Long-Term Care COVID-19 Commission

Via Zoom
on Thursday, September 24, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 24th day of September, 2020, 5:00 p.m. to 6:00 p.m.

BEFORE:

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

PRESENTERS:

David O'Toole, President & CEO of the Canadian Institute for Health Information
Brent Diverty, VP of Data Strategies and Statistics Division of the Canadian Institute for Health Information
Natalie Damiano, Director of Specialized Care of the Canadian Institute for Health Information
Mélanie Josée Davidson, Director of Health System Performance of the Canadian Institute for Health Information
Dr. John Hirdes, Professor and Chair of the Ontario Home Care Research and Knowledge Exchange at the School of Public Health and Health Systems, University of Waterloo

PARTICIPANTS:

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

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist
Lisa Di Felice, Administrative Assistant, Long-Term Care Commission Secretariat

-- Upon commencing at 5:00 p.m.

DAVID O'TOOLE: Okay. So we're all here. So shall we get underway, Jack?

COMMISSIONER JACK KITTS: Yeah, and I know that you know Angela Coke, one of the other Commissioners. I'm the other commissioner.

COMMISSIONER ANGELA COKE: Yeah.

COMMISSIONER JACK KITTS: I'm Jack Kitts, for those of you who don't know me, and we're looking forward to your presentation.

DAVID O'TOOLE: So thank you very much. So I'm David O'Toole. I'm the CEO of the Canadian Institute for Health Information Inc.

Our objective here today is to make you aware of what we do, what our holdings are, and to figure out whether or not we can be of use to you in your deliberations as the Commission.

So I'll turn it over to my colleagues, the people -- the conversation today will be led by Brent Diverty, who is our VP for Data Strategies and Statistics; Mélanie Josée Davidson is our Director of the Health System Performance Branch, and we have one set of pearls that we pass around to the person who's leading the discussion at each meeting.

Natalie Damiano is here as well, Director of Specialized Care Branch, and she's the one who knows the meat of the long-term care data that we hold across the country. And John Hirdes is our close collaborator with us on a number of different fronts. He's one of the leading gerontologists in the country from the University of Waterloo. He's in the School of Public Health and Health Systems, and he's one of the key interRAI fellows in North America.

So with that, I'll turn it over to you, Mel J., to take the Commission through our presentation.

COMMISSIONER JACK KITTS: Thank you.

MÉLANIE JOSÉE DAVIDSON: Sure. Should I be presenting the slides, or will somebody from the Commission do that? I can easily do it on my screen.

DAVID O'TOOLE: Well, maybe, I'm remiss. Maybe aside from Jack, Angela should introduce herself as well.

COMMISSIONER ANGELA COKE: Sorry. Angela Coke. I'm one of the Commissioners.

DAVID O'TOOLE: Okay.

COMMISSIONER JACK KITTS: Alison, do

you know if we're going to present the slides, or will we let Mélanie go ahead?

ALISON DRUMMOND: If Mélanie could, Janet, you have control of the meeting, so if you can hand that over to Mélanie, that would be great.

COURT REPORTER: All right.

DAVID O'TOOLE: Just to fill the slides up. Great.

MÉLANIE JOSÉE DAVIDSON: Let me know if those are up.

DAVID O'TOOLE: We can see them.

COMMISSIONER JACK KITTS: Yeah.

MÉLANIE JOSÉE DAVIDSON: Okay. So on behalf of the Canadian Institute for Health Information, thank you for the opportunity to appear before the Commission. I am speaking to you today from the traditional territory of the Haudenosaunee and the Anishinaabe Nation. I recognize that this land is now the home of many diverse First Nations, Inuit, and Métis people.

As David noted, there's a few of us on the call today from the Canadian Institute for Health Information as well as Dr. Hirdes from the University of Waterloo. We brought this group together because we bring a range of expertise

which we hope will be of value to the Commission.

So what we've done is we've prepared some slides and a short presentation that will take about 20 minutes. And that's really there to set the foundation for what we hope will be a good discussion for the rest of the hour.

So let me start with some quick background.

COMMISSIONER JACK KITTS: Mélanie, just before you start, would you be okay if we interrupted and asked questions as we go?

MÉLANIE JOSÉE DAVIDSON: Absolutely, yes.

COMMISSIONER JACK KITTS: Okay.

MÉLANIE JOSÉE DAVIDSON: So I'm just going to start with a quick background on CIHI, as we're usually called. So since 1994, we've been a leader in health data and information. So CIHI is a not-for-profit independent body funded by the Federal Government and all the provinces and territories to remedy what the chief statistician at the time called the deplorable state of health information in Canada.

Since then, CIHI has earned the trust of Health Systems as the primary stewards of

comparable information that helps inform policy, management, care, and research.

Our ability to lead in health data, methodologies, and measurement of health system performance while also protecting the privacy of Canadians has been recognized internationally.

Our Board of Directors is made up of Deputy Ministers of Health and other health system leaders representing all regions of the country.

CIHI has signed data-sharing agreements with every province and territory as well as several federal organizations. The data is provided to us voluntarily by each of the provinces and territories according to mutually agreed standards. This allows the data to be aggregated and compared and for health systems to learn from each other.

We also work closely with international organizations such as the OECD and the Commonwealth Fund which enables us to learn from other countries.

CIHI makes its data and information available to policy makers, health system leaders, researchers, and the public. We're neutral and objective in fulfilling our mandate to deliver

comparable and actionable information. We neither create nor take positions on policy.

