

# Long Term Care Covid-19 Commission Mtg.

Meeting with City of Toronto  
on Thursday, October 22, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 22nd day of October, 2020,  
1:00 p.m. to 2:00 p.m.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

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10 Paul Raftis, General Manager, Long Term Care, Homes  
11 and Services, City of Toronto;

12 Nelson Ribeiro, Director of Operations, Long Term  
13 Care Homes, City of Toronto.

14

15 PARTICIPANTS:

16

17 Dawn Palin Rokosh, Director, Operations, Long-Term  
18 Care Commission Secretariat;

19 John Callaghan, Counsel, Long-Term Care Commission  
20 Secretariat;

21 Jessica Franklin, Policy Lead, Policy Unit,  
22 Long-Term Care Commission Secretariat;

23 Derek Lett, Policy Director, Long-Term Care  
24 Commission Secretariat;

25 Lynn Mahoney, Counsel to the Ministry of Health and

1 Long-Term Care;  
2 Emma Helfand-Green, Management Consultant, City of  
3 Toronto.

4  
5 ALSO PRESENT:

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7 McKaya McDonald, Stenographer/Transcriptionist.  
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1 -- Upon commencing at 1:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, I'll start. You know, thank you for coming.

5 These interviews are extremely helpful for us, and

6 we find they are a relatively efficient way for us

7 to learn about the area in which we have to report.

8 You know, we're at the investigative

9 stage of what we're doing, and in that sense, we're

10 really trying to look at not only recommendations

11 we can make immediately but other recommendations.

12 We had the opportunity to report on an interim

13 basis and report more than once. So that's kind of

14 what we're about.

15 We have tended to interrupt as you're

16 going long and ask questions rather than trying to

17 go back, Mr. Raftis. We'd like to do that, if

18 that's okay with you.

19 There is a transcript, and we post the

20 transcripts a couple of days after the submission.

21 We try to do that to maintain some transparency

22 because we're at the investigative stage, and we're

23 interviewing people. So that's kind of what we're

24 attempting to do there.

25 So, you know, with that very brief

1 introduction -- and the other thing is we'll  
2 probably take a break around 2:15 or so. So if you  
3 could let me know around that time what works for  
4 you, then we will do that.

5 PAUL RAFTIS: Okay.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 And, you know, beyond that, really, we're ready  
8 when you are.

9 PAUL RAFTIS: Okay. Yeah, no. We're  
10 in your hands.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Okay. So the way it's tended to work is the people  
13 we're interviewing usually have some perspective  
14 they wanted to make sure we understood, and we've  
15 used that as a starting point, really, for  
16 questions that we might have that sort of flow out  
17 of that.

18 PAUL RAFTIS: Okay. Understood. So  
19 thank you very much for that. I had not prepared  
20 sort of a specific sort of perspective to lead  
21 with. Following our first meeting, you know, some  
22 time ago, our team had put together a document that  
23 sort of summarized the challenges that we felt we  
24 faced as well as maybe some of the recommendations  
25 that had come out of our experience through COVID.

1                   And certainly, you know, these  
2 recommendations covered areas of things such as  
3 personal protective equipment; training; education;  
4 staffing levels; you know, building sort of  
5 resiliency; and, you know, a number of different  
6 things within the long-term care sector including  
7 surge capacity for these types of emergencies, as  
8 well as some discussion around communication with  
9 all of the various organizations and groups  
10 involved; and certainly funding, you know, has been  
11 a very significant piece related to all of those  
12 things.

13                   One of the areas that really popped up  
14 for us -- and it continues to pop up for us -- is  
15 the difference in physical environment in the  
16 various homes.

17                   So we have quite a wide range here in  
18 the city where we have, you know, a fairly new  
19 home, just a few years old, you know, right back to  
20 homes that were, you know, built, you know, 50 or  
21 60 years ago that have shared rooms and, you know,  
22 exceptionally intimate environments that in a, you  
23 know, situation such as COVID, really makes it  
24 difficult to have, you know, excellent IPAC  
25 practices.

1                   So, you know, we did talk about sort of  
2 our prevention and, you know, sort of early action  
3 that we had taken getting ready for COVID starting  
4 with our Coronavirus Working Group back in January  
5 and then the various prevention and mitigation  
6 efforts that we had put in place.

7                   And again, not knowing about this  
8 particular virus, we responded using the  
9 information that we had at the time working with  
10 Toronto Public Health and our health partners to  
11 prevent and try to control the spread of the virus  
12 very early.

13                   And in the document, we talked about,  
14 you know, how we quickly learned at Seven Oaks that  
15 those traditional methods, you know, did not work  
16 right off the bat. And so, you know, we changed on  
17 a daily basis as we learned more and new  
18 information became available related to things such  
19 as screening; mandatory masking; elimination of  
20 visitors; you know, enhanced IPAC practices;  
21 cleaning and disinfection; and education and these  
22 types of things; as well as, you know, real focus  
23 on active surveillance and isolation of our  
24 residents very quickly.

25                   Physical distancing was something that,



1 again, was fairly new to the sector. And, you  
2 know, moving to tray service rather than dining  
3 service -- these types of things were exceptionally  
4 important in really controlling the spread of the  
5 virus early.

6 We did find that testing became a very  
7 important piece for us for the identification of,  
8 you know, staff and residents and essential  
9 caregivers that were in the home that, you know,  
10 have proven to be asymptomatic but moving around.

