

Long Term Care Covid-19 Commission Mtg.

Meeting With Dr. Kevin Smith, President & CEO,
University Health Network
on Wednesday, October 14, 2020



77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held Virtually via Zoom, with all participants
15	attending remotely, on the 14th day of October,
16	2020, 8:30 a.m. to 9:28 a.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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9 PRESENTERS:

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11 Dr. Kevin Smith, President and CEO of University

12 Health Network

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16 PARTICIPANTS:

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18 Alison Drummond, Assistant Deputy Minister,

19 Long-Term Care Commission Secretariat

20 John Callaghan, Counsel, Long-Term Care Commission

21 Secretariat

22 Derek Lett, Policy Director, Long-Term Care

23 Commission Secretariat

24 Dawn Palin Rokosh, Director, Operations, Long-Term

25 Care Commission Secretariat

1 Lynn Mahoney, Counsel, Long-Term Care Commission
2 Secretariat
3 Jessica Franklin, Policy Lead of the Long-Term Care
4 Commission

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7 ALSO PRESENT:

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9 Olivia Arnaud, Stenographer/Transcriptionist
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1 -- Upon commencing at 8:30 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So I think we're ready to go, actually. So,
5 Doctor, let me just tell you in a few words just
6 how we're looking at things.

7 Typically, commissions look backwards.
8 Something's happened, public is upset or concerned,
9 and a commission investigates, then it holds
10 hearings, and then it reports.

11 DR. KEVIN SMITH: Right.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 And that process quite often takes two years.

14 We view our situation as a little
15 different. We've been called into existence in the
16 middle of something.

17 DR. KEVIN SMITH: Right.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 And so we're kind of reversing the -- so that
20 traditional scenario doesn't seem like a very good
21 idea from our perspective.

22 And so we thought what we would try to
23 do is find some practical recommendations that we
24 can make quickly to deal with the situation as we
25 see it and then go about the more traditional

1 function of inquiring into what happened in Wave 1
2 and trying to explain that to the public. So
3 that's kind of the way we've approached it.

4 DR. KEVIN SMITH: Okay.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 And so apart from anything -- we're interested in
7 whatever you have to say, but we are very
8 interested in changes that we could recommend
9 immediately that would be helpful in this
10 endeavour.

11 What we've tended to do is sort of
12 interrupt as you go along and ask questions rather
13 than wait till you're finished and then try to go
14 back. And I think that's basically -- there's a
15 transcript; there's a reporter. As you know,
16 Ms. Arnaud is here.

17 DR. KEVIN SMITH: Yeah.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 So with that, by way of an introduction, we're
20 ready when you are.

21 DR. KEVIN SMITH: Okay. I'm ready.
22 Shall I just start with a few reflections?

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Go ahead.

25 DR. KEVIN SMITH: So maybe

1 contextually, I got involved in two ways. First,
2 we operate at University Health Network -- which is
3 made up of Toronto General, Toronto Western,
4 Princess Margaret, Toronto Rehab, and The Michener
5 Institute -- and within that are a couple of
6 long-term care homes. So in addition to being an
7 operator, we have the good luxury of being a part
8 of a large health system.

9 In Wave 1 as things started mounting
10 and we started hearing of the challenges of some of
11 our neighbour organizations, geographically
12 neighbouring us in long-term care, we reached out
13 to a few and said, listen, we're here to support
14 you if we can be helpful -- tell us what you need,
15 how it's going -- and it very quickly went from
16 there to Ontario Health basically suggesting that a
17 number of us buddy up with about 20 homes, 15 to 20
18 homes.

19 That started, then, with a couple of
20 them that were deeply in a very significant
21 challenge. Those that were most challenged already
22 had cases. They were very overwhelmed. They were
23 at times reporting 20 percent of staff reporting
24 for work for 100 percent of the work, and the
25 anxiety was building. We were starting to see

1 mortality.

2 And so we very quickly put out a call
3 to our organization and said, our neighbours need
4 help, and these are the frail, elderly people who
5 build our province; please put up your hand if
6 you'd be interested. And we got roughly about a
7 hundred people come back and say, I want to help if
8 I can.

9 And one of the most inspiring parts of
10 this, they were people from across every
11 discipline, right? I remember one morning myself
12 going to a home to help with some food service and
13 meeting up with a transplant nephrologist there.
14 So, you know, you don't very often see, you know,
15 someone who does kidney transplants doing basically
16 PSW work, but that was her choice because she felt
17 that's where she was needed.

18 So, you know, very inspirational as
19 always. Some just remarkable people in healthcare
20 who step up when the going gets tough, and that was
21 remarkable.

22 The other, I think, important
23 recognition are the people who were there. So I
24 think they often felt very under-appreciated,
25 although many were not in some of these homes.

1 Whoever was -- and in some cases, it was almost
2 full staffing, and in others, it was down to as low
3 as 20 percent -- I think felt very beaten up by
4 particularly the media or their perception of the
5 media that, you know, people were being abandoned
6 in long-term care.

7 And here were these folks who were
8 turning up with a disease that was still very
9 unknown in environments that didn't necessarily
10 have cutting-edge infection prevention and control
11 or air exchanges or the most modern buildings, and
12 the list goes on, and they were absolutely
13 providing loving and compassionate care to our
14 frailest and most vulnerable seniors.

15 We also stood up at this point in time,
16 and I think this was important, not only in
17 long-term care, per se, but a hotel for the
18 under-housed.

