Long Term Care Covid-19 Commission Mtg.

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

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 14th day of October, 2020, 8:30 a.m. to 9:28 a.m.

BEFORE:

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

PRESENTERS:

Dr. Kevin Smith, President and CEO of University Health Network

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat

Jessica Franklin, Policy Lead of the Long-Term Care Commission

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 8:30 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So I think we're ready to go, actually. So, Doctor, let me just tell you in a few words just how we're looking at things.

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

DR. KEVIN SMITH: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): And that process quite often takes two years.

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

DR. KEVIN SMITH: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): And so we're kind of reversing the -- so that traditional scenario doesn't seem like a very good idea from our perspective.

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

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

DR. KEVIN SMITH: Okay.

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

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

DR. KEVIN SMITH: Yeah.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead.

DR. KEVIN SMITH: So maybe

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

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

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

mortality.

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

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

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

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

the standard.

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

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

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

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

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

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

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

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

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

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

DR. KEVIN SMITH: Yeah, of course.

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

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

management-like system was struck.

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

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

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

But as staff saw many hospitals and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Dog barking]

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

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

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

[Dog barking]

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

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

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

apologies about that.

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

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

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

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

In addition, as you know, we also had a

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

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

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

COMMISSIONER JACK KITTS: Okay. Thanks, Kevin.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): 11,000.

DR. KEVIN SMITH: Yeah, 11,000 people.

And our debate yesterday and request of

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

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

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

COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Is --

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

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

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

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

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

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

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

be a relationship that is formed.

COMMISSIONER JACK KITTS: Yes.

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

COMMISSIONER JACK KITTS: Yes.

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

COMMISSIONER JACK KITTS: Right.

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

COMMISSIONER JACK KITTS: Okay. Agreed.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

DR. KEVIN SMITH: Yes.

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

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

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

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

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

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

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

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

We also saw, frankly -- and again, I

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

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

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

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

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

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

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

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

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

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

and accommodation for seniors.

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

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

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

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

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

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

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

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

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

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

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

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

So better models and approaches to screening, better models and approaches to career laddering, better models and approaches to fair compensation, and better models and approaches to job security and advancement, including predictable retirement income as others enjoy in the broader healthcare system, is part of the solution to a system that historically has been very fragmented.

Thank you.

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

DR. KEVIN SMITH: Yes.

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

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

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

COMMISSIONER JACK KITTS: Yes.

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

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

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

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

COMMISSIONER JACK KITTS: Yes.

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Yeah.

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

COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

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

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

important.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks very much.

DR. KEVIN SMITH: Thank you, all.

COMMISSIONER FRANK MARROCCO (CHAIR): Goodbye, Doctor.

DR. KEVIN SMITH: Bye now.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 9:28 a.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, Chartered Shorthand Reporter, certify;

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

That the testimony of the witness and all objections made at the time of the examination 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 14th day of October, 2020.

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