

Long-Term Covid-19 Care Commission

Capital Development and Licensing
on Friday, September 18, 2020



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1 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held Virtually via Zoom, with all participants

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attending remotely, on the 18th day of September, 2020,

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10:05 a.m. to 12:07 p.m.

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13 BEFORE:

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15 The Honourable Frank N. Marrocco, Lead Commissioner

16 Angela Coke, Commissioner

17 Dr. Jack Kitts, Commissioner

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21 PRESENTING:

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23 Michelle-Ann Hylton, Director of the Capital Planning

24 Branch within the Ministry of Long-Term Care

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1 PARTICIPANTS:

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3 Margaret Allore, Capital Planning Branch within the
4 Ministry of Long-Term Care

5

6 Gary Thompson, Manager of the Programs and
7 Policy Unit within the Ministry of Long-Term Care

8

9 Neil Vanderkooy, Manager of the Project Management
10 Units within the Ministry of Long-Term Care

11

12 Alison Drummond, Assistant Deputy Minister,
13 Long-Term Care Commission Secretariat

14

15 Derek Lett, Policy Director, Long-Term Care
16 Commission Secretariat

17

18 Amy Leamen, Counsel, Legal Services Branch for
19 the Ministries of Health and Long-Term Care

20

21 John Callaghan, Lead Counsel, Long-Term Care
22 Commission Secretariat

23

24 Sunil S. Mathai, Counsel, Crown Law Office Civil.

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1 PARTICIPANTS (cont'd):

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3 Roopa Mann, Counsel, Crown Law Office Civil.

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5 Ann Christian-Brown, Counsel, Crown Law Office Civil.

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7 Lynn Mahoney, Counsel to the Ministry of

8 Health and Long-Term Care.

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11 ALSO PRESENT:

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13 Judith M. Caputo, Stenographer/Transcriptionist

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1 COMMISSIONER MARROCCO: Well, I think
2 Ms. Hylton, Gary is connecting to audio so I think
3 he's here.

4 Thank you very much for coming and
5 making the presentation, it's very much appreciated
6 by us. We're at the investigative stage of our
7 proceedings and we're just trying to understand the
8 environment in which we've been asked to report.
9 And we very much appreciate your assistance in
10 giving us a foundational briefing about your
11 responsibilities in the Ministry. So thank you and
12 we're ready when you are.

13 MS. HYLTON: Thank you. It is an
14 absolute pleasure to be here. I should start off
15 by saying I am a Director within the Capital
16 Division of the Ministry.

17 My ADM, and I understand ADMs are
18 typically the ones giving this presentation.
19 Unfortunately, he's away on emergency leave, so I
20 am acting for him for a few weeks here in his
21 stead, and his name is Brian Pollard.

22 Perhaps if there is a reason that you
23 may not hear from me directly again, it may be my
24 ADM at another visit, but I wanted to put that on
25 the table.

1 COMMISSIONER MARROCCO: Thank you.

2 MS. HYLTON: The Capital Division was
3 recently created or established within the Ministry
4 of Long-Term Care, really, with two areas of focus:

5 Licensing long-term care homes being
6 one of them. And the other significant piece of
7 our portfolio, everything related to LTC
8 development.

9 COMMISSIONER MARROCCO: Ms. Hylton, I
10 apologize for interrupting. I should have told
11 you, we will ask questions as we go along rather
12 than waiting until the end.

13 MS. HYLTON: No problem.

14 So again, the two main areas of focus,
15 licensing and development. And so the first
16 presentation today is really a 1-0-1 or
17 foundational from a licensing perspective, and then
18 we'll jump into the redevelopment program.

19 The two are very much intertwined,
20 because the redevelopment program is heavily
21 dependant on licensing. At the end of the day,
22 we're only able to open successfully or
23 redevelopment with the licence issued. So the two
24 programs go hand-in-hand. Maybe we can jump to
25 slide two. And I have a few notes in front of me,

1 so perhaps I may be looking down on my notes when I
2 speak for the next few minutes.

3 Worth mentioning as we get started, the
4 foundation of the licensing framework very much
5 legislated, added a risk-base assessment framework
6 that we utilize. It underlays any licence issued
7 by the Ministry, or any approval provided to
8 operate a home by the Minister.

9 That risk-base assessment, and really
10 that framework is enshrined in the legislation, the
11 Long-Term Care Homes Act and comprises a whole host
12 of things. So checking compliance history of an
13 organization; teaching external feedback;
14 conducting financial review; as well as conducting
15 what we call "public interest text".