Our aim is to give people, including decision makers, the information they need to drive improvements in healthcare, health system performance, and ultimately, to improve the health of Canadians.

With that background, we've structured our comments to the Commissions into three broad sections. So our first one will help situate Ontario's long-term care sector against the experiences of long-term care internationally and in other provinces.

We'll then share with you CIHI's health system performance framework. So this framework has proven to be a valuable tool for health system leaders to evaluate the performance of different sectors of care, and we believe that this tool may be of value to the Commission as you seek to reconcile many facts about a complex care sector.

Finally, my colleague, Brent Diverty, will share with you a few observations about the state of data and information in long-term care.

So the Commission will have heard statistics already about long-term care in Ontario

from other presenters, so I won't repeat these, but rather, I'd like to share with you a few pieces of information that allows you to situate the experiences of Ontario in relation to those of other provinces and territories.

So Ontario has 626 long-term care homes which provide residents with care and personal support on a round-the-clock basis. This represents roughly a third of the long-term care facilities in Canada that receive public funding.

Across the country, there is considerable variation among the provinces and territories in service-delivery models, admission criteria, as well as regulatory regimes for long-term care.

Despite these variations, provinces and territories face many of the same challenges as the population ages across the country: That is, ensuring that older Canadians receive high-quality care in a sustainable manner.

So the demand for residential long-term care is high across Canada and continues to outpace the number of available beds. The care needs of long-term care residents are also becoming more complex and more resource-intensive over time.

In Ontario, CIHI has found that long-term care residents are more cognitively impaired, more medically unstable, and require more assistance with daily activities compared to ten years ago.

Our data also shows that Ontario may have higher needs than those in other jurisdictions as the province has a higher percentage of residents with dementia at approximately two-thirds of residents.

Finally, we know that although all long-term care homes in Ontario receive public funding, the majority of these homes are owned by private and for-profit entities. The proportion of private ownership in Ontario is higher than in other jurisdictions.

CIHI analysis of Canada and 16 other OECD countries shows that Canada's experience of the pandemic is not unique. In other countries, such as Belgium, Spain, and France, have seen an ever greater number of COVID-19 deaths in long-term care as illustrated by the orange bars in this graph.

However, the data also shows that long-term care in retirement homes in Canada have

been disproportionately affected by the pandemic.

As of May 25th, Canada had a lower COVID-19 mortality rate overall than the OECD average, but it had the highest proportion of deaths in long-term care and retirement homes, a proportion that was more than twice the international average.

Countries that implemented specific mandatory prevention measures targeted at long-term care sector at the same time as their stay-at-home orders and closures which are really designated to -- or really designed to limit community spread, had fewer COVID-19 infections and deaths in long-term care.

These prevention measures included broad long-term care testing and training, isolation wards to manage clusters, and additional supports for long-term care workers such as Surge staffing, specialized teams, and personal protective equipments.

When we look within Canada, we see that variation between provinces and COVID-19 death rates in long-term care and retirement homes is much greater than the variation between countries with Quebec by far the province most deeply

affected, followed by Ontario, while the other large provinces of Alberta and British Columbia were less affected.

As the Commission continues its work to understand what happened in Ontario long-term care homes during the pandemic so far and to inform their recommendations for the future, we respectfully suggest that CIHI's Health System Performance Measurement Framework, which was established in 2013, can serve as a useful framework for organizing lines of inquiry and as a basis for collecting information.

So this framework serves as a tool to create a common understanding of a health system's goals and boundaries, how the different components fit together, and what aspects need to be measured to understand its overall performance.

I'll provide you with a brief walkthrough of the visual on this slide and of the four quadrants of the framework, and then I'd like to demonstrate to you its application by having a closer look at each of the quadrants.

So health system inputs and characteristics: So this is on the left side of the visual, the green squares, and refers to the

relatively stable characteristics of the health system, including the governance and leadership capacities, the resources available for use, the distribution and allocation of those resources, the capacity to adapt to meet population needs, and the innovation and learning capacities of the system.

The second quadrant is our health system outputs, and they are seen in the middle orange square --

COMMISSIONER JACK KITTS: Before you go on --

MELANIE JOSEE DAVIDSON: Okay. Yes.

COMMISSIONER JACK KITTS: -- we'll just put up our hands, though. Did you say that the inputs into our health system are -- I think you said are stable and effective, is that -- what did you say?

MÉLANIE JOSÉE DAVIDSON: So we tend to refer to them as, they're relatively stable characteristics of the health system. So they include things like governance and leadership capacities as well as the resources that are available.

COMMISSIONER JACK KITTS: Is this the whole health system, or is this long-term care?

MÉLANIE JOSÉE DAVIDSON: So this is a framework that we use to measure any sector of care. So it is a framework that can be reused in long-term care, so it would be the same exact model.

COMMISSIONER JACK KITTS: So is that what's coming in the next slides, is how long-term care fits up against these things?

MÉLANIE JOSÉE DAVIDSON: Exactly, yes.

COMMISSIONER JACK KITTS: Okay. I'm sorry.

MÉLANIE JOSÉE DAVIDSON: No. That's perfect.

COMMISSIONER JACK KITTS: Okay.

MELANIE JOSEE DAVIDSON: So the second quadrant is that health system outputs which are the middle orange squares, and they refer to the characteristics that contribute to the quality of services.

So these characteristics apply to all services delivered by the health system and refer to aspects such as access, person-centredness, safety, appropriateness, effectiveness, and efficiency.

The third quadrant is the health

systems outcomes which are the far right boxes on your graph, and these refer to the overall goals of the health system.