11 So that testing was very important as  
12 well as, you know, support from our hospital  
13 partners and the LHIN for things such as IPAC  
14 audits and, you know, various medical supports and  
15 those types of things.

16 So, you know, we identify in our  
17 document that, you know, as these things became  
18 available and apparent, we tried to move very  
19 quickly to proactively implement them and, in some  
20 cases, implementing them early before they were  
21 mandated to be implemented.

22 And, you know, we had a very difficult  
23 outbreak at Seven Oaks. But the learnings from  
24 that outbreak really transferred over to our other  
25 nine homes and, we believe, made a very big

1 difference in terms of mitigating the impact at our  
2 other homes.

3 COMMISSIONER FRANK MARROCCO (CHAIR):  
4 Were the residents, then, confined to their rooms?  
5 How did that work in the first wave?

6 PAUL RAFTIS: Yes. Well, it really  
7 depended on, you know, the outbreak status at the  
8 home. So in -- you know, certainly, if there was  
9 an outbreak at the home, if there was any -- you  
10 know, if we had any active cases, then certainly  
11 the residents were isolated in their rooms.

12 But if a home was not in active  
13 outbreak, we tried to allow them to be in home  
14 areas but physically distanced as much as we  
15 possibly could within that. So it was really a  
16 combination and dependent on outbreak status.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Did you have the same staffing issues that we've  
19 heard about? By that, I mean, you know,  
20 significant numbers of people not showing up for  
21 one reason or another?

22 PAUL RAFTIS: Yeah. So we found very  
23 early, and certainly in the Seven Oaks outbreak,  
24 that there were staffing challenges right off the  
25 bat. But we were able to respond relatively

1 quickly, and we redeployed management staff to the  
2 home. We used -- redeployed staff from the City  
3 who were not working in other areas of the city,  
4 non-essential work. And we also utilized the  
5 City's HR department to really put a big push on  
6 for hiring.

7 And we also added agency staff, and we  
8 also added contract staff for cleaning and those  
9 types of things very quickly.

10 So the short answer to your question is  
11 "yes." We saw early challenges. But because of  
12 the -- we believe because of the nature of the  
13 City's organization, we were able to respond very  
14 quickly to those staffing challenges and not  
15 experience some of the real devastating numbers  
16 that we had heard about elsewhere.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Commissioner Kitts?

19 COMMISSIONER KITTS: Yeah. Just along  
20 that, maybe, you spoke about physical distancing,  
21 IPAC, PPE, staffing, testing. And I was going to  
22 ask you about relationships, but you kind of went  
23 ahead, you know?

24 Because you've got lots of  
25 relationships within the City with HR, staffing

1 support, things like that. Did you have to get  
2 other healthcare partners like hospitals and others  
3 involved? And on the other side of that coin, were  
4 you able to help other homes that weren't  
5 necessarily municipal homes with some of the  
6 staffing issues?

7 PAUL RAFTIS: Right. Great question.  
8 Thank you. So we utilized all of our relationships  
9 possible. So I've been with the City for a long  
10 time in emergency services.

11 So we connected deeply with the  
12 Emergency Operation Centre; with Toronto Public  
13 Health; a direct, personal relationship with  
14 Dr. Eileen de Villa and also Dr. Elizabeth Rea.

15 Nelson Ribeiro, our director of  
16 operations who is on the line, worked very closely  
17 with Toronto Public Health on, you know, a daily  
18 basis, really, on these issues.

19 Yes. HR purchasing, you know, the  
20 various emergency services. You know, as an  
21 example, thermometers were really difficult to come  
22 by early on, and, you know, we got a bunch from the  
23 fire department, as an example.

24 So, you know, internally, we really  
25 took advantage of those connections and

1 relationships to respond. The hospitals -- early  
2 on, you know, we didn't reach out to the hospitals  
3 as much. They were very much focussed on their own  
4 response to COVID at the time as the -- you know,  
5 as that curve was really rising. And we felt we  
6 were doing reasonably well.

7 As the hospitals started to have some  
8 capacity, we did connect with them. But back and  
9 forth, it was a two-way relationship. We discussed  
10 things such as access to personal protective  
11 equipment.

12 But again, for us, at the City, because  
13 of our relationship with the Emergency Operation  
14 Centre, we really didn't require those additional  
15 supports. And the hospitals did come out and  
16 support us in terms of doing independent IPAC  
17 audits, but we had some of our own internal IPAC  
18 people at the same time. So it was very much a  
19 collaborative -- continues to be a collaborative  
20 relationship.

21 In terms of other homes, unfortunately  
22 we were very much strapped notwithstanding our  
23 ability to respond. We were not overresourced, so  
24 we did -- we were not able to go out and support  
25 the other 75 homes in Toronto. We just didn't --

1 we would have loved to have been able to do that,  
2 but we just did not have the additional resources  
3 to do it. We were very much focussed on trying to  
4 maintain the levels that we had.

5 COMMISSIONER KITTS: And I think you  
6 said that you have a total of ten homes; is that  
7 correct?

8 PAUL RAFTIS: That's correct.

9 COMMISSIONER KITTS: And Seven Oaks was  
10 the largest outbreak. How many homes did have a  
11 significant outbreak, and you can you tell us what  
12 characteristics, if any, differed in those versus  
13 those who didn't?

