fact that we are not having a coordinated
4 vaccine approach and registry at least in long-term
5 care but more broadly, Commissioners, in Ontario,
6 is a significant oversight. Vaccines cannot be
7 relied on as a one-off panacea to COVID-19. We
8 must invest in making sure that annually or on an
9 appropriate basis, that vaccines are prioritised,
10 recorded, and the data is collected particularly in
11 that what's often known as the holy trinity of
12 seniors adults' vaccinations, you know, enhanced
13 flu vaccine, viral pneumonia vaccine, in
14 particular, the most modern best in-class one, and
15 then the Shingrix vaccine.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Okay.
18 Commissioner Kitts.
19 COMMISSIONER JACK KITTS: Yeah, I just
20 want to go back to the comments. You spoke about
21 the lack of preparedness of Ontario versus
22 British Columbia, and I think you said 90% of the
23 deaths were within a window from mid-March to
24 something. Did I hear that correctly? I wasn't
25 sure what I had heard.

1 U/T LAURA TAMBLYN WATTS: Yeah. Thank you,
2 Dr. Kitts, and we can share that information with
3 you. There's been a study that's come out quite
4 recently that was looking -- and our colleagues at
5 the NIA were engaged in that study. And I believe
6 you've had submissions from Dr. Stall as well.
7 So there was a recent study reviewing
8 where the originator tracing of the virus came
9 from. So in many -- most cases, they can trace
10 back to where the spread occurred. And my
11 understanding of that study is that more than 90%
12 of the cases of infectious spread in Ontario could
13 be traced back to that period of inaction between
14 mid-March and, my understanding, it was end of
15 April, but we can provide you with that article as
16 a follow-up piece of information.
17 U/T COMMISSIONER JACK KITTS: Okay. Thank
18 you very much.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Would you mind doing that? That's very helpful.
21 That's one of the things -- what you just referred
22 to is one of the things that we are curious about.
23 LAURA TAMBLYN WATTS: Yeah. We've
24 certainly seen that where action was taken on a
25 prioritised basis for long-term care as opposed to

1 exclusively acute care, where lines of
2 communication were clear and consistent, and where
3 there was really a flow of supply, we had better
4 outcomes.
5 And again, I just wanted to share with
6 you, it's our understanding that, you know, from
7 our colleagues in B.C. that, you know, there was a
8 number, like, a number to phone call that you could
9 call to get PPE, and again, not perfect in every
10 instance. I'm not saying it was immaculate, but it
11 was a one place to call, and the PPE was, then,
12 reliably showing up.
13 But by contrast, you know, five to six
14 weeks where you couldn't get PPE, and then when you
15 could, our colleagues on the ground were saying it
16 was three to four-step process to get it, quite a
17 difference in terms of response time.
18 COMMISSIONER JACK KITTS: Thank you.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Did you have any sense or come across how long it
21 would take from the time -- this three to four-step
22 process, how long it would take for a long-term
23 care home to make the request and then get the PPE?
24 LAURA TAMBLYN WATTS: We heard some
25 horror stories from administrators and members of

1 the associations overseeing long-term care. What I
2 never heard one time was that it was quick, easy,
3 and streamlined. We heard it would sometimes take
4 days, sometimes take weeks to get the PPE.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 So this is at the point in time when there is --
7 there is personal protective equipment. It's
8 taking weeks to get it.
9 LAURA TAMBLYN WATTS: Yes, Mr. Justice
10 Marrocco.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Is that right?
13 LAURA TAMBLYN WATTS: Exactly. So in
14 the period of five to six weeks -- and I say five
15 to six weeks because there was an announcement, as
16 we know, on April the 22nd that some of these
17 priorities that were put into place in B.C. would
18 be finally put into place in Ontario. The reality
19 of that roll-out, though, was at least another
20 week. So it may say five weeks, but the reality
21 was it was more like six and in some cases seven
22 plus weeks for it to actually start happening.
23 And in that period of time between,
24 sort of, end of April and then well into June, we
25 heard consistently about challenges in getting PPE.