19 So we saw in emergency rooms, as an
20 example, a large number of people who were homeless
21 or who were under-housed and couldn't keep social
22 distancing and realized that that was an unsafe
23 practice. And so, working with the City of
24 Toronto, stood up a couple of hotels where people
25 could safely go while they were under investigation

1 or if they were positive, and again, the tremendous
2 importance of creating that environment.

3 From there, I would say inside UHN and
4 other hospitals who mobilized greatly -- and I'm
5 going to forget, Judge, the exact date. I then, in
6 discussion with the province, was asked if I would
7 share the Incident Management System --

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Right.

10 DR. KEVIN SMITH: -- and that really
11 got me much more deeply involved bringing together
12 a table of people from Health, operators from the
13 field, from long-term care. Originally, I think
14 the ministers were at least, on more than one
15 occasion, involved. They weren't necessarily daily
16 attenders but frequent attenders, and so very, very
17 responsive in terms of the Ministry.

18 And of course, the whole concept of an
19 Incident Management System was rapid
20 decision-making and rapid outcomes.

21 And so we really focused on what I
22 believe were and, more importantly, the group
23 believes were the two most important issues, and
24 that was ensuring adequate staffing to ensure care
25 and ensuring infection control practices were up to

1 the standard.

2 And a third, not quite as important but
3 close, was helping those homes with their
4 occupational health and return to workplace since a
5 number of people were off, some out of fear, some
6 out of symptoms, and any number of ranges in
7 between.

8 But as you'll know and I'm sure you've
9 heard already in the Commission, many people were
10 very, very frightened, not only families and
11 residents, but those who worked in environments
12 like that, and the backdrop was continually
13 shifting, as you know, and it continues to
14 continually shift with science.

15 And so there would be a new study that
16 came out, and it would be picked up in the popular
17 press. And, you know, it would say, someone has
18 now discovered that this might be an airborne
19 disease, not an aerosolizing disease but an
20 airborne disease; you can get it simply by
21 breathing it. And that didn't seem consistent with
22 what we were seeing in hospitals, didn't seem
23 consistent with what was being seen in airplanes,
24 but, of course, it was extremely frightening for
25 people.

1 And then, of course, during this
2 process, we saw two dedicated PSWs, two to three --
3 I think two PSWs sadly contract the disease and
4 die, which very much, of course, exacerbated the
5 anxieties.

6 From there, IMS really began what I'll
7 call a fairly traditional incident management
8 process, very regular meetings -- if necessary,
9 daily -- very focused on problem-solving, very
10 focused on the hot spots. We created a data system
11 or the ministries created a data system that
12 allowed us to group homes into, you know, green,
13 yellow, and red, and I guess at some points super
14 red if they had really [indecipherable] situations.

15 And daily or regularly, we went through
16 the process: What are the markers or metrics that
17 we would worry about in a situation like this? So
18 do they have adequate staff? Is PPE adequate? Are
19 we going in on every shift and ensuring that IPAC
20 training is being preserved or protected? What are
21 staff worried about?

22 And there were issues, Commissioners,
23 from, you know, long-standing issues. Like, in
24 some cases, they had an infestation of bugs that
25 had nothing to do with IPAC -- sorry, had nothing

1 to do with COVID but had a lot to do with infection
2 prevention and control. So in addition to the IPAC
3 initiatives, we obviously focused on what were the
4 things that were problematic for the residents and
5 for the staff.

6 And at a certain point, you all know
7 this -- I'm sure you'll talk to the Canadian Armed
8 Forces -- the province also requested the support
9 for long-term care of the Canadian Armed Forces.
10 That process didn't flow through the IMS. That was
11 a -- CAF did that in their own structure, but we,
12 again, were kept apprised by officials at the IMS
13 table.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Doctor, can I interrupt you for a second?

16 DR. KEVIN SMITH: Yeah, of course.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 The incident management group, where did it derive
19 its authority from? How could you make your
20 decisions effective?

21 DR. KEVIN SMITH: So I believe that it
22 derived its authority from the Cabinet and the
23 Premier. It was the chief of staff to the Premier
24 who was our liaison, and it was at the Premier's
25 request, as I recall, that an incident

1 management-like system was struck.

2 It wouldn't -- unlike a traditional
3 Incident Management System in some sectors, it
4 still had, of course, the political decision-making
5 tables to work with or through, and frankly, that
6 was left more to the government officials after our
7 meetings than it was to those of us from the
8 outside. But I will say, they were extremely
9 responsive, accessible, available, and at every
10 level of government: Municipal, provincial, and
11 federal.

12 So one of the most impressive things
13 for me coming into this one was to see the unity of
14 all levels of government around this issue. There
15 wasn't a single occasion where we felt like we
16 needed the support of our public officials that we
17 didn't receive it. There were things we wished we
18 could have achieved more quickly, mostly staffing,
19 and particularly staffing with expertise in IPAC.

20 And, of course, as in all pandemics,
21 one of the main motivators was fear, and overcoming
22 fear amongst the staff was an incredibly important
23 and, frankly, daunting and challenging piece of
24 work.

25 But as staff saw many hospitals and

1 other healthcare facilities going in to support
2 them, that adequate IPAC was not only available as
3 I believe it had been, but it was visible; that
4 regular training by experts was an on-the-ground,
5 regular occurrence, and all they had to do was put
6 up their hand if they needed more help or
7 questions.

8 And then, of course, staff slowly
9 started coming back as well as the homes had more
10 capacity because of the help to both recruit and to
11 work on their occupational health, safe return to
12 work. That was incredibly important.

13 Obviously, no one can operate optimally
14 with 20 percent of your staff showing up and
15 100 percent of your folks needing help, and in some
16 homes, a very large contingent being COVID-positive
17 or in active disease and quite ill. So it was
18 very, very challenging times.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Do you think in the second time around that the
21 same staffing problems will present?