14 PAUL RAFTIS: Right. So, you know,  
15 "significant" is fairly subjective. I would say --  
16 so when we look at the home -- so Seven Oaks, if  
17 you look at the first patient on the -- it was  
18 right on the very edge of the curve going up and  
19 before we knew anything about the virus.

20 And that's why we believe that we had  
21 such a large outbreak there. There were two other  
22 homes in very short order with Seven Oaks that had  
23 an exposure and an outbreak, and that was Kipling  
24 Acres and Lakeshore Lodge.

25 And I'm just looking at my time lines

1 here. So Seven Oaks was mid March. I don't have  
2 it right in front of me. So, you know, mid towards  
3 the end of March was the first resident there. And  
4 then March 30th and April 1st were the start of the  
5 Kipling Acres and Lakeshore Lodge.

6 But just in that short period of time,  
7 we had started to implement very significant  
8 measures at those homes as well. So their  
9 outbreaks were much smaller.

10 And then the other seven homes that we  
11 have, everyone, at some point, had had an outbreak.  
12 But the spread just did not happen in the same way  
13 at Seven Oaks because of all of the mitigation and  
14 prevention measures that we had put in place as we  
15 had learned very quickly what worked and what  
16 didn't.

17 COMMISSIONER KITTS: Thank you.

18 PAUL RAFTIS: And, Nelson, I'm not sure  
19 if you had anything else that you wanted to speak  
20 about there.

21 Nelson has said that March 19th was the  
22 first resident case.

23 NELSON RIBEIRO: Yeah, it was --

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 So --

1 Oh, sorry.

2 NELSON RIBEIRO: Go ahead.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Go ahead.

5 NELSON RIBEIRO: No. Paul covered it  
6 off, so it's fine.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 So you, first, are alerted to this in January of  
9 the potential problem?

10 PAUL RAFTIS: Yes. So, of course, we  
11 were watching it, you know, at the end of -- you  
12 know, the end of 2018, you know, as things were  
13 starting.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 2019.

16 PAUL RAFTIS: Or sorry, 2019. But it  
17 was really in January, the beginning of January,  
18 that we said "okay. Let's get a Coronavirus  
19 Working Group going. Let's connect with Toronto  
20 Public Health. Let's make sure that all of our,  
21 you know, appropriate measures are in place because  
22 a case is going to come."

23 We knew that was going to happen.  
24 Let's get ahead of it. And, in fact, the first  
25 case, as I understand it, was in and around



1 January 25th in Ontario.

2 So we were -- you know, we sent our  
3 first communication out to families on January 23rd  
4 just, you know, letting them know that we were  
5 aware and preparing for this and, you know, making  
6 sure that, you know, we got ahead of it.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 And how were decisions made...

9 PAUL RAFTIS: In terms of, you know, if  
10 we needed to make changes in real time?

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Yes.

13 PAUL RAFTIS: Yeah. So, you know,  
14 there's a small -- we would meet on a daily basis  
15 as a leadership team and talk about these things.  
16 I participated in our Strategic Command Team  
17 meetings with the Emergency Operation Centre and  
18 the City manager and all of the appropriate  
19 resources from the City.

20 And, you know, I was connected directly  
21 with Dr. de Villa just, you know, in terms of us  
22 being colleagues at the same table for many years.

23 And so we would be looking on an hourly  
24 basis what is happening? What's going on? What  
25 decisions do we need to make? And we would make a

1 decision, and they would be rolled out in real time  
2 to the homes.

3 We would talk to the homes every day at  
4 10 o'clock, the leadership of the homes, and so we  
5 were very much directly connected with all of the  
6 homes and supporting the homes on a daily basis.

7 So decisions were made quickly and  
8 implemented efficiently, and we certainly didn't  
9 have any barriers in that regard. If we had any  
10 challenges, the City was absolutely focussed on  
11 providing whatever support we needed.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Do you think that when you're dealing with  
14 something -- when -- that in dealing with Wave 1,  
15 it's better if the decision-making is local rather  
16 than provincial?

17 PAUL RAFTIS: Well --

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 Or do you -- I don't want to ask you an unfair  
20 question. So, you know, I certainly understand it.

21 But what prompted the question is  
22 you're very locally connected. So it's Toronto.  
23 You know where the homes are. You know who all the  
24 people are that you need to deal with in order --  
25 and you know what your particular circumstances

1 are. And so as you were speaking, it was occurring  
2 to me that perhaps a more localized response is  
3 more effective.

4 PAUL RAFTIS: Yes. I understand. I  
5 think I would say that, you know, the way that it  
6 worked for us with the support that we had worked  
7 very well. So there weren't any barriers for us in  
8 terms of making decisions; that's for sure.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Okay. Do you think the circumstances this time  
11 around -- like, in Wave 2, do you have any sense of  
12 whether it's a repeat of Wave 1 or it's different  
13 or...

14 PAUL RAFTIS: So the last four weeks,  
15 you know, we've been seeing exposures very  
16 regularly. As soon as we start to see, you know,  
17 the community numbers go up and the spread go up,  
18 we are getting positive tests back, you know,  
19 whether it's with an essential caregiver or you  
20 know essential visitors or staff members. Just  
21 naturally, as the numbers have been going up in the  
22 community, those positive tests have been coming  
23 back.

24 You know, outbreaks are a big concern  
25 for us, and it's hard to say -- I think it's a

1 little early to know what it's going to be like. I  
2 would say that, you know, for the most part, with  
3 all the exposures that we've had in the last number  
4 of weeks, there's been limited spread.