1 This is during the time where it was supposed to be
2 available and supposed to be able to be prioritised
3 at that point for long-term care, but the
4 functional reality was, that was not the case.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Did you come across any -- get any sense of how
7 many people got sick and died in that period where
8 there's, for example, universal -- no universal
9 masking directive, that sort of thing, that period
10 between, like, the -- or mid-March or the 20th --
11 20, somewhere in there, March, to that point in
12 April when the -- when there's a directive? Did
13 you get any sense of what that looks like in terms
14 of people who died?
15 LAURA TAMBLYN WATTS: Yes, Justice, we
16 do, and it's a tragic, tragic number. So if we
17 take a comparison between the implemented steps in
18 British Columbia in the same time period -- and
19 remember, B.C. had it first, so it's of note that
20 they were ahead and were more responsive.
21 Between the period of mid-March, let's
22 say about the 15th or 16th of March until the
23 changes were announced in Ontario April 22nd, but
24 in functional reality more like somewhere between
25 end of April and beginning of May, so that period

1 of time, we're now getting some sense of both
2 counted loss of life and then looking backwards and
3 trying to actually unpack how many people died that
4 were uncounted, so let me just delve into that a
5 little bit.
6 U/T So there are some studies that are
7 already counting, and, again, it's that same
8 article I can share with the Commission, and we'll
9 follow up with that immediately for you. It
10 appears to be losses of hundreds, perhaps,
11 thousands of lives that could be directly tethered
12 to it. And by that, I'm not just saying about the
13 people who died in that differentiated period, but
14 who got infectious spread and then later died.
15 We also know that there was significant
16 morbidity and -- that happened as well. So they
17 may not have actually died, but their health
18 significantly deteriorated and probably is not ever
19 going to come back, so we can find you that
20 information and follow up with you on that article.
21 The piece that I also want to share --
22 and this is a really important one that we were
23 speaking to the media, in some cases, on average,
24 you know, 20 and plus times a day was that there
25 was so little understanding about how urgent it was

1 to implement a protocol that was not flu-based.
2 So we were so challenged by the fact that the
3 initial response in Ontario was a flu response by
4 contrast not in B.C. where it was considered a
5 COVID response. Let me delve into that.
6 The flu response is to test up to three
7 people to see if there is influenza, and if, at
8 that point, it's been established that there is
9 influenza, then an outbreak is declared, and no
10 more testing is done. And that was what was
11 happening from late winter and early spring into,
12 finally, the end of April where they started
13 testing for COVID-19. And so there were hundreds
14 of people that were uncounted. Quebec decided to
15 go back and have a look to see --
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Just hold on. Let me get rid of this.
18 (BREAK)
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Sorry. I interrupted you.
21 LAURA TAMBLYN WATTS: Thank you,
22 Justice. What I would offer is Quebec was in a
23 very similar circumstance to Ontario, and I think
24 it's helpful to compare not just the B.C. more
25 urgent and more active response, but Quebec, who

1 was in the analogous response with the military and
2 how they pulled ahead, in many cases, due to quick
3 action when they finally did move into gear, if you
4 will.
5 And so while both had the military
6 response and both had terrible whistleblower
7 reports, you know, what we saw with Quebec was they
8 started to say, you know, we're going to look
9 backwards and try to count people who we believe
10 would have been -- died under the presumption of
11 COVID-19. So they were able to retroactively count
12 people.
13 Now, it certainly wasn't perfect or
14 precise, but they were able to say, you know, last
15 week before we were testing for COVID-19, this
16 person died from, you know, lack of ability to
17 breathe. They showed, you know, other signs of
18 infection and contention. We're going to designate
19 them as a deemed COVID case. Ontario did not do
20 that.
21 So for at a minimum one to two months,
22 we have really a very poor understanding of how
23 many people actually died of COVID and what the
24 infection rates actually were, and the lack of
25 testing of all staff, all residents, and all

1 limited visitors in long-term care during that time
2 means that we will really never know how many
3 people actually died that didn't need to, not that
4 anyone should need to die, but there were some
5 people for whom --
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 No. No. I understand what -- I understand what
8 you meant. My question was -- I wasn't concerned
9 just with people who actually died in that period.
10 I was concerned with in that period between, say,
11 the -- late March to April when -- April 8th or
12 whenever it is that we start having a masking
13 policy, how many people got sick and then later
14 died? Because, you know, there's a delay with the
15 symptoms, and then people get sick, and then they
16 get sicker and so on, so it's -- it's to trace the
17 illness back to that period.
18 And I -- you know, so many people died
19 in long-term care homes, I was just curious if
20 there was some sense of how many of them.
21 U/T LAURA TAMBLYN WATTS: Again, without a
22 capital 'E' on evidence, Justice, you know, the
23 answer is a horrible one. You know, we believe
24 that there were hundreds of people that were
25 infected and died because of that delay. Again,