So these outcomes reflect improvements in the health of the population, the health system's responsiveness to the needs of Canadians, and the value for money that underpins the health system's sustainability.

Finally, the fourth quadrant is the social determinants of health which are depicted as the two light blue boxes at the top of the framework. So the social determinants of health are factors outside of health care of the healthcare system, such as education or income, that influence the health of a population and the inequalities in health.

You'll notice as part of the frameworks that there are arrows between the different dimensions of the frameworks. So these arrows represent how the different components of the system fit together, how they interact and impact one another.

You'll also notice that the four quadrants sit within the sociopolitical, cultural, and demographic contexts which may also impact the

system and its performance.

So what I'd like to do next is share a few examples to demonstrate how the framework has potential application to the Commission and see how it can be applied to generate an organized lines of inquiry.

So if we take a closer look at inputs and characteristics dimension of the framework, we can see that one of the dimensions there is health system resources.

So health system resources are the financial, human, physical, technical, and informational resources that are available to the health system.

So examples of facts that we know about this dimension is that, prior to the pandemic, Canada had a lower ratio of nurses and personal support workers per hundred long-term care residents compared to the average of reporting OECD countries.

We also know that in Ontario, 35 percent of registered nurses working in long-term care homes have part-time or casual positions, meaning that there is a higher likelihood of them working in multiple settings.

We also know from the SARS experience that the health workforce can be a vector for the spread of infections between care sites.

So using this dimension as a prompt for the development of lines of inquiry, you could come up with questions like: What role has infrastructure, such as the long-term care home's age, size, and number of residents per room, played in the spread of infection? Or how have long-term care homes with fewer casual and part-time workers had different experiences and outcomes of COVID-19?

Or -- and another line might be around: How has personal protective equipment been supplied, distributed, and used in long-term care?

COMMISSIONER JACK KITTS: Well, excuse me.

MÉLANIE JOSÉE DAVIDSON: Go ahead.

COMMISSIONER JACK KITTS: When we ask that, who do we ask, and is there anyone that we ask that has the answer, with data -- with data?

MÉLANIE JOSÉE DAVIDSON: With data. So what we find is that many dimensions of the framework have different sources of data, some of which is good quality data and comparable between provinces, so that's the kind of data that CIHI

could supply. And then there's different types of data that are available more locally or that are harder to access.

So I think part of your inquiry will require you to speak with lots of different experts who might be able to speak to one specific question within each of these dimensions of the frameworks that you would need to, then, evaluate against each other to get a full picture of the system.

COMMISSIONER JACK KITTS: So I take it you don't have much [indecipherable] in long-term care; is that correct?

MÉLANIE JOSÉE DAVIDSON: We do -- so what we have tried to do is highlight a few of the statistics that we know, and then we would be willing to work with the Commission to investigate the ones that are particularly of interest to you to see what types of data we might be able to provide or where we know of examples.

So, for example, CIHI has a network of partners across the country, and we're affiliated with experts across the country and internationally. So if there's a particular line of inquiry that you're interested in, we can tap that network to find you the best experts.

COMMISSIONER JACK KITTS: Well, it's not -- I think you --

DAVID O'TOOLE: So, Jack, if I could just -- like, by just total coincidence, we were on a call earlier this afternoon with the Western provinces doing one of our consultations, and it's clear that what they've learned about the health human resource employment profile for some of the folks working in the long-term care facilities across the country came as a total surprise to them in the Ministry.

The number of folks working in long-term care facilities in some of the Western provinces that were working in some -- like, at two full FTE complements, so, like, 200 percent of their time was committed to long-term care work in three or four different facilities.

So it's kind of emerging information to put together there a profile.

COMMISSIONER JACK KITTS: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry. I arrived late, and I apologize for that. Would you be able to figure out why somebody would be working at, effectively, two full-time jobs, whether it's just money -- they just want to make

as much money as possible -- or whether they're driven to do that because they're not paid enough, or some other reason which we don't -- we can't imagine?

DAVID O'TOOLE: That's a whole line of inquiry, Commissioner, that I think is worth following up on, and there are other provinces who are deeply, sort of, concerned with that question.

Is it a question of basically making a living wage for the standard of living in the jurisdiction within which you're trying to work and raise a family? There's no simple answer to it.

I have to confess, my screen just went black, so I can hear everybody fine, but I can't see a darn thing, so --

MÉLANIE JOSÉE DAVIDSON: Well, we can still see you, David.

COMMISSIONER JACK KITTS: We can see you.

DAVID O'TOOLE: Okay. So I'll mind my 'P's and 'Q's, then. Thank you.

MELANIE JOSEE DAVIDSON: Commissioner Kitts, shall I continue?

COMMISSIONER JACK KITTS: Yes, please.

MÉLANIE JOSÉE DAVIDSON: Okay. So I'll

just continue with some of the examples of lines of inquiries and some quick statistics that we have in each of the quadrants of that framework.

So that second quadrant is really around those outputs. So if we look at the outputs quadrant, one of the dimensions is safety. So a couple of examples of things that we know about safety is that 17 percent of the COVID-19 cases in Ontario so far have been among health-care workers, with long-term care staff being disproportionately affected.

As of today, our latest statistics, there have been just over 3,500 cases of infection among Ontario long-term care and retirement home staff including eight deaths.