5 But there still are outbreaks in there,  
6 and generally, what we've seen is when there is an  
7 outbreak, it's from asymptomatic transmission where  
8 you're not able to see -- you know, you're just not  
9 able to see the symptoms, and you're only  
10 recognizing the case from a positive test. And so  
11 that individual, you know, can be shedding the  
12 virus, and no one knows about it.

13 So I think what's different this time  
14 at the beginning of the wave, if I can put it that  
15 way, is all of the, you know, prevention and  
16 mitigation efforts are in place on the front end.  
17 So I think that's, obviously, been very helpful.  
18 But with the very serious numbers in the community,  
19 the risk is -- it remains very, very real.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Was there a pandemic plan in place or a plan to  
22 deal with, you know, like, a SARS-type  
23 reoccurrence?

24 PAUL RAFTIS: Yeah. I would say that  
25 the answer is "yes." You know, certainly the

1 City's homes have been very much used to dealing  
2 with infectious diseases. And post-SARS -- you  
3 know, there were a lot of learnings as a result of  
4 SARS. But the homes deal with norovirus and, you  
5 know, influenza, and, you know, different  
6 coronaviruses. They have for many years.

7 And I think the behaviour of this virus  
8 has been different than the other viruses, and I  
9 think that's -- you know, that's what the  
10 difference was. We were preparing for those -- you  
11 know, those other things that we were familiar  
12 with, and the behaviour of this virus was so  
13 different.

14 And just as an example, the notion of  
15 not allowing visitors into the homes is something  
16 that is quite shocking, you know, for residents.  
17 When you think about that, you know, actually  
18 closing the homes to visitors is not something  
19 that's happened in the past, but it turned out to  
20 be an exceptionally important move early on to stop  
21 the spread.

22 COMMISSIONER COKE: Can I ask you a  
23 question? This is in the staffing area. I'm just  
24 curious if you -- what is the sort of proportion in  
25 your homes in terms of full time versus part-time

1 staff? Do you have some sort of average sort of  
2 proportion that you're working with?

3 PAUL RAFTIS: Yes. So we have --  
4 approximately two-thirds are part-time staff and  
5 one-third is full time.

6 And so when the single-employer  
7 legislation came into place, about 89 percent of  
8 our staff chose the City of Toronto. And what we  
9 tried to do there at the time -- because we know  
10 that, within the sector, there's a very high  
11 percentage of part-time staff and they have  
12 multiple jobs. In order to, you know, keep them  
13 going, we offered full-time hours to respond to the  
14 pandemic.

15 And, you know, that was very helpful  
16 but certainly is not sustainable in the long run  
17 given, you know, the extreme cost associated with  
18 that. But during the first wave, we really needed  
19 the extra staffing hours, and that was one of the  
20 strategies that we had put in place.

21 Now, we had done a report to council at  
22 the end of last year, and one of the things in  
23 there was increasing the number of staffing hours  
24 for the homes. And one of the strategies was to  
25 move that ratio of part-time to full-time staff to

1 have more full-time staff to help with those  
2 staffing issues in the homes. So we were already  
3 thinking of this as a move pre-COVID.

4 COMMISSIONER COKE: Okay. Thank you.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 The two-thirds to one-third ratio, has that been  
7 constant over a period of time, or has it evolved  
8 over a period of time.

9 PAUL RAFTIS: Nelson, maybe you could  
10 chime in with that answer?

11 NELSON RIBEIRO: About our ratio for  
12 staffing? So Paul's right in terms of the current  
13 staffing. So typically, our approval has -- or our  
14 staffing model was 60/40 so 60 percent full time  
15 and 40 percent part time.

16 As a result of people being on  
17 maternity leave, absences for different reasons, we  
18 end up staffing at more of the reverse, so  
19 40 percent full time, 60 percent part time. And  
20 it's just trying to manage those.

21 So Paul, since he joined the division,  
22 identified that as a concern in trying to increase  
23 the full-time ratio to try to further adjust that.  
24 So that's what we've been working towards, but it's  
25 been a challenge in terms of trying to manage that

1 for some time.

2 COMMISSIONER FRANK MARROCCO (CHAIR):  
3 The reason I ask the question is I'm trying to  
4 understand -- there seems to be, from what we've  
5 heard, a bias, if you like, towards part-time  
6 staff.

7 And I understand that, and I understand  
8 if people say, "you know, it's better if there were  
9 more full-time people." And you've tried to  
10 achieve that and experienced whatever difficulties  
11 you've experienced trying to do that.

12 But I guess I'm -- that seems to be  
13 across the industry. It doesn't matter whether  
14 you're a profit or not-for-profit or...

15 So I'm trying to understand why that  
16 happens, why that happened.

17 PAUL RAFTIS: Right. Right. Well, if  
18 I can speculate a little bit on that, I think from  
19 a 24/7 operations point of view, part-time staff  
20 are very helpful for a couple of reasons:

21 flexibility is one.

22 So Nelson had mentioned, you know,  
23 coverage for things such as maternity/paternity  
24 leave, illness, all types of non-productivity.  
25 Part-time staff, it's much easier to cover those



1 things off.

2 Typically, you know, there is a cost  
3 savings associated with part-time staff, so you  
4 might end up with more staffing hours for the same  
5 amount of salary dollars.