1 that most recent article tracing back the
2 infectious spread would give a sense of that, and
3 we're happy to share that with you. We will never
4 really know, but if you even just compare on an
5 epidemiological basis, British Columbia and its
6 time where it put those matters into force and
7 compared them against when Ontario put those
8 matters into force, you know, we could -- it
9 doesn't need to be a direct study, but we can
10 certainly see the differential impact of those
11 safety measures, those response measures that were
12 taken five to six weeks earlier. The curve is a
13 stark and sharp one.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay. Thank you.
16 LAURA TAMBLYN WATTS: The expression
17 that we were using, perhaps, just to, kind of, give
18 a bit of colour to that is we were crying into the
19 wind to put these measures in place. And we
20 actually could not understand for any -- and this
21 goes to Dr. Kitts' points, and, you know, there was
22 no real reason why not except that long-term care
23 and older vulnerable people were simply not
24 prioritised.
25 And, you know, when we look at how we

1 compared to other OECD countries, when we look at
2 how Ontario, in particular, has compared in
3 response to similar provinces like B.C. or Alberta
4 or even Quebec with its changes in staffing and
5 infection prevention and control, Ontario does very
6 poorly indeed.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Did you form a conclusion about why the
9 decision-making was slower?
10 LAURA TAMBLYN WATTS: We believe that
11 key components were part of it. Again, it's --
12 maybe next year, we'll have a more robust
13 retroactive review. It appeared that there was
14 very little leadership within the Ministry of
15 Long-Term Care. There were very few responses to
16 inquiries provided that were robust. There was, in
17 some ways, a sense of, kind of, washing your hands
18 of the sector or acceptable losses. There was this
19 fixation on acute care which made no sense, not to
20 say that acute care isn't important, but that's not
21 where the urgency was lying.
22 It was a confused response. When you
23 would write, it would sometimes take weeks or
24 months to get a joint response back. There was a
25 sense of reticence from Dr. Williams consistently

1 saying that, you know, it would not be prioritised
2 much to the bafflement of the sector and the horror
3 of families and residents. Why that choice has
4 been made, it's hard to understand it from any
5 reason except agism in action.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Okay. Thank you.
8 LAURA TAMBLYN WATTS: It certainly
9 makes no epidemiological sense, and the lack of
10 leadership and coordination from the Government
11 was, as I say, so distressing that the sector
12 actually had to bond together and figure it out
13 itself which has been a cohesive and important
14 development, a positive development because the
15 sector has actually come together and created
16 really wonderful resources and trusting
17 relationships, but that's not how leadership in the
18 time of a crisis should unfold.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 It's really a matter of top-down leadership in a
21 crisis.
22 LAURA TAMBLYN WATTS: And by
23 comparison, when we look at either the response, as
24 I say, in British Columbia, or even if you look at
25 responses in -- and I use Quebec as an example

1 because it was a very poor -- it was a very poor
2 outcome as well, you can see at least Quebec, when
3 it finally moved to address some of the real
4 challenges and horrors, you know, did something.
5 And there's been this sense that
6 families, caregivers, and residents were really out
7 of the loop and that associations and
8 not-for-profit organizations were kept at an arm's
9 length at a time where a coordinated,
10 all-hands-on-deck response was really needed.
11 So if we even look at how we
12 communicate, you know, the not-for-profit sector,
13 organizations like ours were creating communication
14 tools and infographics, and, you know, we were
15 actually, in some cases, leading the information
16 and having The Ministry of Health and Long-Term
17 Care take weeks in response afterwards to put out
18 what would have been most basic information.
19 Again, CanAge was pleased to play that
20 shared role with our colleagues, but it wasn't
21 really our place to being doing it.
22 U/T I've just put in the chat here another
23 report which I think may be of help, and we'll
24 coordinate to make sure we give you a package of
25 follow-up materials, but the report that we just