22 DR. KEVIN SMITH: They haven't so far.
23 We reconvened the IMS structure a few weeks ago,
24 and I was asked to come back, and I am happy to do
25 so. And so far, I think by expecting the second

1 wave to be like the first, all of us came to the
2 table thinking, okay, we better be ready for this
3 need for massive numbers of staff to be redeployed.

4 And so far, thank God, we have not seen
5 that as our largest challenge, and we continue to
6 see even those homes with cases, and again, what
7 I'll call the "hot watch list" functioning fairly
8 well. And we're not seeing the kind of lack of
9 staff presentation that we saw in Wave 1 yet, that
10 the numbers are much more modest this time.

11 But again, we're much more proactive in
12 being in there as infection prevention and control
13 leaders. You've seen in the media, as I have, the
14 importance and draw on and worry about things like
15 N95 masks. So again, I think that we are in a
16 better position.

17 In addition, our first order of work
18 was to recognize that because of the physical
19 configuration of homes, Ontario has lost over 6,000
20 long-term care places because of the configuration
21 of rooms or multiple residents in one room or
22 infection control standards. And that's at a time
23 when, as you all know, the healthcare system really
24 does have to work as a flexible balloon. If you
25 squeeze one part of it, another may pop out.

1 So in Wave 1, we dramatically scaled
2 back activity in acute care for two reasons; one,
3 to prepare for that wave of acutely ill COVID
4 patients that thankfully didn't come. Unlike
5 Italy, even New York, and parts of Europe where
6 they saw this overwhelming surge of patients come
7 in who needed ventilation, luckily Canada did not
8 experience that, but we had slowed down activity in
9 case, in the event that that was required.

10 To some degree for those homes that did
11 need to empty out -- and there was an example in
12 Hamilton that was well-covered in the media where
13 they found very significant challenges and gaps in
14 a home and literally moved the population of that
15 home to two hospitals. So frankly, now, we don't
16 have that capacity in the rest of the system if
17 that were to occur.

18 Most hospitals are today running at or
19 above 100 percent, in part to catch up on those
20 100,000 procedures that we cancelled during Wave 1.
21 So one of the things we proved, I think -- none of
22 us wanted to -- but we could actually turn off work
23 of acute care hospitals pretty quickly. So in
24 Wave 1, we discovered, really, in 24 hours, for
25 elective procedures, we can turn it off or patients

1 can turn it off. We saw numbers of patients call
2 and say, I'd like to delay my elective work until
3 after COVID; I don't want to come to a place where
4 a bunch of COVID disease exists.

5 We haven't seen that yet in this round,
6 and I hope we don't because, you know, we have
7 significant populations of patients who, without
8 timely care, will go on to a worse outcome.

9 But I think we also realized in IMS-2
10 that our biggest focus now needs to be recruiting
11 and finding expansion capacity for those over-6,000
12 places. And so this week, we've been very focused
13 on what's -- not yet an official name; I'm sure
14 government will come up with the official name --
15 but really, an Ontario Seniors Reserve Force, going
16 out and calling out to people, particularly in
17 sectors like the hospitality sector that have been
18 hit so hard, screening and attracting those
19 individuals to a career, if they wish; if not, some
20 short-term support in long-term care environments.

21 And doing so in a way that is organized
22 and doesn't overwhelm the home by new people coming
23 in, but by sending them teams of people who can
24 augment what they're doing and make the quality of
25 life for residents better and the quality of work

1 life for staff good enough that they'll continue to
2 be able to report without undue stress.

3 COMMISSIONER JACK KITTS: Kevin, we've
4 heard from a number of sources that because the
5 hospitals in Wave 1 were not at capacity, they were
6 able to take some patients from long-term care
7 homes and cohort and isolate that way.

8 I think you just said that's not likely
9 to happen in Wave 2, so you're looking at other
10 opportunities to create capacity.

11 We've heard about the -- on a number of
12 occasions, the Windsor, I don't know, army tent or
13 whatever that a lot are saying was very helpful in
14 reducing the magnitude of the challenge in Windsor.

15 Do you know about that, and is there
16 any plans ongoing to create capacity through these
17 army tents?

18 DR. KEVIN SMITH: Yes. So let me
19 first, Jack, as you well know, go back a little bit
20 to the literature and evidence on what's good for
21 frail, elderly seniors, and two things, if I maybe
22 wasn't clear enough: So at no time during Phase 1
23 did IMS or, to my knowledge, any of the hospitals
24 that we talked directly with -- although I saw some
25 media this week that I'll be happy to comment on in

1 a moment -- ever say, if you have an acutely ill
2 person or if you think it is in the resident's best
3 interest to be transferred to hospital, absolutely
4 call an ambulance and transfer them hospital; in
5 other words, never any intention not to support
6 those who wished hospital care.

7 As you all know as well, a large number
8 of people in long-term care have chosen with
9 advance care directives to say, in the event that I
10 get ill, I'd like supportive care in place; I don't
11 want acute care. So again, it went back to what
12 was the desire of the resident.

13 I mean, one recommendation I think that
14 I would respectfully suggest the Commission
15 consider is, do we do a good-enough job on those
16 advance care directives of ensuring, you know, what
17 patients or residents and families want.

18 The second, I think, as we -- we have
19 to remember acute care environments are really
20 lousy places -- Jack, you've spent your career at
21 this -- for non-acutely ill patients, particularly
22 immune-compromised, frail patients, patients with
23 dementias, and issues of falls, issues of infection
24 control, every number of measures we can offer, and
25 that we don't do a very good job in acute care

1 environments in terms of the activities of daily
2 living of a long-term care resident.