16 So all of these pieces are part of a
17 risk-base assessment framework that supports the
18 issuance of a licence or approval by the Minister.

19 A bit of background information here.
20 There are currently 627 homes licensed in the
21 Province of Ontario, licensed by the Ministry.
22 626 in operation, as there is one home that is
23 essentially offline due to an emergency that caused
24 their beds to be closed for a period of time.

25 The licensing program, the licensing

1 arm the Ministry essentially has four key areas of
2 focus at this point.

3 So number one, the majority of our work
4 on a day-to-day basis now really supports the
5 development and redevelopment of capacity across
6 the Province.

7 So as I mentioned before, the
8 redevelopment program, development of new beds, all
9 of that has implications from a licensing
10 perspective. As the licence is tied to the age of
11 the bed and certainly is the what I would call
12 essentially the piece of paper that facilitates the
13 flowing of funding from the Ministry to a home.

14 And so about 60 percent of our work at
15 this point is really focused on building new
16 capacity and facilitating the development of older
17 capacity.

18 About 40 percent of our work, so beyond
19 that, is really focused on what I would call
20 "routine licence transactions".

21 So if you think of the 626 homes that
22 are in operation, there is always some movement in
23 the system. Always, you know, the opportunity
24 perhaps to transfer licenses where operators are
25 either getting out or coming into the business.

1 Oftentimes companies, organizations who
2 hold licensing have made decisions around
3 controlling interest. Oftentimes we have local
4 partners requesting new beds, perhaps, to come on a
5 temporary basis to alleviate pressure in a
6 particular area of the Province.

7 We also have management contracts where
8 operators may want an entity, or need an entity to
9 come in, manage the day-to-day operations of a
10 home.

11 All of these speak to routine licensing
12 transactions for existing facilities within the
13 system. And again, a critical part of the work of
14 the licensing team. Margaret Allore, who is on the
15 line, is my senior manager with responsibility for
16 licensing as well.

17 The other areas are focused -- so the
18 other two from our licensing perspective, really
19 focused on what I would call modernizing the
20 licensing system within the Province.

21 So looking at opportunities to increase
22 efficiency, as well as opportunities to digitize
23 the program.

24 Historically, licensing has been
25 somewhat of a tedious process internally, certainly

1 felt by our stakeholders. And depending on the
2 transaction, can take very long.

3 We've also applied, over the years,
4 sort of a one-size-fits-all approach. So if you
5 are looking to add two beds temporarily compared to
6 building a net new home, historically, the program
7 would have put an operator through the same steps
8 than, of course, from an efficiency perspective and
9 really a real estate perspective, that's not
10 necessarily what's needed, depending on the
11 transaction. So we are very much focused at this
12 point in terms of opportunities to modernize the
13 licensing program.

14 Lastly, and I will jump to the next
15 slide. The licensing program is very much focused
16 now on looking at opportunities to sustain capacity.

17 We have about a third of the capacity,
18 so about 26,000 beds coming up for expiry. They
19 hold licenses that will expire in 2025.

20 So from a licensing perspective, we
21 need to ensure that we have a sense of next steps,
22 that these operators -- will this capacity exist
23 beyond 2025? Will they meet the criteria to hold a
24 licence beyond 2025? And under the legislation,
25 we're also required to provide them notice three

1 years before the expiry of the Ministry's intention
2 to provide a licence beyond that upcoming date.

3 So quite a bit happening from a
4 licensing perspective, and those are our areas of
5 focus.

6 The next slide gives you --

7 COMMISSIONER MARROCCO: Excuse me, hold
8 on a second. Commissioner Kitts?

9 COMMISSIONER KITTS: I have a question
10 about the bed numbers.

11 So I understand that in the next five
12 years we will expand the capacity of beds by an
13 additional 15,000, right?

14 MS. HYLTON: Yes.

15 COMMISSIONER KITTS: And the current
16 compliment is 78,890, so I add 15,000 to that.

17 But 26,000 beds may disappear in 2025.
18 Is that what we're facing?

19 MS. HYLTON: Yes. We know that all
20 26,000 will not disappear. Because many of the
21 operators of those 26,000 beds have indicated,
22 either by way of applying through the development
23 program, or through the licensing team directly,
24 their intentions to redevelop and continue to
25 operate.

1 But we do know that there are some that
2 are really making decisions now as to whether or
3 not they intend to continue to operate. But you're
4 exactly right. We have 78,000, almost 79,000 beds
5 in operation. Come 2025, 26,000 are holding a
6 licence that will expire by that point in history.