1 shared -- and I am happy to share it on the screen
2 just for a quick moment so you can see. It is
3 quite, I think, a useful one from Public Health
4 Ontario; one, perhaps, that you've seen as well.
5 And it goes and talks about some of the summaries,
6 but again, this is as of June 1st, 2020. We will
7 create a package of further materials and ship it
8 to the Commission as a key set of resources.
9 U/T COMMISSIONER FRANK MARROCCO (CHAIR):
10 Okay. Thank you. Well, you know, there's been
11 a -- one of the issues that comes up is the
12 difference between for-profit and not-for-profit
13 homes and their performance in Wave 1 -- well,
14 their performance generally, I think.
15 Our remit isn't exactly restricted to
16 Wave 1, but, of course, Wave 1's a little easier to
17 look at since it's over than Wave 2 when you're in
18 the middle of it.
19 But did you have a sense -- did CanAge
20 have a sense of whether there was really a --
21 whether there was a -- whether it mattered whether
22 it was for-profit or not-for-profit?
23 LAURA TAMBLYN WATTS: We've been very
24 cautious on this answer. Certainly, there's been a
25 public narrative, a vilification of for-profit

1 homes as a kind of a slapback response. I think
2 it's fair to say that in 1987 when we created the
3 Canada Health Act with an average age of death of
4 76.4 years, we were not as a country proactively
5 thinking about how to design long-term care.
6 So I don't -- I don't believe we didn't
7 mean to include it as a purpose. I think it just
8 wasn't included. People went into some extended
9 care or into acute care, and then they, frankly,
10 died.
11 And so it's been -- it's not been
12 unique to Canada to have a mixed model as, again,
13 Australia and some other countries do as well. I
14 have not seen really good evidence that has
15 differentiated exclusively on a for-profit to
16 not-for-profit model. What I have seen is that
17 where, in some cases, infection got into long-term
18 care on a for-profit model, it was also perhaps the
19 morbidity was greater.
20 I am cautious about the evidence in
21 this area because I do not believe that it has been
22 robust enough and hasn't really looked at the issue
23 of leadership, the issue of staffing levels, the
24 issue of culture, of different kinds of models of
25 care.

1 And so I believe that there is a
2 question, and one that should be answered, about
3 how is it that long-term care for-profit entities
4 were paying out dividends during the time where
5 they were receiving benefits and were not being
6 able to provide adequate PPE and other testing
7 supports. I think that is a clear question to
8 better understand.
9 But at this point, I have not seen good
10 enough analysis to be able to rest it on a
11 for-profit versus not-for-profit model. Many
12 not-for-profit homes simply don't have the
13 resources or the key learnings that for-profit
14 homes have or resilience in the sector. And I
15 would offer, Commissioners, that unless the
16 insurance backstop issue becomes more clear, the
17 first ones to go will be the not-for-profit homes
18 because Board members can't be personally liable,
19 and they won't be able to get the type of leverage
20 and debt coverage that they need as well. So I
21 think it's still unclear.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Did you in terms of the -- you know there's a
24 shortage. There's a waiting list and so on, and
25 I'm sure you know that. We now know that.

1 Do you have a sense -- does CanAge have
2 a sense of whether not-for-profits are more -- are
3 inclined or disinclined to create more housing or
4 more beds?
5 LAURA TAMBLYN WATTS: I think it
6 depends a combination of both willingness and the
7 resources to do so. And if we look at, for
8 instance, the B.C. model who has an organized --
9 you know, kind of a section of government called
10 B.C. Housing -- and this is one of our key
11 recommendations as well, B.C. Housing supports
12 innovation and has been a key element in creating
13 backstops for innovative programs like dementia
14 villages like we have in Langley and up in Comox
15 and also now in Abbotsford.
16 So not-for-profit homes are more able
17 to leverage, more able to get debt purchase, more
18 able to negotiate for services in B.C. than they
19 are in Ontario; and, again, one of our key
20 recommendations is to implement something like a
21 B.C. housing type model in the Ontario context.
22 Long-term care, I think, has been an
23 integral part -- or aged care has been an integral
24 part of the not-for-profit sector particularly in
25 the area of enthnocultural diversity, and we really