6 And, you know, the other reason  
7 specific to this particular industry, I'm not too  
8 sure. I haven't sort of grown up in the industry,  
9 as it were.

10 But in other operations I've been  
11 involved in, those are the two primary drivers of  
12 part-time. It's flexibility and more hours for the  
13 same salary dollars.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 And I guess the other part of my question was  
16 whether, in your experience, this is an evolving  
17 trend, a trend that's emerged over time, or whether  
18 it's been constant.

19 PAUL RAFTIS: Right. So I'm not sure  
20 about the long-term care sector. Nelson could  
21 chime in.

22 But I can say that, just broadly, in  
23 operations in the last, you know, 20 years, I would  
24 say that there has been more of a move to  
25 additional part-time hours to cover that

1 flexibility piece.

2 Nelson, did you have anything else you  
3 want to add in?

4 NELSON RIBEIRO: Yes. So it's always  
5 been there. I've been in long-term care for my  
6 entire career. As Paul mentioned, there's  
7 definitely a growing focus on part time.

8 Part of that is related to how we're  
9 funded in long-term care. So we heavily rely on  
10 the CMI complement in nursing. CMI is adjusted on  
11 an annual basis, and there can be some significant  
12 fluctuations in terms of funding.

13 So for a lot of the private and  
14 not-for-profit operators, they're constantly making  
15 changes in terms of their staffing complement on a  
16 year-to-year basis, and it's just easier to cut and  
17 add part-time hours than it is to try to hire  
18 full-time people and then lay off full-time people.  
19 So that also is one of the factors influencing the  
20 trend towards part time.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 And those funds that are -- they have to be  
23 directed towards staffing, or they go back to the  
24 province; is that --

25 NELSON RIBEIRO: Yes. So long-term

1 care has funding envelopes. The CMI is directly  
2 impacting nursing, so that would be your PSWs,  
3 RPNs, and RNs.

4 COMMISSIONER KITTS: Did you experience  
5 the similar -- we've heard that there was a lot of  
6 staff who left long-term care homes, some through  
7 fear and some for their own loved ones' sake.

8 Did you experience a loss of staff and  
9 have difficulty either continuing to retain them or  
10 recruit them back?

11 PAUL RAFTIS: So we did experience some  
12 of that loss. But I would say, you know, it was a  
13 small percentage. The single employer, we lost  
14 about 350 people as a result of the legislation.

15 However, we did hire -- we were able to  
16 hire more than 600 people back to the organization.  
17 So we've done pretty well on staffing. And then  
18 that along with, you know, the support that I had  
19 described earlier of redeploying staff from the  
20 City was very helpful.

21 COMMISSIONER KITTS: Did you find that  
22 the pandemic pay made a difference in terms of  
23 retention and recruitment?

24 PAUL RAFTIS: Certainly the pandemic  
25 pay -- you know, I think it made a big difference

1 in terms of people being at work and staying at  
2 work. So actually, once the first wave started to  
3 slow down, we tried to get people to take some  
4 vacation to get rested in the event of a second  
5 wave.

6 But, in fact, it was kind of difficult  
7 to incent people to take vacation because there was  
8 the -- you know, they were able to make that  
9 additional money. So yeah, there was -- it was an  
10 important incentive at the time, for sure.

11 COMMISSIONER KITTS: So going into  
12 Wave 2 now -- I don't want to put words in your  
13 mouth, but you seem to be more comfortable with the  
14 staffing levels today as opposed to in Wave 1.

15 PAUL RAFTIS: Yes. We have -- you  
16 know, we have similar concerns if you get into  
17 significant outbreaks. You know, we're really  
18 preparing in the event that we have staffing  
19 pressures, but I would say that we're more  
20 comfortable based on our initial experience in  
21 Phase 1, yes.

22 COMMISSIONER KITTS: Thank you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 When you were --

25 Oh, sorry. Commissioner Coke?

1                   COMMISSIONER COKE:    Sorry, were you  
2 following on the same topic?

3                   COMMISSIONER FRANK MARROCCO (CHAIR):  
4 No, no.   Go ahead.   Go ahead.

5                   COMMISSIONER COKE:    Okay.

6                   COMMISSIONER FRANK MARROCCO (CHAIR):  
7 I've asked too many questions already.

8                   COMMISSIONER COKE:    Okay.   I just want  
9 to understand a bit more.   My understanding is that  
10 the City provides some additional funding in  
11 addition to the provincial allocation, if that's  
12 right.   And how exactly does that work?

13                  PAUL RAFTIS:    Yeah.   So just in round  
14 numbers -- I don't have them in front of me.   But  
15 generally, the City ends up paying about 18 percent  
16 of the total cost of our long-term care services in  
17 a normal year.

18                  And so the City chooses to, you know,  
19 have additional staffing hours and those types of  
20 things within their home, and that's in the order  
21 of about 18 percent.

22                  During COVID, though, we've spent more  
23 than 20 million additional dollars on the response.  
24 And, you know, we'll see what happens when we  
25 receive all of the provincial funding, but it

1 certainly looks like the City will end up spending  
2 quite a bit more than, you know, the funding that  
3 will be available.

4 COMMISSIONER COKE: Okay. And the  
5 18 percent, how is that figured determined? Has  
6 that just been a number for some time, or is it  
7 based on anything in particular?