Again, so if you take this dimension as a prompt for the development of lines of inquiries, you could come up with questions like: Prior to COVID-19, what was the pattern of other types of infection in long-term care homes? Or what infection control practices and policies have been put in place to help minimize and control the spread of COVID-19 in long-term care, in what homes, and at what point in time? And what types of patients were at greatest risk of adverse

outcomes during the first wave, and what additional safety precautions may need to be put in place for similar populations in the current or future outbreaks?

If we look at the outcomes quadrant, so one of the dimensions here is the health status dimension. So health status here refers to individuals and populations and the level of health conditions, health function, mental, physical, and social wellbeing as well as overall quality of life.

So related to this, we know that 79 percent of Ontario long-term care residents were at moderate risk of severe complications from COVID-19, and 14 percent were identified as high risk during the first wave.

We also know that in Ontario, prior to the COVID-19 pandemic, nearly one in five long-term care residents experienced worsened depressive mood. So when considering this particular dimension of the framework, you could come up with questions like: Beyond the COVID-19 deaths, how has the mortality rate changed in long-term care homes over time, and did resource constraints lead to excess mortality not directly related to

COVID-19? Or how has the separation of residents from their families influenced their experience and health status?

COMMISSIONER ANGELA COKE: Just one question, sorry, on the previous slide.

MELANIE JOSEE DAVIDSON: I'm not sure how to go backwards, so just give me one second.

COMMISSIONER ANGELA COKE: Okay.

DAVID O'TOOLE: There you go. You did it.

MELANIE JOSEE DAVIDSON: This one, or the one before?

COMMISSIONER ANGELA COKE: Yes, this one. So just where you're talking about the moderate risk or high risk, I'm just trying to understand how you would determine that, and when would people have known that risk-level profile?

MÉLANIE JOSÉE DAVIDSON: So that is research, actually, that Dr. Hirdes and my colleague Natalie Damiano led early on in the pandemic. So perhaps I'll turn it over to them to provide you with a bit more information on how we created those profiles.

So John or Natalie?

JOHN HIRDES: Yeah, sure. I'd be happy

to help with that. And what I would say here is meant by moderate risk is in the middle risk category for long-term care, if I was to compare this with the general population, what we call moderate risk here would actually be very high risk.

So what we did when the pandemic began, we looked at all the available literature, and virtually the only literature that was published at the time was coming out of China out of the acute hospital system.

And what they pointed to was a series of comorbid medical conditions, so heart conditions, respiratory conditions, diabetes and so on that they said would elevate risk of mortality, and then they also pointed to age. That was the entirety of what was known at the time in terms of people who were more likely to die related to COVID.

So what we did in the start of March was to map that to the assessment data that we had for long-term care. It was a joint team of my research staff and CIHI staff, and we created a measure called the Major Comorbidity Count which basically takes the WHO evidence to create a

severity scale. And we were able to release that to folks in the field. I believe it was by early to mid-April is when we got the information out. I also made the information available on a preliminary basis to the Ministry of Health.

And what we were trying to do with this was to point out to folks that based on WHO criteria, the folks in long-term care were at substantial risk of mortality.

At the time, most of the focus was really happening for the hospital system. But if you were to look at the combination of comorbid medical conditions plus advanced age, that was 80 percent of the long-term care population, so we were trying to get the message out that, with a pandemic like this, long-term care is basically dry tinder in a forest fire.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. Hirdes, did your research indicate when that would have been apparent or how obvious that was?

JOHN HIRDES: It was obvious on March 17th. We were able to do the analysis because of the data that CIHI has on all nursing home residents in the province. We were able to analyse

those, map the WHO criteria to that, and we saw that evidence virtually at the time the pandemic was announced.

What we are doing now is to try to refine that measure because we actually have a great deal more clinical information for that population that we can get a better measure of mortality risk for the second wave.

So in the Chinese data, they mentioned age was a risk factor, but they also mentioned diabetes, but they didn't control for the two, the two characteristics. It may be that diabetes only matters because it happens in older individuals.

So what we'll be able to do for the coming wave is to more carefully refine which are the medical diagnoses that are problematic and other clinical signs so we can help to better target the high-risk population. And that's based on data that are now available for Ontario where we can start to try to understand the mortality experience that happened in Wave 1.

COMMISSIONER JACK KITTS: Just a follow-up on that, every year a flu season comes to Canada, and often the long-term care homes are a larger target than the rest of the population.

Do you have pre-COVID statistics or data to show that, every flu season, this vulnerable population is at higher risk than the others?

JOHN HIRDES: Yes. In fact, we've already started to take a look at that. So I can tell you in 2018 was a pretty bad year in terms of influenza. And there was an up-tick of about 1 percent in absolute rate in mortality in long-term care compared to 2019 which wasn't as bad.

So if I'm recalling the analysis that we've just done a couple days ago, it was about a 5 percent overall mortality in 2019 and about 6 percent in 2018 when we had the elevated -- the more severe influenza strain.

And now we're just starting to assemble the mortality data for 2020 to look at the differential and excess mortality for this year compared to all other years.

COMMISSIONER JACK KITTS: So based on that, would it not -- and I don't want to talk about hindsight, but would the long-term care homes not expect that this is going to be, like, the worst flu season ever and would have known that

earlier on when they started preparing the hospitals?

JOHN HIRDES: Well, that's why we tried to get the message across with respect to the potential impact of COVID. So what we did is in March, nobody -- nobody had COVID in Ontario in the first week of March, and so we tried to look at, well, what proxy data do we have.

So we looked at previous years' experience with pneumonia, and then we did some simulation modelling of those comorbidity variables in the presence of pneumonia, age, and to try to get a sense of how bad this could be in March.

