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

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

BEFORE:

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

PRESENTERS:

Paul Raftis, General Manager, Long Term Care, Homes and Services, City of Toronto;
Nelson Ribeiro, Director of Operations, Long Term Care Homes, City of Toronto.

PARTICIPANTS:

Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Policy Unit, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and

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

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I'll start. You know, thank you for coming. These interviews are extremely helpful for us, and we find they are a relatively efficient way for us to learn about the area in which we have to report.

You know, we're at the investigative stage of what we're doing, and in that sense, we're really trying to look at not only recommendations we can make immediately but other recommendations. We had the opportunity to report on an interim basis and report more than once. So that's kind of what we're about.

We have tended to interrupt as you're going long and ask questions rather than trying to go back, Mr. Raftis. We'd like to do that, if that's okay with you.

There is a transcript, and we post the transcripts a couple of days after the submission. We try to do that to maintain some transparency because we're at the investigative stage, and we're interviewing people. So that's kind of what we're attempting to do there.

So, you know, with that very brief

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

PAUL RAFTIS: Okay.

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

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

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

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

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

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

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

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

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

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

Physical distancing was something that,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAUL RAFTIS: That's correct.

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

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

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

And I'm just looking at my time lines

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

NELSON RIBEIRO: Yeah, it was --

COMMISSIONER FRANK MARROCCO (CHAIR): So --

Oh, sorry.

NELSON RIBEIRO: Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead.

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

COMMISSIONER FRANK MARROCCO (CHAIR): So you, first, are alerted to this in January of the potential problem?

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

COMMISSIONER FRANK MARROCCO (CHAIR): 2019.

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

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

January 25th in Ontario.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

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

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

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

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

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

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

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

PAUL RAFTIS: Well --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER COKE: Okay. Thank you.

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

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

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

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

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

for some time.

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

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

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

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

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

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

things off.

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

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

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

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

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

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

flexibility piece.

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

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

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

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

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

NELSON RIBEIRO: Yes. So long-term

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

Oh, sorry. Commissioner Coke?

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

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

COMMISSIONER COKE: Okay.

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

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

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

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

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

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

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

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

COMMISSIONER COKE: Okay.

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

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

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

care which has been a historical goal within the sector.

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

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

COMMISSIONER COKE: Thank you.

PAUL RAFTIS: You're welcome.

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

PAUL RAFTIS: Nelson, could you comment on that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAUL RAFTIS: Correct, correct.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So it's --

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes. So in other words, the people who would finance the construction of a project can't figure out how the developer is going to make enough money to pay the interest on the mortgage or however they finance it plus repay back the capital?

NELSON RIBEIRO: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

NELSON RIBEIRO: They're using financers' money to finance it and provincial funding to pay for that.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

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

Wave 2.

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

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

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

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

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

that emergency or those challenges.

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Okay. Thank you.

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

But anything else proactively at the moment, Nelson?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PAUL RAFTIS: Fantastic. Thank you so much.

COMMISSIONER KITTS: Thank you.

COMMISSIONER COKE: Thank you.

PAUL RAFTIS: Thank you.

-- Adjourned at 2:00 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, 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 22nd day of October, 2020.

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