8 U/T PAUL RAFTIS: You know, we could break  
9 that down for you, if you'd like. I could take  
10 that away and we could break that down for you, but  
11 that's been sort of our historical spend year over  
12 year.

13 COMMISSIONER COKE: Okay.

14 PAUL RAFTIS: And it's generally  
15 staffing hours that are the -- you know, the  
16 additional cost that we're providing.

17 COMMISSIONER COKE: Do you have a  
18 target or a particular number that you're trying to  
19 achieve in terms of the hours of care for  
20 residents?

21 PAUL RAFTIS: So we are, and I included  
22 in our chart, generally, the City has been at, you  
23 know, sort of the three and a half hours per  
24 resident of direct care. And we've really tried to  
25 make that pitch to move that up to four hours of

1 care which has been a historical goal within the  
2 sector.

3 So we took a report to council last  
4 year that talked about that, and we were going to  
5 try and achieve that over the coming five years by  
6 adding additional staffing hours every year for the  
7 next five years. And council did approve that, and  
8 then, of course, COVID hit.

9 And so we actually -- through COVID,  
10 we've been a little bit higher than the four hours  
11 of direct care, and we've also injected some  
12 additional other hours into the system. So we're  
13 at about -- when you combine the two, about  
14 6.1 hours of care per resident, and we did include  
15 that in our submission on page 24 for your  
16 reference.

17 COMMISSIONER COKE: Thank you.

18 PAUL RAFTIS: You're welcome.

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 Do you know how they set the CMI or how that is  
21 determined?

22 PAUL RAFTIS: Nelson, could you comment  
23 on that?

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 Or how ( indiscernible ) on this.

1                   NELSON RIBEIRO: Sorry, can you repeat  
2 that? How is the CMI determined?

3                   COMMISSIONER FRANK MARROCCO (CHAIR):  
4 Well, and what's the extent to which there's some  
5 consultation with the persons providing the homes?  
6 And are there issues around that?

7                   I mean, I appreciate it can always be  
8 higher, but are there issues around the way that  
9 it's done?

10                  NELSON RIBEIRO: So CMI is based on a  
11 resident's care needs, and it's just on the  
12 documentation. So through the rise (ph) structure  
13 in terms of the wraps (ph) and everything that the  
14 homes complete and submit to the Ministry, there's  
15 a formula that determines what the actual CMI will  
16 be for the home for the following year.

17                  So it's never an accurate reflection of  
18 what the current care needs are in the home, so  
19 it's retrospective. So as part of the challenge  
20 with the process, it's that the City homes have  
21 taken sometimes the more difficult to serve, the  
22 behavioural, which don't always give the same  
23 funding as sometimes the heavier care needs.

24                  And there's always been an indication  
25 sometimes that some operators need documents for



1 funding. I don't know if that's completely proven  
2 or not. So it does impact the end amount in terms  
3 of what someone receives, but it's purely based on  
4 documentation.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 And there's a waiting list, as we've talked about.  
7 Do you have any sense of why -- what has held back  
8 the building or the creation of more beds?

9 PAUL RAFTIS: So certainly, you know,  
10 within the city, there's huge competing demands for  
11 capital funding. And, you know, the lion's share  
12 of the funding in the past for new beds has been,  
13 you know, taken on by the operator. So, you know,  
14 there's a formula for what you get back.

15 But, you know, for the City to be able  
16 to put out the capital dollars and build those  
17 beds, that's been a very significant challenge.

18 Now, we do have a couple of homes in  
19 our capital plan, and certainly there are four  
20 others that are on the list. But, you know, a  
21 couple hundred million dollars a home, you know,  
22 it's a very significant challenge with all of the  
23 other competing demands from the City.

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 And so do you rely on the private sector, then, to

1 build them? Is that the logical conclusion from  
2 that or no?

3 PAUL RAFTIS: Well, I think the City  
4 has been committed to moving forward with  
5 redevelopment. It's happening over a period of  
6 time because of the lack of available capital  
7 funding.

8 You know, I think the other piece to  
9 this is, you know, the City putting in that  
10 additional 18 percent. You know, as you add more  
11 beds, you add more operating dollars. And again,  
12 you're competing with all of the other services,  
13 you know, that the City needs to provide.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 So do you know -- and not in detail but -- what the  
16 deal looks like from the point of view of a  
17 provider putting up enough money to construct a  
18 long-term care home?

19 I've just been trying to understand the  
20 nature of the investment, what the transaction  
21 looks like or the deal looks like.

22 U/T PAUL RAFTIS: Right. So we could get  
23 you some more information on what that looks like  
24 for the City. Like, an example of -- we have  
25 Carefree Lodge in our budget currently.

1           But essentially, the City would put up  
2 the capital dollars, and then the province would  
3 pay back a certain amount of money per bed over a  
4 25-year period. And, you know, it's a percentage  
5 of the overall cost, capital cost, to do that.

6           And I don't have that calculation in  
7 front of me at the moment, but we could certainly  
8 get that for you.

9           COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Okay. But the general idea is, having put up the  
11 money to construct the facility, the cost of that  
12 is reflected over a 25-year period in a payment  
13 that the province is making per bed?

14           PAUL RAFTIS: Correct, correct.

15           COMMISSIONER FRANK MARROCCO (CHAIR):  
16 Is there a separate payment for the return? Let's  
17 just say you were private rather than the City of  
18 Toronto.