So in March, where we did a variety of scenarios of potential outbreaks and severity of the condition, we, at that point, predicted that we could be looking at 1,200 deaths. And in fact, the experience of COVID has been much worse than that experience that we had with general pneumonias.

COMMISSIONER JACK KITTS: Okay. Thank you.

I think you can proceed, Mélanie.

MÉLANIE JOSÉE DAVIDSON: Okay. So if we look at the social determinants of health quadrant, I'll just point out one piece of evidence

that we've raised in the paper that was submitted to you that kind of gets at some of the questions that Commissioner Marrocco had which is on the social determinants of health front. We know from other researchers in Canada that over 1 million personal support workers have precarious employment positions.

So these are primarily older women, visible minorities, or immigrants with low levels of education and training, and they tend to work in multiple long-term care homes without the same level of training in infectious disease protocols as nurses.

We also know from the Quebec experience that, obviously, these women live in communities, and that they also tend to live in poorer housing or more crowded housing. And so the example in Quebec has shown that infections have flowed from the community to the homes as well as from the homes back to the communities.

So the last part of the framework that I wanted to share with you was just a reminder to also consider the context around the health system. So this part of the framework is important because it brings together the different dimensions of the

framework and how they interact with each other and how our society and our broader social policies influence our health system's functioning. It also helps you think about the flow of patients between the different sectors of care.

So there are a number of pieces that we know about the context around long-term care. So, for example, we know that the proportion of seniors living in long-term care and retirement homes in Canada is higher than in the average OECD countries despite most seniors' desire to remain at home for as long as possible.

Canada's long-term care population also tends to be older than in other OECD countries with three-quarters of them being over the age of 80.

So the availability and funding of other levels of care also influences who is in long-term care in Ontario. So while retirement homes can offer somewhat similar levels of care, seniors may not be willing or able to pay for it out-of-pocket.

When we look at how patients flow through the system, a recent CIHI report on advanced directives in long-term care found that transfers to hospital tended to be higher in

Ontario even for residents that have a do-not-hospitalise order.

So the examples that we tried to provide you today are to show how the framework could be used in order to evaluate the long-term care sector's response to COVID-19 so far and how it could help the Commission with the organization of many pieces of information that you will hear over the course of your inquiry as well as the identification of lines of inquiry that could be pursued.

As you will hear from my colleague Brent Diverty next, it can also be used to identify the important information and knowledge gaps that we have about this sector. So we hope that this is helpful to you in your deliberations.

And, Brent, I'll turn it over to you, and let me know when you want me to change the...

DAVID O'TOOLE: I think Angela is pointing at --

COMMISSIONER ANGELA COKE: Just this last point on slide 14, it mentions that countries with centralized regulation and organization of long-term care, just -- I'm just trying to think of an example, or are you getting at the level of

system integration?

MÉLANIE JOSÉE DAVIDSON: It is the level of system integration that we've seen. So the countries in particular have been -- let me just pull up my list here -- Austria, the Netherlands, Hungary, and Slovenia had fewer infections in long-term care than in Canada. Interestingly, Australia also did, and Australia, like us, has a federated and decentralized system, but also did quite well in the COVID period or that first wave.

COMMISSIONER ANGELA COKE: Okay. So I'm just trying to understand what in particular about that model or organization helped them through this?

MÉLANIE JOSÉE DAVIDSON: So the prevention measures that we saw that were extremely helpful was that concurrence of the long-term care measures being instituted at the same time as the stay-at-home orders and other closures, so it was about maintaining similar public health interventions in the community and in long-term care at the same time as well as broad testing and supports for staff.

So those, presumably, have been easier

to do when you have a centralized model that requires less coordination.

DAVID O'TOOLE: If I can just -- Angela, I would project, like, it's the clarity and consistency of communication and the clear accountabilities that derived from one model potentially over another.

Sorry, Jack.

COMMISSIONER ANGELA COKE: So just as an example, sorry, to follow up on that: So places like B.C. or places that have the health authorities, did they prove to be doing better in terms of -- and that being a factor?

MÉLANIE JOSÉE DAVIDSON: So when we look currently at what's happened in Alberta, which has the integrated single health region, the cases have been much lower and much more controlled than in other provinces where there's been more decentralization like Ontario and Quebec.

COMMISSIONER ANGELA COKE: Thank you.

MÉLANIE JOSÉE DAVIDSON: Perhaps, John, did you want to jump in on that one too?

JOHN HIRDES: Yeah. The other thing I would add for regional variations within Canada and across national comparisons, so we have to be

careful of that, is we have to think about the degree of community spread.

So for Australia and New Zealand, things looked pretty good in those two countries, but there was very little COVID in those two countries to speak of. So it's not always that informative to think about the Australia/New Zealand experience in long-term care compared to ours.

Because if you look at Belgium, they were particularly hard-hit by COVID because Belgians went on March break earlier than the rest of Europe, and they went to two places: They went to France and Spain for warm weather; and then they went to the Italian Alps for skiing then came back and spread COVID across the country.

Well, in that country, you have massive COVID-related mortality in long-term care, and in some sense, it may be a better comparator.

So you need to think about what degree of community spread there was before you, then, evaluate the impact of COVID in long-term care.

It's sort of like saying not a lot of civilians died in fighting in Canada in World War 1. Well, that's because they didn't have

fighting on Canadian soil in World War 1. So it's not really a great comparison in that case. So you want to find places with substantial community outbreak as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Would it be possible or consistent with the work you do to find a jurisdiction that is a good parallel to ours that did well with the virus, and then perhaps we could compare?

