

Long-Term Care COVID-19 Commission

Via Zoom
on Thursday, September 24, 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 24th day of September, 2020,
16	5:00 p.m. to 6:00 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

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7 PRESENTERS:

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9 David O'Toole, President & CEO of the Canadian

10 Institute for Health Information

11 Brent Diverty, VP of Data Strategies and Statistics

12 Division of the Canadian Institute for Health

13 Information

14 Natalie Damiano, Director of Specialized Care of

15 the Canadian Institute for Health Information

16 Mélanie Josée Davidson, Director of Health System

17 Performance of the Canadian Institute for Health

18 Information

19 Dr. John Hirdes, Professor and Chair of the Ontario

20 Home Care Research and Knowledge Exchange at the

21 School of Public Health and Health Systems,

22 University of Waterloo

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

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7 ALSO PRESENT:

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9 Janet Belma, Stenographer/Transcriptionist

10 Lisa Di Felice, Administrative Assistant, Long-Term

11 Care Commission Secretariat

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

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

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

7 COMMISSIONER ANGELA COKE: Yeah.

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

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

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

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

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

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

14 COMMISSIONER JACK KITTS: Thank you.

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

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

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

24 DAVID O'TOOLE: Okay.

25 COMMISSIONER JACK KITTS: Alison, do

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

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

6 COURT REPORTER: All right.

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

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

11 DAVID O'TOOLE: We can see them.

12 COMMISSIONER JACK KITTS: Yeah.

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

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

1 which we hope will be of value to the Commission.

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

7 So let me start with some quick
8 background.

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

12 MÉLANIE JOSÉE DAVIDSON: Absolutely,
13 yes.

14 COMMISSIONER JACK KITTS: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 been disproportionately affected by the pandemic.

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

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

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

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

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

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

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

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

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

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

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

10 COMMISSIONER JACK KITTS: Before you go
11 on --

12 MELANIE JOSEE DAVIDSON: Okay. Yes.

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

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

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

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

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

9 MÉLANIE JOSÉE DAVIDSON: Exactly, yes.

10 COMMISSIONER JACK KITTS: Okay. I'm
11 sorry.

12 MÉLANIE JOSÉE DAVIDSON: No. That's
13 perfect.

14 COMMISSIONER JACK KITTS: Okay.

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

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

25 The third quadrant is the health

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

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

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

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

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

1 system and its performance.

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

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

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

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

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

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

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

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

15 COMMISSIONER JACK KITTS: Well, excuse
16 me.

17 MÉLANIE JOSÉE DAVIDSON: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

20 COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

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

18 COMMISSIONER JACK KITTS: We can see
19 you.

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

22 MELANIE JOSEE DAVIDSON: Commissioner
23 Kitts, shall I continue?

24 COMMISSIONER JACK KITTS: Yes, please.

25 MÉLANIE JOSÉE DAVIDSON: Okay. So I'll

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

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

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

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

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

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

12 So related to this, we know that
13 79 percent of Ontario long-term care residents were
14 at moderate risk of severe complications from
15 COVID-19, and 14 percent were identified as high
16 risk during the first wave.

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

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

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

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

8 COMMISSIONER ANGELA COKE: Okay.

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

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

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

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

24 So John or Natalie?

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

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

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

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

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

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

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

10 At the time, most of the focus was
11 really happening for the hospital system. But if
12 you were to look at the combination of comorbid
13 medical conditions plus advanced age, that was
14 80 percent of the long-term care population, so we
15 were trying to get the message out that, with a
16 pandemic like this, long-term care is basically dry
17 tinder in a forest fire.

18 COMMISSIONER ANGELA COKE: Thank you.

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

22 JOHN HIRDES: It was obvious on March
23 17th. We were able to do the analysis because of
24 the data that CIHI has on all nursing home
25 residents in the province. We were able to analyse

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

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

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

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

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

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

5 JOHN HIRDES: Yes. In fact, we've
6 already started to take a look at that. So I can
7 tell you in 2018 was a pretty bad year in terms of
8 influenza. And there was an up-tick of about
9 1 percent in absolute rate in mortality in
10 long-term care compared to 2019 which wasn't as
11 bad.

12 So if I'm recalling the analysis that
13 we've just done a couple days ago, it was about a
14 5 percent overall mortality in 2019 and about
15 6 percent in 2018 when we had the elevated -- the
16 more severe influenza strain.

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

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

1 earlier on when they started preparing the
2 hospitals?

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

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

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

20 COMMISSIONER JACK KITTS: Okay. Thank
21 you.

22 I think you can proceed, Mélanie.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 system integration?

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

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

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

25 So those, presumably, have been easier

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

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

8 Sorry, Jack.

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

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

20 COMMISSIONER ANGELA COKE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

17 JOHN HIRDES: Yes. So --

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

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

1 system has more comparability to the Canadian
2 system.

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

5 Mélanie, if you could go back.

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

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

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

1 Canada did as a country.

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

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

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

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

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

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

1 they the same?

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

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

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

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

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

1 formula nationally.

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

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

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

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

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

25 So those nursing-home residents that

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

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

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

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

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

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

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

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

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

18 COMMISSIONER JACK KITTS: Thank you.

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

25 So that is also a difference in how our

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 COMMISSIONER JACK KITTS: Thank you.

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

10 COMMISSIONER JACK KITTS: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

25 Despite the overall improvements in the

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

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

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

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

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

1 incomplete.

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

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

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

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

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

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

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

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

1 labour.

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

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

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

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

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

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

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

14 COMMISSIONER JACK KITTS: Okay.

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

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

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

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

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

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

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

23 DAVID O'TOOLE: Yeah.

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

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

12 COMMISSIONER JACK KITTS: Thank you.

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

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

24 So thanks. And we are happy to answer
25 questions.

1 COMMISSIONER JACK KITTS: Thank you.
2 Commissioner Coke, do you have any
3 questions?

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

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

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

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

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

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

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

1 COURT REPORTER: Thank you.

2 COMMISSIONER JACK KITTS: Bye.

3 COMMISSIONER ANGELA COKE: Take care.

4 Thank you.

5 DAVID O'TOOLE: Thank you.

6 -- Adjourned at 6:00 p.m.

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REPORTER'S CERTIFICATE

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

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

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

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

Dated this 28th day of September, 2020.



NEESONS, A VERITEXT COMPANY

PER: JANET BELMA, CSR

CHARTERED SHORTHAND REPORTER

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