3 So when looking at the risk, I think we
4 always want to ask: Where is the best place for
5 the patient? And the best place for the patient is
6 undoubtedly in an environment for long-term care.

7 [Dog barking]

8 If you'll excuse my dog, I'll just open
9 the door and let him go outside at this point, and
10 then I'll come right back. Unscheduled things,
11 Your Honour.

12 COMMISSIONER FRANK MARROCCO (CHAIR): I
13 think I'll get rid of my phone.

14 DR. KEVIN SMITH: This is the challenge
15 of working from home. So we did, Jack, look at --
16 very much look at --

17 [Dog barking]

18 Now I'm going to shut the door because
19 he's barking outside. The challenges of working
20 from home, Your Honour.

21 COMMISSIONER FRANK MARROCCO (CHAIR): I
22 got rid of my phone because it rings every single
23 time we're doing one of these.

24 DR. KEVIN SMITH: Watch it, that'll
25 probably happen in a minute with mine. My

1 apologies about that.

2 So we did throughout this look at
3 increased capacity, and I would say there was a
4 to-and-fro about, for sure, we need to expand
5 capacity in the system.

6 Are tents the best environment for
7 frail, elderly people, a large percentage who have
8 dementia? Or would it be better off to take, for
9 example, end-of-stage medical patients or complex
10 care patients or other patients, perhaps patients
11 who didn't have as high a probability of dementia,
12 since we know an environmental change can be very
13 challenging to people suffering with dementia?

14 So it's still on the table what is the
15 best environment to expand, whether it's hotels or
16 tents or others, and I would say at the moment
17 we're just literally wrapping whatever capacity we
18 can and then looking at who is best served in that
19 environment.

20 But what we do know is we definitely
21 are undersized for the long-term care population
22 that we need, and government has -- successive
23 governments have talked about a massive rebuilding
24 campaign.

25 In addition, as you know, we also had a

1 lot of what are known as C&D beds, so environments
2 that were not modern in terms of design or
3 infection control, and optimally, today, we
4 wouldn't be building an environment where --
5 ideally would be each resident had their own
6 bathroom where maximal infection control could be
7 deployed in long-term care, and I know the Ministry
8 has already begun looking at changing the criteria
9 and the standards.

10 But specifically to your question,
11 Jack, we have to expand capacity. I think we
12 should look at it overall in terms of what's
13 available and of the patients who can move, what's
14 the best place for them to move? So if a tent is
15 the best environment of all our choices, then we
16 absolutely need to consider that.

17 If that's not the best environment, if
18 actually we should consider moving other patients
19 to a tent-like environment because they're shorter
20 stay and moving long-term care patients to more
21 residential-like facilities, then that would be my
22 own personal preference.

23 COMMISSIONER JACK KITTS: Okay.
24 Thanks, Kevin.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 The 6,000 beds, this temporary capacity, these
2 field hospitals or whatever the correct term is for
3 them, do you have any sense of how many beds they
4 would replace? Is it 6,000, 3,000, 1,000? Do you
5 have any sense of that?

6 DR. KEVIN SMITH: Yeah. It's a great
7 question. We had this discussion just yesterday:
8 What's the goal? And we had a very good debate
9 about the goal being -- we've lost 6,000, and we
10 had about 5,000 people in what we designate as
11 "alternate level of care." I'm sure you've heard
12 about that.

13 Alternate level of care are patients
14 who are in acute care environments or others --
15 rehab or complex care -- who a physician has
16 designated that you no longer need to be in an
17 environment with daily medical services; that's not
18 where you're at in your recovery. And that would
19 have been about 5,000, so we're talking about up to
20 11,000 --

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 11,000.

23
24 DR. KEVIN SMITH: Yeah, 11,000 people.
25 And our debate yesterday and request of

1 government is, where would you like us to get to in
2 terms of creating alternate capacity? To 11,000,
3 which would allow appropriate flow and capacity
4 issues? Or to 6,000 so we're back to at least the
5 baseline we were when we started all this?

6 And our work has continued in saying,
7 go find as many environments as you can for us to
8 accommodate or secure, and then we will determine
9 what kinds of residents or patients are best served
10 there.

11 At the moment, we've seen about 2,300
12 spaces secured, not yet opened entirely. But,
13 Jack, in your community, which has had a great
14 challenge in the last few weeks, we, I think, have
15 seen a number of hotels and other environments now
16 that have begun opening, and more will be open by
17 the end of October and a significant increase by
18 the end of November, assuming staffing is
19 available.

20 COMMISSIONER JACK KITTS: Yeah.

21 DR. KEVIN SMITH: And, you know, in
22 every one of these, Commissioners, I want to
23 underline: One of the greatest challenges, even if
24 we can find the appropriate physical environment,
25 is ensuring that we have adequate staffing and that

1 we're making this a long-term, attractive
2 profession to serve seniors.

3 And clearly, our seniors' reserve is an
4 attempt to begin that. The Government of Ontario's
5 investments to more equitably remunerate people in
6 these professions is also important, but again, as
7 you've heard over and over and over again, this has
8 been uncovered much more by this pandemic, but
9 these are issues in long-term care that many of us
10 who've operated in long-term care have struggled
11 with for many years: The daily per diem, the
12 funding rate, the state of the physical plant, and
13 the access to specialized services.