Can you compare the structures in the two -- in a comparable jurisdiction, give us a sense of whether we've got the structure right or not, you know? If there has to be clear accountability, then you wonder about a structure where there are all kinds of people contributing to --

JOHN HIRDES: Yes. So --

COMMISSIONER FRANK MARROCCO (CHAIR): Like, you wonder about collective decision-making in that situation.

JOHN HIRDES: So two places that I would think that would be, the Netherlands and the United States: You know, the United States because it's another North American jurisdiction; the Netherlands because in some sense, the Dutch health

system has more comparability to the Canadian system.

And if you look at this graph that we just had there --

Mélanie, if you could go back.

-- you'll see the Netherlands there had quite a high rate of community-based mortality but a lower mortality in the nursing home population, so that's interesting. They had spread in the community, but it didn't hit their long-term care sector as much. So we're investigating a bit further with our Dutch colleagues what happened there.

The United States graph today would look different from this graph from May 25th. We are currently doing a scientific paper comparing the impact of the quality of nursing homes in New York State, Michigan, and Massachusetts and how that related to mortality, and the same analysis for Ontario, to see, you know, was there something about how good the home was that affected mortality in the two jurisdictions.

Then in later June, by the end of that month, Massachusetts and New Jersey and New York had higher overall mortality in nursing homes than

Canada did as a country.

So the -- you know, Canada is kind of in the middle of the pack with this, and, you know, Ontario got hit fairly hard, but a good deal of this wave that we see in Canada also comes from the Quebec homes.

But that's -- the short answer is the Netherlands and the U.S. would be where I'd look for some comparisons.

DAVID O'TOOLE: I just want to point out that Commissioner Kitts, I think, was trying to get in at one point.

COMMISSIONER JACK KITTS: Yeah. Yeah, so if you could move to the next slide, I was curious about the comparator between the provinces because we're all -- we all have a very high, proportionate deaths in the long-term care, no matter how big it is in the community.

And I'm wondering whether that -- there's -- we can read anything into that because if you look at the previous slide, they had much more community spread in there, and, therefore, the proportionality was different.

Is there anything to read into that here in terms of Ontario versus the rest, or are

they the same?

MÉLANIE JOSÉE DAVIDSON: So if you do look at the types and demographics of the patients that are in long-term care in Canada versus some of the other OECD countries, we do know that the Canadian residents tend to be much older.

And, John, you could perhaps speak to the case mix of those patients.

But we do know in Ontario, in particular, these are very sick residents to begin with. I think I would point out, Commissioner Kitts, that, from a population perspective, if you look at the overall spread, you would expect Alberta and B.C. to be relatively big provinces and to have a much higher rate both in their community and probably proportionately in their long-term care homes. So there are probably lessons to be learned there as well.

John, did you want to talk to the case mix line?

JOHN HIRDES: Sure. So there's a way that you can look at the overall resource intensity or complexly of residents in long-term care using a fairly sophisticated formula that comes from the assessment data, and CIHI (phonetic) manages that

formula nationally.

What we know is that if we look at Ontario over time, the intensity or medical complexity of residents has gone up substantially.

So that early slide that Mélanie showed about, you know, 80 percent of nursing home residents in Ontario could have been cared for elsewhere, in all the other provinces, that rate is actually higher.

We've made it more difficult to get into long-term care homes, and we've kept more complex people in the community which means that the nursing homes today are dealing with a much more difficult and at-risk population than they were a decade ago.

When I started my career in long-term care research in the 1980s, the length of stay in Ontario nursing homes was at least four years. And it's not like that at all now. It's a much more intense population.

And in my view, there's a mismatch between the clinical resources that are available in long-term care and the intensity of the residents that are there today.

So those nursing-home residents that

are much more complicated than they used to be, three-quarters of their care comes from personal support workers who don't really have a lot of clinical training, and when COVID hit, what happened is that in many ways, those personal support workers were on their own.

There's now evidence that's come out that medical directors were less likely to go to homes in person; there was less contact with medical expertise during the pandemic; and those homes were staffed at razor-thin levels for clinical nursing expertise.

In part, it's because there's this belief that long-term care isn't a medical setting; it's a supportive home environment. But that belief is a mismatch with the true complexity of the people that are there.

COMMISSIONER JACK KITTS: Thank you. I think it was 12 years ago, a study was done and the estimate was 20 to 25 percent of people in long-term care homes in Ontario didn't need to be there. And I think it seems like the pendulum has swung.

Do you have any idea what the right ratio would be so that you don't miss them -- and,

like, 80 percent seems to be too low, and 25 is too high.

JOHN HIRDES: And so this get into -- this now goes from science to politics. So the case mix has been the way to describe the clinical and resource intensity of the population that gets translated into a funding formula. And since I'm not from CIHI, I can say something about policy.

What you need to look at is the match between funding and the change in the complexity levels that are there, and I would suggest that we haven't followed the increased intensity of clients with the funding levels.

And in particular, we're not putting the resources to put more registered-nurse-level nursing into these homes which could have made a difference.

COMMISSIONER JACK KITTS: Thank you.

MÉLANIE JOSÉE DAVIDSON: I think if I could add as well, John, that we, as in comparison to other countries, have less hospices and palliative care homes that are dedicated to end-of-life care and tend to provide that care in long-term care settings.