1 believe that there's an important role to play
2 here. But unless the sector gets the supports it
3 needs and the help, whether that be by land
4 donations or whether that be through other types of
5 leverage, I think that we will see the austerity in
6 the New Year and ongoing and the hits
7 not-for-profits have taken as charitable
8 organizations themselves are unlikely to have
9 adequate resources at this point to follow their
10 desire to go into long-term care.
11 And then the second corollary piece I
12 would offer is, you know, the sector's had such a
13 hit, and there's so little protection for Board
14 members that I think unless we fix those underlying
15 issues, not-for-profits are unlikely to want to go
16 more into long-term care.
17 We are seeing management flee from the
18 sector and to go into areas where they have less
19 vilification and get paid more.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 When you say a backstop, do you mean liability over
22 and above a certain level and the Government picks
23 it up? Is that what you mean by a backstop?
24 LAURA TAMBLYN WATTS: Yes, Sir.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.
2 LAURA TAMBLYN WATTS: Yes. Right now,
3 essentially, long-term care is almost uninsurable.
4 We've been part of conversations with CALTC, with
5 the Canadian Association of Long-Term Care Homes.
6 We've hosted not-for-profit round tables. We have
7 been part of the conversations with the insurance
8 folks across this country, so about five major
9 providers of insurance.
10 And, you know, we have looked at
11 coinsurance, and they've looked at, you know, other
12 forms of insurance. But in the end, it appears
13 that really the only viable version is that the
14 insurance companies under a reinsurance process
15 would have an insurance from the Government. And
16 this would be quite analogous to terrorism which
17 seems like an unfortunate comparison, but that is
18 actually the model of insurance that we're looking
19 for.
20 And right now, the for-profit homes,
21 because of their differentiated models, they get --
22 they don't make most of their home for -- money
23 from long-term care. I think people forget that.
24 They make most of their money from retirement
25 living or supportive housing or home care. And so

1 because they have differentiated income streams,
2 they have more resilience to withstand some of
3 these issues, and they have -- they're, kind of,
4 more help and support amongst their own internal
5 networks.
6 By contrast, not-for-profit homes are
7 rarely chains, and if so, they are just a couple of
8 homes, and they don't have some of those supports
9 at play to help them scale.
10 So I do think that not-for-profit homes
11 do a wonderful job, but we need to do much more to
12 help them achieve the goal and not just hold them
13 on a pedestal, but to actually provide them with
14 the help and support they need. But unless they
15 finish, you know, coming up with some type of real
16 active response for insurance backstop, it doesn't
17 matter if it's for-profit, not-for-profit, or
18 municipal. Long-term-care will cease to exist in
19 2021.
20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 The -- it's been suggested to us that there are a
22 significant percentage or -- but a goodly
23 percentage of residents in long-term care homes who
24 could be looked after in their -- in their own
25 homes if there were more supports in place. Does

1 CanAge have a view about that?
2 LAURA TAMBLYN WATTS: Very much so.
3 You know, we are familiar with the evidence, and
4 we're part of the conversations around that. It is
5 clear, and we've had, what, something like 20
6 studies in 31 years that have looked at seniors
7 care across this country. You know, home care is
8 the answer. Not to say that there will not always
9 be some people who need some form of congregate
10 care, but if we're looking at the Nordic Model, for
11 instance, where you have our care-at-home model
12 where people come to you, whether it be nurses,
13 doctors, physiatrists, podiatrists, social workers,
14 they come to you and provide you with integrated
15 supports. And where testing can be done in home,
16 in-home testing is done there as well.
17 That is what people prefer. That is
18 what is the least expensive. That is the best way
19 to support people aging in place, and that is the
20 area that we invest the least in.
21 That is a common theme in the area of
22 age sector where we know what works and where we
23 know it's least expensive is what we ignore.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 I'm not going to -- I'm not going to say anything

1 further on that, but thank you for that.
2 Commissioner Coke.
3 COMMISSIONER ANGELA COKE: Just a
4 comment you'd made earlier about inspections and
5 the -- you know, people probably inspecting the
6 wrong things. Now, I was just curious if you are
7 familiar with anywhere that has a good inspection
8 regime and where they are using maybe better
9 performance measures, more outcome focus. Does --
10 yeah.
11 LAURA TAMBLYN WATTS: Thank you very
12 much for the question, Commissioner. You know, we
13 think it's important to kind of focus in on what
14 we're inspecting to begin with. And so I just want
15 to -- I want to address that part of your question
16 first.
17 You know, Ontario, as you know, has the
18 second most regulated system of anything that gets
19 inspected in theory in Ontario, nuclear power being
20 the only one that has more inspection. And yet
21 it's set up for so much tick-boxing and so much
22 procedural oversight that the quality of care and
23 the environment of care, we believe, is
24 problematic, and we don't get what we were looking
25 for.