14 This is a sector that's been waiting
15 for significant investment, not only in capital,
16 but in operating dollars for some time.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 What's the barrier? What's been the barrier? You
19 said it's gone on for a number of years, and you
20 obviously have some background with this because,
21 at least as far as the UHN is concerned, there are
22 some long-term care facilities within that
23 catchment area, I guess. What's the barrier?

24 DR. KEVIN SMITH: So I guess, like
25 always, I think it does come down to opportunity,

1 costs, and resource allocation, and governments of
2 successive stripes I think have said, you know,
3 we're growing by 3 percent or 5 percent or whatever
4 the number is per year, and oftentimes, it will be
5 the acute care environment that is very present,
6 that there's a threat in emergency rooms to keep
7 them open, and people can relate to that fear of
8 not having their local hospital be available to
9 them.

10 We've also been through, again,
11 successive governments' reductions or annual
12 targets that funding may not meet the true
13 inflationary pressures. So each year, every
14 organization, including long-term care
15 organizations, have a gap between what their
16 funding increase is and what their costly reasons
17 are.

18 In addition, and legitimately, there
19 have been a lot of new regulatory changes, so more
20 infrastructure required for evaluations, resident
21 councils, all very good things, but all additional
22 costs that wouldn't be seen as direct care costs.

23 And so as costs have increased and
24 spending has tried to be contained and you then
25 make choices within the long-term care system, I

1 don't think that long-term care has had the same
2 presence or -- I'll be very blunt, perhaps. It
3 isn't as sexy as some of the issues of, you know,
4 scary cancers and horrible trauma and those
5 immediate healthcare needs.

6 And I think it has culturally been not
7 as attended to as our acute care system has been.
8 At a time when, within the sector, there has been a
9 look at what are the most pressing issues of
10 funding, and, you know, sadly, I think this has
11 proven to us that we need to completely readdress
12 this.

13 The other issue may be that in the rest
14 of the healthcare system, there is a
15 federal-provincial-territorial relationship that
16 the federal dollars do consider transfer payments
17 related to acute care and that long-term care has
18 not been included in our health transfer payments.

19 And I, for one, hope you'll consider
20 recommending -- I recognize your responsibility is
21 back to the Provincial Government, but your sway
22 will be with all decision-makers that got Ottawa
23 and the cities in which these facilities operate --
24 the multiple governments really need to come
25 together and talk about, what is our collective

1 vision and responsibility for long-term care, and
2 what is the cost-sharing arrangement?

3 In my opinion, long-term care should be
4 included in Medicare, and it's an important area
5 that has not yet been adopted after many, many
6 years of socialized healthcare and a shared
7 responsibility for payment between the provinces
8 and the Federal Government.

9 COMMISSIONER JACK KITTS: Kevin, can I
10 shift now from -- a lot of attention has been paid
11 to staffing being the huge problem, lack of IPAC
12 presence and measures, practices, and, you know,
13 other things -- not enough PPE -- but I want to ask
14 you a bit about what you've learned about
15 leadership during your IMS experience and even your
16 own hospital experience.

17 And I'm talking about local leadership
18 which would include public health, hospitals, and
19 long-term care homes, which is kind of what we saw
20 when the hospitals came in to help the ones that
21 were in trouble; there was a triad of them working
22 together.

23 Give me your thoughts around the
24 leadership and how that triad might work in the
25 short term for Wave 2.

1 DR. KEVIN SMITH: Okay. Well, let me
2 start at the very highest level, Jack, and then go
3 to much more granular, you know, observations.

4 So at the highest level, I guess most
5 of us came into this thinking there was a clearer
6 and more robust chain of command as is enshrined in
7 legislation that starts with the Public Health
8 Agency of Canada and its leadership, medical
9 leadership back to the provincial chief medical
10 officers of each of the provinces, and in most
11 provinces that have divisional responsibilities
12 like Ontario where there are 34 chief medical
13 offers of health based around municipal regions
14 that, in times of a pandemic, there would be a more
15 clear and action-oriented chain of command.

16 And that has not been the experience
17 that I saw at IMS. I often saw jurisdictional
18 issues. I, on occasion, saw disagreements between
19 people at various of levels of the system including
20 areas of public health but not exclusively in
21 public health. And to be frank, I think, like
22 everything in life, there was a normal
23 distribution. You know, the 20 percent of folks
24 who you'd say, wow, that they really, really need a
25 tonne of help or push.

1 The majority of folks in the middle
2 around the mean, 60 percent, and then again
3 20 percent of remarkable and exemplary and go way
4 beyond the cause of duty like most things in life
5 that are normally distributed.

6 So, you know, there were times when I
7 was absolutely impressed by that, the nature of
8 that, how the Medical Officer of Health and the
9 Medical Director and the primary care community
10 worked completely in sync, and there were other
11 extremely disappointing times when there appeared
12 to be little or no cohesion, coordination, and,
13 frankly, relationship.

14 And, you know, as much as we talk about
15 systemic development, at the end of the day in
16 health and social services, these often come down
17 to the local relationships that are formed and the
18 way that leaders within those various sectors of
19 health choose to interact and build a seamless
20 continuum.

21 I saw examples of that that were
22 excellent, and I saw examples of that that were
23 wanting, greatly wanting. I think that's a very
24 important follow-up question, and I hope that the
25 various levels of government will be seized with

1 examining what went well and what didn't go so
2 well.

3 What I will say is in Wave 1 that we
4 absolutely were able to use the IMS as a table that
5 said "time out." We've had a lot of interesting
6 discussion about this. It doesn't appear that you
7 have locally found a solution, so here's what we're
8 recommending or directing in the IMS structure, and
9 here's how it needs to go forward. And at that
10 point, I think it worked better.