So that is also a difference in how our

systems are structured and the kinds of patients that get admitted to the different sectors.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any sense of the people that are in Ontario who have medical training but for one reason or another, are not licensed to do anything and are, therefore, doing something else?

MÉLANIE JOSÉE DAVIDSON: We do have some information about registrations and people who have lapsed in their registrations. I know it is something that we looked into earlier in the pandemic. I don't have the details with me.

But, Brent, perhaps you have some of that information from our health workforce team?

Otherwise, it is something that we can easily follow up for you.

BRENT DIVERTY: I think that's one we can definitely follow up on, Commissioner. I don't have the statistics handy today.

COMMISSIONER FRANK MARROCCO (CHAIR): But you think it would be possible to get a sense of how many people there are in Ontario who have some degree of medical training, in the broadest sense of the term, who are available, in a sense, except that they're not in the stream?

BRENT DIVERTY: For certain professions if they're registered with their college, we know the subset of those that are not practicing or practicing to their full scope of practice.

And there's one other thing that we can pull on. We did some work early in the pandemic to gather that sort of -- the surge capacity in certain professions across the country as well. So we can look at these. It might be people who came out of retirement or, you know, came out of, sort of, non-practice to practice. So we may have some information there that we could look at and share with you.

COMMISSIONER JACK KITTS: Brent, a follow-up on that: So regulated professionals, there's a register of how many there are in each province or area. Is this -- does that -- I understand PSWs are not regulated.

Is there a register of PSWs in the country or in the province?

BRENT DIVERTY: No. Certain provinces have -- actually, that's a good segue into just the last couple slides too, Commissioner Kitts.

Certain provinces have registries of personal support workers, but as a country, we

don't. And I think that's something that we -- that many have suggested would be important for the future is to have a better sense of that group given their critical role in long-term care.

COMMISSIONER JACK KITTS: Thank you.

BRENT DIVERTY: So, I mean, it's a great discussion, and we're moving into data. Perhaps, there's just a few slides left in our presentation; I can briefly go through those --

COMMISSIONER JACK KITTS: Go ahead.

BRENT DIVERTY: -- and just give you a sense here. So, you know, Mélanie Josée's walked us through the framework, and what I will do is just highlight Pan-Canadian health information available through CIHI or that we work with that you may want to consider.

So CIHI, its, you know, in the heart of this mandate, we work with provinces and territories to collect reliable and comparable standardized data allowing jurisdictions to monitor health system performance, identify areas for improvement, and share best practices.

We've got a summary here on this slide for long-term care. So I'll just start on the left with the strengths. The availability and quality

of health data about long-term care has improved considerably over the past decade across the country including in Ontario.

In fact, Ontario was a leader. More than ten years ago, the province mandated collection and submission of data from all long-term care homes to CIHI's continuing care reporting system, the CCRS.

This system provides rich longitudinal clinical information based on the standardized clinical assessment instrument developed by interRAI. And John is the -- John Hirdes, Dr. Hirdes is the senior Canadian interRAI fellow. This is a clinical and research group involving individuals from more than 30 countries.

The clinical assessment is known as the MDS 2.0, and it collects information on the health status of residents and their care needs every quarter. And in addition to supporting individualized care planning through risk-based triggers and outcome scales, we can also aggregate the data and compare by facilities and track that over time.

So we have comprehensive coverage with -- coverage and comprehensiveness in the CCRS

data is very high. The timeliness, collection burden, and efficient implementation remain issues including in Ontario. And to this end, accelerating the transition of Ontario long-term care to CIHI's newer IRRS system, our integrated RAI reporting system, we think it should be a priority.

This is an updated version of the clinical assessment instrument of interRAI, called the LTCF, or Long-Term Care Facilities Assessment. It's about 30 to 40 percent shorter in its content. It allows streamlined work flow, and the IRA system that CIHI operates allows near realtime submission and reporting of data. So basically, data can flow in as assessments are done and reports can be sent back, so there's a big improvement there.

In addition to the clinical information I just described, and John and others have talked about some of the uses of the data so far, we also collect data on health spending and on the registered health workforce including information on the supply, distribution, and payment of doctors, nurses, and other regulated professionals. And we were just discussing that a moment ago.

Despite the overall improvements in the

breadth and coverage of certain health data, important gaps remain that prevent a full accounting of the pandemic experience in long-term care. And this is the middle section of the slide I'll just briefly talk about.

Of note, and as we just mentioned, information on unregulated healthcare workers, including PSWs, is generally limited and of poor quality across the country including in Ontario.

And in light of the central role that PSWs played in the sector and how their working conditions and training may have affected the course of the pandemic, this is a significant gap.

Another gap, also critical during the pandemic, is the experiences of long-term care residents and their family caregivers. And this is not systematically collected either. Increasingly, we have that type of information in acute care but not in long-term care.

And finally, the financial data about the long-term care sector, and critically, the detailed characteristics of its facilities, including information about the density, the presence of infection control, programs, about staffing mix, et cetera, are fragmented and

incomplete.

So the last column in this slide is about opportunities to better use the existing data and information, to use it closer to its full potential.

So as one example, there are many pieces of information generated through the ongoing government's management and accreditation of long-term care homes, and while this information may be available locally for decision-making or may be centralized for one purpose, such as the inspections branch of the Ministry of Health and -- the Ministry of Long-Term Care, excuse me -- the information is not often shared in a manner that allows it to be used to gain insights about the system or the sector as a whole.

And this includes information on the supply and use of PPE, distribution of staff across homes, and some of the financial operations of long-term care facilities' relative spends on different things.