1 And I think we're actually inspecting
2 the wrong things. So if by regulation -- and I
3 think it's Section 18 -- you know, you want to
4 change the lighting, it's a regulatory concern, and
5 yet we may know that certain kinds of softer
6 lighting would work better for people with
7 behavioural responses.
8 And so we've created this, sort of,
9 calcified regulatory system, and then we have not
10 done a good job of inspecting it because we've been
11 reducing and reducing and reducing inspectors.
12 We certainly know and have heard
13 in-person reports that when people know inspections
14 are happening, like anything else, you tidy your
15 room, that things get sorted out, and there's lots
16 of staff on that day, and then when inspections
17 aren't coming forward, that things are reduced back
18 again.
19 And I think it speaks to, again, both
20 your question, which is what are we trying to
21 inspect and what are we trying to achieve, but also
22 the shortages that exist in the system.
23 We prefer looking at the Australian
24 Model, and again, I'm calling that one out because
25 it is most analogous, in our respectful view. It

1 has the division of powers. It has a fairly
2 similar balance between for-profit and
3 not-for-profit. It has a National regulator in
4 that dynamic environment and yet really is looking
5 at an outcomes-focused model, Commissioner. It's
6 looking at the well-being, the dignity, the care,
7 the infection prevention readiness, the staffing,
8 whether it be ratios or types of staffing in terms
9 of its diversity, and we think that that's a good
10 model.
11 I would also recommend to the
12 Commission looking at the Nordic Model which is
13 fairly shared amongst Sweden, Finland, and Norway.
14 What I would offer, though, is that Sweden's
15 response to this pandemic has not been, perhaps,
16 one that we would want to engender. So I would
17 offer that the inspection system and the
18 care-at-home system is good in Sweden but not
19 the -- not the response, perhaps, to COVID-19. So
20 Australia and the Nordic Models, I think, are
21 inspecting more robustly.
22 In Canadian context, I think that, you
23 know, Nova Scotia is an area that we can look
24 towards that has a more flexible approach that's
25 really quite outcomes-focused, and Alberta has been

1 updating as long as B.C. as well has been updating
2 some of their inspection. I think the B.C. care
3 providers would be a key informant, and I'm happy
4 to provide you some of their information, if you
5 would like, around inspections.
6 The BC Care Providers is an association
7 that represents overwhelmingly the providers of
8 care, whether it go from home care, assisted living
9 support, and housing and residential care.
10 U/T And if you would like, Commissioner, I
11 can provide you with that information about what
12 they're inspecting and how it's reviewed.
13 U/T COMMISSIONER ANGELA COKE: Thank you.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 That would be helpful, I think, too.
16 LAURA TAMBLYN WATTS: Would it help the
17 Commission if I also provided some of the other
18 inspection, maybe, summaries or links around the
19 Nordic Model, the Australian Model, and also Nova
20 Scotia in some type of more synthesized approach?
21 U/T COMMISSIONER FRANK MARROCCO (CHAIR):
22 Well, you know we've recommended -- in the second
23 interim report, we commented briefly on
24 inspections, but you can -- you could -- it would
25 be helpful because we're not -- we may not be

1 finished with that.
2 U/T LAURA TAMBLYN WATTS: We're happy to
3 provide you with further information, and I always
4 like a good chart, so one of the pieces that we'll
5 do is provide your secretariat with the long-form
6 materials but synthesize it into a chart with some
7 key takeaways so you can understand the information
8 a bit more at a glance, if that's helpful to the
9 Commission.
10 U/T COMMISSIONER FRANK MARROCCO (CHAIR):
11 It would be. Thank you.
12 COMMISSIONER JACK KITTS: Can I just
13 come back to your model homes because we've heard
14 from many sources that the type of patient in the
15 long-term care home today is quite different than
16 ten years ago. The acuity is much higher, but we
17 also know that the acuity is a continuum, and it
18 goes from self-care to activities of daily living
19 to more assisted care on into almost a level of a
20 subacute care.
21 So I'm kind of wondering how you
22 rationalize the ideal home. I think you said about
23 20 to 25 residents with the very different levels
24 of acuity and whether there is a place for some
25 sort of -- some higher level of care that's not