11 I suspect that it would be good to have
12 that kind of structure going forward, for more
13 normal management processes that, on occasion, end
14 up just, frankly, stalled because local players
15 can't agree -- local and national players can't
16 agree, and where does one take those things? I
17 hope one of your recommendations will be if there
18 are outstanding issues, there needs to be a clear
19 form where those will be addressed.

20 COMMISSIONER JACK KITTS: Is --

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Doctor -- oh, sorry, Jack. Go ahead.

23 COMMISSIONER JACK KITTS: Just, is it
24 feasible, and if feasible, is it workable for
25 something like the IMS to direct local hospitals,

1 public health officers, and long-term care homes
2 that don't have a relationship to recommend or
3 direct them to enter into these relationships
4 before they have to be told to go in?

5 DR. KEVIN SMITH: You know, I think
6 that, frankly, like everything in life, we already
7 have that remark- -- that 20 percent I spoke about
8 and maybe even more like 40 to 50 percent to the
9 right side of the mean who are talking about,
10 exploring, undertaking, and making that happen.

11 Those aren't the ones I'm worried about
12 or you're worried about. It's the other 40 or
13 60 to 50 percent on the left side of the mean who
14 are at times intransigent and feel as though, I
15 want to run -- you know, ride my own horse on my
16 own trail and do it my own way.

17 So yes, during times of IMS, we've had
18 the ability of, you know, more than gentle
19 persuasion and to bring to bear the various
20 ministers, ministries, city councils, mayors.

21 But I don't think that that's a
22 good-enough future response, and I hope you'll
23 consider in your recommendations on the quality
24 IPAC and culture side, including occupational
25 health and safety, actually recommending that that

1 be a relationship that is formed.

2 COMMISSIONER JACK KITTS: Yes.

3 DR. KEVIN SMITH: So just as an example
4 in [indecipherable], I am an operator of both
5 hospitals and long-term care. Neither is perfect,
6 and neither is villainous, but the lack of a formal
7 quality structure that can be overseen, medical
8 quality structure and nursing quality structure
9 that can be overseen by a body large enough to
10 wield some independence who, in my opinion, would
11 be much better than the current approach to
12 inspectors.

13 COMMISSIONER JACK KITTS: Yes.

14 DR. KEVIN SMITH: The inspectors are
15 looking -- in my view, inspectors are always
16 looking at the minimum acceptable standard. I
17 don't believe that that's the approach we should be
18 taking in healthcare with frail seniors.

19 COMMISSIONER JACK KITTS: Right.

20 DR. KEVIN SMITH: It shouldn't be the
21 minimum available standard. It should be a
22 standard of care set by evidence and research.

23 COMMISSIONER JACK KITTS: Okay.

24 Agreed.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I've been having some difficulty, and maybe you
2 could assist me with it.

3 It seems to me that there is a
4 structure in place where there's an infectious
5 disease outbreak. When I say a structure, I mean a
6 legal structure. I'm not disputing that it may not
7 exist in reality, but it seems to me that the local
8 medical officers of health and the Chief Medical
9 Officer of Health have had the authority to act.

10 DR. KEVIN SMITH: Yes.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 And do you have the same understanding?

13 DR. KEVIN SMITH: Certainly. In
14 legislation, that is absolutely the case. To my
15 earlier example of --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 No, no, I know what you...

18 DR. KEVIN SMITH: Yeah. I think, you
19 know, what -- there are 34 medical officers of
20 health and a Chief Medical Officer of Health, and
21 in no way, shape, or form to diminish the great
22 work that each of them are trying to do, there are
23 massive variations in undertaking this in downtown
24 Ottawa or Toronto or Kingston or London, to have
25 the benefit of an academic centre, and, you know,

1 small communities like I was born in, Brockville or
2 Kapuskasing or what you have you, and that mass --
3 massive land regions for some of these
4 municipalities as well.

5 I think the other piece is that when
6 outbreak occurs, and for me, we should be swimming
7 upstream, not to wait until a medical officer of
8 health or an inspector has to give orders but for
9 an approach to education and quality of work life
10 and standards of care that allow everyone in the
11 organization to better understand their role and,
12 frankly, that that requires investment. Right?

13 That requires training and ongoing
14 investment and assessment and models of adult
15 education that make everyone in that home
16 responsible for the quality of life of the resident
17 and the quality and standard of care for infection
18 prevention and control, as opposed to waiting until
19 the Chief Medical Officer of Health for the region
20 needs to jump in and then, if a fire erupts, you've
21 then got a situation where you have to empty out a
22 home into an already fragile and stretched system.

23 But you're absolutely right. It exists
24 in name.

25 We also saw, frankly -- and again, I

1 want to pay tribute to the vast, vast, vast
2 majority of excellent operators and the
3 overwhelming majority of workers in long-term care.
4 And then there would be that very small minority,
5 like in every sector, who were intransigent, who
6 didn't want to work with the Medical Officer of
7 Health, who were challenging, who would look at
8 every legal avenue to prevent that.

9 And unfortunately, departments of
10 health got consumed in the work that actually
11 wasn't value-added by having to deal with the
12 intransigent rather than having a very quick
13 mechanism and model that said, you know what, we're
14 actually just going to put in a supervisor to that
15 environment or put in a ministerial order that
16 suspends your management responsibility.

17 And I hope that your work will also
18 consider whether we need to be quicker in
19 environments -- in those few environments that are
20 like that, to address them very quickly of the
21 minor number of -- or operators that consume a vast
22 amount of the investigators in a public health
23 [storm] (ph).