19           Is there a separate payment that  
20 amounts to the return on the investment, or do you  
21 know?

22           PAUL RAFTIS: I don't know that. I  
23 wouldn't want to comment on that. But from the  
24 City perspective, you know, it certainly doesn't  
25 come close to covering their capital expenses over

1 the 25 years. You know, it's a fraction of the  
2 actual capital cost.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. So it's --

5 NELSON RIBEIRO: Just to add to what  
6 Paul is saying, there's a number of the advocacy  
7 associations associated with the long-term care  
8 that have been pushing that the biggest deterrent  
9 from the operators redeveloping is that they can't  
10 get the mortgages, so the banks are unwilling to  
11 sign on. So the funding just doesn't work.

12 So based on what the current per diem  
13 is, it just didn't work in terms of the dollars for  
14 the actual build. So that was part of the delay,  
15 and the Ministry has increased that funding in the  
16 hopes that that could stimulate more redevelopment  
17 in the private and not-for-profit sector.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Yes. So in other words, the people who would  
20 finance the construction of a project can't figure  
21 out how the developer is going to make enough money  
22 to pay the interest on the mortgage or however they  
23 finance it plus repay back the capital?

24 NELSON RIBEIRO: That's correct.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 And so they won't fund. So if they won't fund, you  
2 can't build?

3 NELSON RIBEIRO: Correct. Because  
4 they're not investing their own -- typically  
5 they're not investing their own dollars.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Right.

8 NELSON RIBEIRO: They're using  
9 financiers' money to finance it and provincial  
10 funding to pay for that.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Well, I don't know if -- are there any other  
13 aspects of this that you think is important for us  
14 to understand?

15 PAUL RAFTIS: So I think that we tried  
16 to cover off all of the -- we tried to cover off  
17 all of the pieces within our submission. So I  
18 think we touched on most of them, yeah, within  
19 those recommendations and then within all of, you  
20 know, the various challenges.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Commissioner Kitts?

23 COMMISSIONER KITTS: Yeah. Just maybe  
24 one last question. You've done a lot to try and  
25 prevent the virus from coming into your homes in

1 Wave 2.

2 I think we know now that the prevalence  
3 of that virus in your community where the homes are  
4 is probably the single most important factor that  
5 you're not going to be able to prevent it from  
6 coming in.

7 So then the second thing they need to  
8 do, then, is once it's in, can you control the  
9 spread? And you've listed all of the right things  
10 that we now know after Wave 1 that will help  
11 control the spread.

12 Is there anything in that list of yours  
13 that you think could be done and hasn't been done,  
14 in your mind? I mean, you know, you can't change  
15 the infrastructure for Wave 2. There's things that  
16 you just can't do.

17 But is there anything that you feel  
18 that this Commission should hear that could be done  
19 but isn't being done?

20 PAUL RAFTIS: Well, I think -- I don't  
21 know if I would say "isn't being done," but I think  
22 one of the things that is really important is the  
23 staffing surge capacity so, you know, really moving  
24 to a higher level of staffing to be able to create  
25 that surge capacity for the moments when you have

1 that emergency or those challenges.

2 I think that's quite -- that's a  
3 proactive thing that could be done. So in regular  
4 times, you know, the residents would really benefit  
5 from the additional hours of care that are  
6 provided. And in emergency situations, the surge  
7 capacity is there to be able to manage.

8 So I think that that's -- you know,  
9 that's an area where we could really improve.  
10 We're trying to do that currently within our  
11 City-run homes, but obviously it's very expensive,  
12 and funding is a significant issue.

13 You know, on the PPE side, I think  
14 that, you know, there still are global supply chain  
15 challenges certainly for N95s which we're not  
16 using, you know, a ton of those. But, you know,  
17 getting ahead of those supply chain issues and  
18 inventory and those types of things, I think, are a  
19 really smart thing to do.

20 The other thing is, you know, coming  
21 from EMS, I think the sector would really benefit  
22 from incident management system training broadly in  
23 the sector to have more of a culture of emergency  
24 management within the long-term care sector to be  
25 able to respond to these types of emergencies.

1 I have a very strong team led by  
2 Nelson, and, you know, I think that that's an area  
3 broadly in the sector that, you know, we could be  
4 doing now to help continue to prepare.

5 COMMISSIONER KITTS: Are you talking  
6 about a specific long-term care EMS or IMS?  
7 Because I would imagine the City has a pandemic  
8 plan, and it covers a lot. But are you talking  
9 about, in addition to that, the City pandemic plan,  
10 a pandemic plan or whatever, IMS/EMS just for  
11 long-term care?

12 PAUL RAFTIS: Yeah. I mean, the  
13 hospitals had been getting into incident management  
14 system training in previous years. It comes out of  
15 emergency management -- fire, police, paramedic  
16 services -- type approach, and I think that that  
17 moving into the long-term care sector would help  
18 the sector in general be more prepared for  
19 emergencies. And we include that in our  
20 recommendations.

21 COMMISSIONER KITTS: Would you suggest  
22 that, perhaps, you broaden it to call it a health  
23 sector where all the partners are working in --  
24 instead of the hospitals here, and long-term care  
25 there?



1                   PAUL RAFTIS: Yeah, no. That's a good  
2 point. Yeah, for sure. And, of course, you know,  
3 the funding is a significant issue. So I think  
4 that's one of the reasons why the City has done  
5 relatively well versus maybe others is, you know,  
6 when we've had to overspend to respond, we've done  
7 that.