There's also a need for more integrated data across sectors and across the country. So in Canada, we have excellent information about hospitals and emergency room use, but it doesn't

flow quickly enough nor is it integrated with long-term care data to inform pandemic-type decision-making about patient flow. Mortality is another critical data source with the same issues, mortality data.

So just in closing on this slide, I think that, you know, collectively, we want to say a word about the need to balance the need for ongoing collection of data in times of crisis when such activities could be deemed extraneous in the moment with the need for planning and future need for retrospective information about the period of the crisis.

In some cases in the past months, assessing residents using RAI assessment has been de-prioritized, which is concerning, and we are currently assessing the impact of that on the completeness of the CCRS data and recommend that streamlined or subsets of data collection continue even in times of crisis in the future. So --

DAVID O'TOOLE: If I could just intervene for a second, Commissioners. I just want to underline this: During a crisis, the practical inclination is to repurpose people to the highest and best use of the urgent requirement for their

labour.

One of the first things that got jettisoned was data submission. So precisely the kind of information you are requesting and would be useful to you in your deliberations may not have been submitted because those folks got repurposed to other things inside the long-term care facilities or the other institutions.

So we think, in the interests of preparedness for the future, it's worth thinking about a critical subset of data that ought to be submitted regardless of the circumstances, with a view to automating as much as possible, where possible, but that in the future, that there's not an absence of data to support discussion and deliberation around decision-making, such as you're doing now.

COMMISSIONER JACK KITTS: Can I just ask, because I think I heard that there's large gaps in data, so there's not a lot of data that CIHI gets from long-term care; is that correct?

BRENT DIVERTY: We have very complete and comprehensive clinical data on residents themselves. Our main gaps are around the workforce, particularly with the unregulated

workforce. The characteristics -- detailed information of the characteristics of the individual facilities and also resident quality of life experience-type information, those, I think, are our gaps.

COMMISSIONER JACK KITTS: Okay. And you said that that data may exist, but it's kept local and not shared, or it may not exist at all; is that correct?

BRENT DIVERTY: I think there's a mix there. And actually, we could break that out for you in more detail, Commissioner, and send that if that's helpful.

COMMISSIONER JACK KITTS: Okay.

BRENT DIVERTY: But, yeah, there's a mix. And sometimes we have, like, inspections data, often, because it wouldn't get integrated with quality data. And John can talk about if we really want to look at the relationship, for example, between, you know, the accreditation and their, you know, performance on inspections, the outcomes for patients in terms of quality and COVID, you need this integrated data set from --

DAVID O'TOOLE: What became clear very early on was a tremendous appetite,

Commissioner Kitts, for some basic, like, real property data. How old is the building? How many residents? When was it built? How many people per room? How many clinical staff per patient? Like, basic registry stuff that became desired by every jurisdiction across the country, and it doesn't exist in one place.

COMMISSIONER JACK KITTS: Okay. That summarizes it well. Thank you.

JOHN HIRDES: And on the clinical side, if I could just step in, we have very rich clinical data about residents with the CCRS system that is in Brent's slide. The challenge with that is the data are only submitted once every three months.

So when the pandemic hit, we did not have access to timely data even though there was rich data about what it was like three, four months ago.

New Brunswick has moved to the IRA system, the second one that's in Brent's slide. Which means that their data in New Brunswick right now is two days old.

DAVID O'TOOLE: Yeah.

JOHN HIRDES: If New Brunswick had a disaster tomorrow, they would have data less than a

week old to understand, and it flows continuously. So the two challenges with the clinical data are timeliness in terms of getting it in fast and then the -- the cessation of use of those clinical measures during the heart of the pandemic when they should have been looking at others who by falls, depression, behaviour, cognitive decline, functional decline, which likely happened during the pandemic in -- particularly in the homes where there was outbreak, and they turned the lights off in that case, and that was probably a mistake.

COMMISSIONER JACK KITTS: Thank you.

BRENT DIVERTY: Well, I'm mindful of the time. And I think I will just close my remarks with this last slide and really cut to the chase, which is, we've tried to summarize here what we think are priority areas for data improvement.

And those can be, as John -- that can be improvement in timeliness, completeness, or filling the gaps. This is our list, and I think we would, you know, respectfully ask that you consider the importance of complete and timely data in your recommendations from this Commission.

So thanks. And we are happy to answer questions.

COMMISSIONER JACK KITTS: Thank you.

Commissioner Coke, do you have any questions?

COMMISSIONER ANGELA COKE: Not at the moment. Thank you. That was very, very helpful.

COMMISSIONER JACK KITTS: Commissioner Marrocco? You're on mute.

COMMISSIONER FRANK MARROCCO (CHAIR): I have no questions. Thank you.

COMMISSIONER JACK KITTS: Okay. Well, I want to echo what Commissioner Coke said that that was incredibly useful. At a meeting this morning, someone said this was going to be very informative, and I think it was understated.

So great team, great presentation, lots of information. And we may, down the road, get back to you with some clarifications and some asks if that's okay with you.

DAVID O'TOOLE: Well, thank you for the opportunity to speak to you folks today. And if there's anything else we can do to help, just let us know.

COMMISSIONER JACK KITTS: Thank you all. You've been very helpful. Thank you and have a good evening.

COURT REPORTER: Thank you.

COMMISSIONER JACK KITTS: Bye.

COMMISSIONER ANGELA COKE: Take care. Thank you.

DAVID O'TOOLE: Thank you.

-- Adjourned at 6:00 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 28th day of September, 2020.

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