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Does the structure exist for the exercise of that

1 kind of authority, or does it need to be created?
2 Because I'm suspicious of creating more structures.

3 DR. KEVIN SMITH: Yeah, I'm with you.
4 I always say, don't create a structure if one
5 already exists and go around [indecipherable].

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Right.

8 DR. KEVIN SMITH: I think it exists,
9 but here's my observation without probably adequate
10 data: It gets caught up between the fact that
11 Public Health has a municipal role and
12 responsibility and authority and accountability,
13 often to the municipalities, and then in times like
14 these, to the Chief Medical Officer of Health.

15 And I do think that the structures are
16 confounding at times, where we, of course, want to
17 see appropriate degrees of autonomy in the various
18 regions of the province -- they are different --
19 but in times like these, perhaps there needs to be
20 a very different, clear structure and much more of
21 a command-and-control opportunity during crises.

22 And so it may not be changing the
23 structure; it may be clarifying the structure in
24 unusual times or clarifying the structure around
25 which greater provincial action is possible when

1 homes fall afoul of what people would say is good
2 practice.

3 And for all of you in your professions,
4 you [indecipherable] who or what organizations were
5 in back, you know, top 20 percent and what
6 organizations are people who were in that bottom
7 20 percent. And I would be very surprised if our
8 medical officers of health and public health
9 agencies didn't have that same understanding of the
10 homes that they work with.

11 But unfortunately, they are spending an
12 inordinate amount of time on the difficult and not
13 an adequate -- not as much time as one would hope
14 for in building a better system for those who are
15 anxious and willing to do so.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Thank you. Well, there's a silence here. I don't
18 know -- I think we've probably exhausted our
19 questions for now.

20 Are there any other thoughts that you
21 have about what we might constructively recommend?

22 DR. KEVIN SMITH: Yeah, I think a
23 couple of observations: One, you know, what is the
24 strategic direction and plan for Ontario when it
25 comes to what I'll call the continuum of housing

1 and accommodation for seniors.

2 I think, you know, we've talked for
3 many years about how do we create these graduated
4 campuses where people can go and successfully age.
5 If one of a couple develops the need for more
6 supports and the other member is still cognitively
7 or physically well, how can we explore a better
8 campus of care model that allows people to age in
9 place?

10 So we see in many other countries an
11 example where you would, at a certain point in
12 time, determine to move into a retirement-like
13 residence. If one of the couple that requires
14 additional care, one can either get it through home
15 care or possibly and ideally onsite by moving into
16 long-term care and palliative care.

17 And a real continuum within the
18 spectrum of combining the residential services: So
19 a good place to live, and, of course, moving
20 towards long-term care and end-of-life care that is
21 exemplary and that is not institutionally based.

22 The other, I think, that we touched on
23 briefly is those who are inordinately touched by
24 every pandemic are, unquestionably, the most
25 marginalized in our society, mostly economically

1 marginalized but not exclusively. We see in recent
2 data that that could also include minority groups
3 and groups deserving of equity, diversity, and
4 inclusion.

5 And I think that when we look
6 particularly at the homeless -- and the homeless
7 populations are obviously economically
8 disadvantaged. There's a disproportionate number
9 of Blacks and a disproportionate number of people
10 with mental health and addiction issues. And I
11 don't think just the standard long-term care system
12 is going to actually address the needs of the most
13 vulnerable in our society, and many of those are
14 those suffering long-term with mental health and
15 addiction.

16 And so thinking about, are there, in
17 long-term care, some special considerations of how
18 the system will accommodate those that have been
19 marginalized possibly throughout their life or
20 later in life come to an environment of
21 marginalization, and how does one find that?

22 At UHN, we've made a decision as a
23 hospital, which is unusual: Our healthcare system,
24 which includes long-term care, to move into the
25 creation of public housing and assisted living,

1 since housing is one of the most important
2 ingredients -- sorry, housing is one of the most
3 important ingredients in health. And that
4 includes, of course, the times of long-term care.

5 But the most marginalized populations,
6 I think one has to consider differently as we think
7 about a long-term care system that historically has
8 been built for the "average" Canadian or Ontarian.

9 Last but not least, Commissioners, I
10 think it's about quality of work life and value of
11 work, and while we are moving more towards an
12 environment where one can see a career and a
13 progressive career and a liveable wage, we still
14 have some ways to go to create the kind of
15 environment where this will be truly both a
16 vocation and a profession that calls to people who
17 have the very special desire to work with and serve
18 the elderly. It's a very special group of people
19 who do this well.

20 And even in our working-forward
21 movement, I would say one of my greatest anxieties
22 is ensuring that we find people whose calling it is
23 to serve those who are marginalized because they're
24 very vulnerable, and that isn't a role for
25 everyone.

1 So better models and approaches to
2 screening, better models and approaches to career
3 ladderling, better models and approaches to fair
4 compensation, and better models and approaches to
5 job security and advancement, including predictable
6 retirement income as others enjoy in the broader
7 healthcare system, is part of the solution to a
8 system that historically has been very fragmented.

9 Thank you.

10 COMMISSIONER JACK KITTS: Kevin, you
11 spoke to the importance of stature in terms of
12 being recognized. They should have a quality of
13 work life similar to hospitals. They should be
14 recognized at hospitals. You spoke to even
15 bringing long-term care into the Canada Health Act,
16 and you have a hospital or a network of hospitals,
17 acute care hospitals, that are actually joined with
18 a network of long-term care homes; is that correct?