8                   And, you know, maybe other  
9 organizations don't have the capacity to be able to  
10 do that, and we certainly hope that those funds  
11 come to cover the cost of the response. But we  
12 didn't have to know in advance if they were going  
13 to. We were able to respond first.

14                   COMMISSIONER KITTS: Okay. Thank you.

15                   PAUL RAFTIS: Nelson, was there any  
16 other key pieces? Certainly the recommendations  
17 that we have there on page 6 and 7, you would be  
18 able to see all of those.

19                   But anything else proactively at the  
20 moment, Nelson?

21                   NELSON RIBEIRO: The only proactive one  
22 is that our homes have been utilizing the  
23 auditoriums to try to create the potential for an  
24 isolation unit within -- so Fudger House has the  
25 outbreak right now, and we are basically just

1 looking at how we can separate out those positive  
2 residents into a separate area. And most of the  
3 municipal homes have that auditorium capacity, and  
4 we're creating a make-shift home area which gives  
5 us a lot more capacity.

6 So that's something we may look at to  
7 add to our plan to address it if we have future  
8 COVID outbreaks in terms of how we respond.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Can I just ask about that? Who do you move out?  
11 Does it depend on the situation, or is there more  
12 of a rule?

13 NELSON RIBEIRO: So if you had  
14 identified positive residents, you would set up a  
15 make-shift home area. So basically we literally  
16 bring down the resident's bed, personal items, and  
17 we just create a home area within the auditorium.

18 So at Fudger House, we had capacity to  
19 fit 15 residents in an auditorium that were COVID  
20 positive so that they have a dedicated washroom,  
21 dedicated staff, and it's in that separate area.  
22 So you minimize your risk for your transmission.

23 Now, that's only effective until you  
24 reach your capacity, and then, potentially, you're  
25 back in the same position where you've got

1 COVID-positive residents within the same home area  
2 as negative residents.

3 PAUL RAFTIS: It just provides some  
4 additional flexibility and, you know, cohorting  
5 capacity.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Yes, Commissioner Coke?

8 COMMISSIONER COKE: So these are  
9 auditoriums in your structures already in the  
10 homes? Did you have to decant anywhere else or use  
11 any other facilities outside of the homes?

12 PAUL RAFTIS: No. So we used the  
13 homes -- our own facilities, the ten homes. We did  
14 not go anywhere else other than, you know, of  
15 course, if there was an emergency or something and  
16 a resident was transported by ambulance to hospital  
17 on the rare occasion. But no, we just use the  
18 existing homes that we have.

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 When you figured out or became alert in January to  
21 this potential or this problem that was coming, did  
22 you have --

23 We've heard other people that had had  
24 difficulties getting personal protective equipment  
25 and so on. Did you face those challenges, and if

1 you did, how did you solve it, or did you?

2 PAUL RAFTIS: Yes. So we definitely  
3 could see those challenges on the horizon. We very  
4 quickly connected with the Emergency Operation  
5 Centre that ended up managing the PPE inventory for  
6 the entire city including all of the emergency  
7 services of public health, our division, as well,  
8 the shelter system.

9 And they managed the ins and outs and  
10 worked with the province if there were any  
11 challenges. But the Emergency Operation Centre did  
12 an excellent job of being able to get enough  
13 inventory for us that PPE didn't really become an  
14 issue.

15 Now, there was one challenge that  
16 popped up where we received a bad batch of surgical  
17 masks. You may remember from the media we received  
18 a large batch of surgical masks. And, you know,  
19 very quickly, within a day or so, our staff  
20 identified that they were breaking when they were  
21 trying to put them on and that sort of thing.

22 So we immediately -- again, this was  
23 helpful having the City resources to deal with  
24 this. You know, we sent all of these masks back,  
25 and they replaced them with different masks, and

1 then they undertook an investigation. It turns out  
2 that the masks were -- you know, they were not of  
3 the quality that we should have received.

4 But really, it was those relationships  
5 and that support at the City level that helped us  
6 to manage our PPE issues.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Okay. Thank you.

9 Well, I don't know if there are -- it  
10 doesn't appear there are any other questions.

11 If we've heard anything you thought we  
12 should hear, then I guess it falls to me to thank  
13 you for the presentation and thank you for  
14 answering our questions.

15 PAUL RAFTIS: Well, we'd like to thank  
16 you very much for all of your work and the  
17 Commission's work and taking the time to chat with  
18 us.

19 Certainly there is the submission. If  
20 you have any questions related to the submission,  
21 please feel to reach out to us any time. We're  
22 available at your convenience any time.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 Well, thank you, and we probably will do that. So  
25 thanks for making that offer.

1                   And I guess with that, I'll say good  
2 afternoon and see you again, perhaps.

3                   PAUL RAFTIS:   Fantastic.  Thank you so  
4 much.

5                   COMMISSIONER KITTS:  Thank you.

6                   COMMISSIONER COKE:  Thank you.

7                   PAUL RAFTIS:  Thank you.

8 -- Adjourned at 2:00 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, MCKAYA MCDONALD, CSR, Certified  
4 Shorthand Reporter, certify:

5  
6 That the foregoing proceedings were  
7 taken before me at the time and place therein set  
8 forth;

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
12 thereafter transcribed;

13  
14 That the foregoing is a true and  
15 correct transcript of my shorthand notes so taken.

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18 Dated this 22nd day of October, 2020.

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