1 acute hospital care but more care than you would
2 get in a home.
3 LAURA TAMBLYN WATTS: Thank you for the
4 question, Commissioner. The answer, in short, is
5 yes. There will always be people who will need a
6 higher level of care, but what they don't need to
7 be is institutionalised in a hundred, 200,
8 300-person home. And so we know that people can
9 have a better quality of care, perhaps, in a Campus
10 of Care Model, and I'm sure you've been familiar
11 with the Campus of Care Model, but just for
12 clarity, what I'm speaking about is a grouping of
13 types of levels of care usually in a built
14 environment which is low to the ground in a more
15 home-like setting environment.
16 Some of them look like suburbs or
17 little villages in communities and where you would
18 have independent living with layered support where
19 that needs additional support; they may need to
20 move to a different small type of home that's
21 shared with resources, or in the ideal environment,
22 just more supports come. It helps to promote
23 greater activities of daily living. It helps to
24 reduce behavioural responses and support people
25 with dementia in particular but also more

1 physiological engagement.
2 For people who are moving up the acuity
3 scale, it's also important to remember that
4 rehabilitation therapy is one of those key issues
5 that we don't often get into long-term care, and so
6 we have a sense that people will just follow along
7 the continuum and get worse and worse, and then
8 they die. And with great respect, Commissioners,
9 that's only because we don't provide them with the
10 type of occupational and physiotherapy that they
11 need to get better.
12 And so we can make sure that we get
13 more integrated, you know, physio, OT, and allied
14 supports in there to reduce levels of acuity and
15 get people active and moving.
16 We believe that there will always be
17 some people who need very heavy care, and we should
18 be reserving that very heavy care for those cases,
19 but, again, not in an institutional model,
20 Commissioner, but in a model where people are
21 living and getting the supports that they need.
22 COMMISSIONER JACK KITTS: Thank you.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Well, I think that -- I think that does exhaust the
25 questions for now. Thank you very much for the --

1 not only the presentation, but the questions and
2 answers as we were able to talk about a number of
3 things that we have been thinking about ourselves
4 and we're looking into, and your comments and
5 perspective is very helpful in that regard.
6 With your permission, you -- we may get
7 back to you because I'm sure, as we reflect on the
8 exchange we've had, we will probably come up with a
9 couple of questions or more that we wish we had
10 asked. So with your permission, we may come back,
11 but thank you. Thank you very much for a very
12 thoughtful presentation.
13 U/T LAURA TAMBLYN WATTS: Thank you very
14 much for the opportunity. We are hoping to be a
15 resource to the Commission, raising up the voice of
16 older adults but also as a place where we can
17 provide a bit of a broader perspective about what's
18 happening in different jurisdictions in Canada and
19 comparing some of those models around the world.
20 We have provided to your secretariat and to you our
21 Voices of Canada's Seniors Policy Platform, so
22 we're really hopeful that that will be a resource
23 to you. I would also offer that it's fully cited,
24 and we have additional citations should your
25 secretariat or should the Commission want to know

1 more about particular areas. So we -- we sit as an
2 eager resource to the Commission and would welcome
3 the opportunity to further supplement these remarks
4 with any questions or answers that you may have.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Well, that's good to know because the resource
7 assistance would be -- will be appreciated. Thank
8 you.
9 LAURA TAMBLYN WATTS: Thank you for
10 your time today and all of the very hard work you
11 do. Ontarians are very well served by your hard
12 work, your passion, and your expertise. We know
13 it's a lot of work and time, but the work that you
14 are doing is making the world better for Ontarians
15 and, more broadly, for older people. Thank you,
16 again, for your help and time today.
17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Thank you.
19 COMMISSIONER JACK KITTS: Well, thanks.
20 Thank you.
21 COMMISSIONER ANGELA COKE: Thank you.
22 COMMISSIONER JACK KITTS: Yeah.
23 COMMISSIONER ANGELA COKE: Very
24 helpful.
25 -- Adjourned at 3:18 p.m.

1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:
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10 That all remarks made at the time
11 were recorded stenographically by me and were
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14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.
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