19 DR. KEVIN SMITH: Yes.

20 COMMISSIONER JACK KITTS: Do the nurses
21 and other staff in the long-term care homes get to
22 go back and forth between the hospital and the
23 long-term care home?

24 DR. KEVIN SMITH: The daily
25 practitioners do not, partly because as you, Jack,

1 can understand from your past, we're amalgam of
2 previous organizations --

3 COMMISSIONER JACK KITTS: Yes.

4 DR. KEVIN SMITH: -- and so we have
5 many contracts with our bargaining unit partners,
6 and they have tended to be geographically based.

7 Where they do or where we do have the
8 opportunity to do more of that, and I think we
9 should be encouraging or, in fact, demanding that
10 is -- and I had this conversation in our own
11 organization yesterday -- are we ourselves seeing
12 this as an equal and important player in our own
13 network of healthcare institutions to acute care?

14 So my question to my colleagues
15 yesterday was, are we reacting to this crisis in
16 our long-term care sites as we are in Canada's
17 largest, multi-organ transplant site, which is
18 another part of the programs we operate?

19 And I would say while well-intentioned,
20 it isn't always the case, and we need to up our
21 game on that one. I think not being -- like, we're
22 consciously called a "health network," and I think
23 part of the importance of that is, yes, we operate
24 hospitals, but hospitals are not the be-all and
25 end-all, and hospitals are lousy places --

1 COMMISSIONER JACK KITTS: Yes.

2 DR. KEVIN SMITH: -- for frail,
3 vulnerable, elderly people, particularly those who
4 would be much better stimulated and supported by an
5 environment like long-term care with recreational
6 therapy and appropriate psychosocial supports. So
7 we can go a long way there.

8 I think we also can go a long way in a
9 movement of staff, whether they're part of the same
10 corporation or "drafted" to be part of a regional
11 team to say, it doesn't matter who owns you; this
12 is the IPAC standard, and these are the IPAC
13 professionals that you'll be overseeing.

14 Similarly, one of the strengths of the
15 healthcare system, in my view, and the
16 self-regulation of physicians within it is we have
17 a medical advisory committee that actually monitors
18 and evaluates: Are our physicians performing at
19 the standard of care and with the behaviours that
20 are relevant, including presence?

21 So, you know, one of the shocking
22 things of the homes that did less than well during
23 this -- not exclusively, and again, it is the flea
24 on the tail of the dog. I would never want to
25 suggest this for the majority of medical directors

1 or physicians who serve long-term care; again,
2 remarkable people called to challenging work. But
3 we did, through IMS, find examples where that was
4 not the case, where we didn't see physicians in the
5 environment nearly often enough, where we didn't
6 see the physician's voice nearly loud enough.

7 And that may not be in any way, shape,
8 or form the physician's fault. That may be a
9 management challenge that needs to be addressed.

10 COMMISSIONER JACK KITTS: Yeah.

11 DR. KEVIN SMITH: But I absolutely hope
12 you will recommend that there needs to be a quality
13 system that is greater than the individual home or
14 the individual corporation in the large networks --

15 COMMISSIONER JACK KITTS: Yeah.

16 DR. KEVIN SMITH: -- and that, frankly,
17 we can call on the local medical establishment. It
18 also speaks to our opportunity to better serve
19 people in the environment in which they reside, and
20 I know, again, Jack, you did remarkable work in the
21 Ottawa Valley with the paramedics, as an example.

22 So why are we relocating long-term care
23 residents to acute care environments and exposing
24 them to unnecessary illness when, for example,
25 something as simple as starting an IV could well be

1 done as a designated act by an extended
2 [indecipherable] provider with a physician's
3 oversight? And so I think those are all issues we
4 should be thinking about in a very, very, very
5 different way.

6 In doing that, I think we can't forget:
7 These are already people -- our paramedics, our
8 nursing staff, our IPAC folks -- who are working at
9 110 percent. So we either need to say, here's some
10 low-value work we can stop doing in order to do
11 this high-value work, or here's some additional
12 investment.

13 And I'm not naïve enough to forget
14 we've now spent or we probably will spend half a
15 trillion dollars in this country on this pandemic.
16 There will come a point when the economics are more
17 challenging to continue to just make
18 recommendations about more and more investment. Do
19 we need to prioritize what's important with the
20 initial investments, and I think we do.

21 COMMISSIONER JACK KITTS: Yeah. Lots
22 of challenges and thankfully lots of opportunities.
23 So thank you.

24 DR. KEVIN SMITH: Yes, thank you.
25 Thank you for what you guys are doing. Very

1 important.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Well, thank you. We're all thanking each other,
4 but thank you for your time and your thoughts.
5 It's very instructive for us, and hopefully we'll
6 be able to fashion something that has two feet in
7 reality that we can pass along to the minister, and
8 if we're able to do that, to some extent, we'll be
9 in your debt. So thank you very much.

10 DR. KEVIN SMITH: No, thank you. And
11 as we complete what I hope is a short IMS round
12 two, if there's anything that we learn or discover,
13 we'd be most happy to share that with the
14 Commission.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Thanks very much.

17 DR. KEVIN SMITH: Thank you, all.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Goodbye, Doctor.

20 DR. KEVIN SMITH: Bye now.

21 COMMISSIONER ANGELA COKE: Thank you.

22

23 -- Adjourned at 9:28 a.m.

24

25

1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, Chartered
4 Shorthand Reporter, certify;

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth, at which time the witness was put under oath
9 by me;

10
11 That the testimony of the witness
12 and all objections made at the time of the
13 examination were recorded stenographically by me
14 and were thereafter transcribed;

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

18
19 Dated this 14th day of October, 2020.

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