7 And so the decision certainly have to
8 be made, some have made the decision and have
9 started the process to redevelop, or to even expand
10 their homes; but there are some who are still
11 deciding at this point.

12 But, yes, there is the potential to
13 lose capacity to the tune of thousands, given the
14 pending licence expiry.

15 COMMISSIONER KITTS: Are these 26,000
16 beds in what would be described as older homes,
17 perhaps not meeting the design conditions that
18 exist today?

19 MS. HYLTON: Yes. So the majority of
20 these would be older beds. So beds that would've
21 held a licence prior to the current legislation
22 coming into force. And when the legislation came
23 into force in 2010, they would have received a
24 longer term licence that would expire come 2025.

25 So, yes, they are older beds.

1 COMMISSIONER KITTS: So the likelihood
2 that a number may disappear is relatively high?

3 MS. HYLTON: Yes.

4 COMMISSIONER KITTS: One last thing. I
5 understand that some of the homes to meet Public
6 Health or IPAC requirements, have already decreased
7 the number of beds to decrease the crowding and
8 comply with the IPAC and public health structure.

9 Do you take those into account as well,
10 are they counted in here, or are they just being
11 looked at?

12 MS. HYLTON: They're not counted in
13 here, because essentially those beds are still
14 licensed.

15 From a capital perspective, when we
16 talk about development in our analysis that the
17 Ministry is starting to undertake now from a
18 development perspective, the discussions
19 internally, when we think about where there will be
20 a need to fluctuate capacity or boost capacity in
21 certain areas, we will take into consideration
22 expectations for beds to close, as per the 2025
23 expiry, as well as where capacity has been, or
24 licence will be lost, as a result of reducing
25 occupancy to deal with the pandemic. Because we

1 know that essentially many of those homes will
2 likely never reopen all of those beds. They will
3 likely stick to fewer numbers for better IPAC
4 measures. And so from a capacity perspective, the
5 development program certainly has to take that into
6 consideration.

7 COMMISSIONER KITTS: Thank you.

8 COMMISSIONER MARROCCO: Ms. Hylton, as
9 we sit here today, is there a waiting list for
10 people to get in, or is that -- you're nodding yes.

11 So there is a waiting list?

12 MS. HYLTON: Yes. A waiting list for
13 people to get into long-term care?

14 COMMISSIONER MARROCCO: Yes.

15 MS. HYLTON: Absolutely there is a
16 waiting list. I don't want to speak to the
17 numbers, but it's close to about 30,000 people
18 waiting to get into long-term care at this point.

19 My colleague, Sheila Bristo, has
20 responsibility of the operations division, she has
21 oversight on those numbers, perhaps on a more
22 frequent basis. But I know last I checked it was
23 close to 30,000 waiting for long-term care.

24 COMMISSIONER MARROCCO: So then in
25 addition to the fact that some of the 26,000 will

1 expire, there's also the 30,000 on the waiting
2 list.

3 MS. HYLTON: Yes, absolutely.

4 The 30,000 on the wait list, very much
5 distributed in different ways across the Province.
6 So we know historically the waitlist is longer in
7 urban areas, or in specific areas where there are
8 fewer long-term care homes.

9 That doesn't necessarily jive with
10 where all the capacity will be lost, or potentially
11 could be lost. Again, some of these operators are
12 still making those decisions as to whether or not
13 they will continue to operate.

14 But, yes, we do have a waitlist to the
15 tune of about 30,000. As well as the potential to
16 move beds coming up in 2025, given the pending
17 licence expiry.

18 COMMISSIONER MARROCCO: Does that sort
19 of the overall circumstance that you've described,
20 does that exert a pressure on the licensing of
21 facilities in the sense that you kind of want them
22 to be able to comply and -- at one level, want them
23 to carry on because there's this numerical
24 situation that you've described?

25 MS. HYLTON: Yes. Justice, I would say

1 that's a fair question. To some extent the
2 Ministry has to take that into consideration,
3 because we do want to add capacity. And part of
4 the licensing risk assessment framework, we have to
5 talk to external parties.

6 So closer to home, for example, we
7 talked to Local Health Integration Networks. And
8 they're responsible for placing applicants into
9 long-term care. They are the holders of that
10 waitlist.

11 So, yes, in speaking with them, there's
12 always that strong need to look at opportunities,
13 to open more beds or maintain capacity as best we
14 can.

15 We have to, in the Ministry, though,
16 strike an important balance, because the safety of
17 residents, the safety of the structures, the
18 financial health of the licensee and the
19 organization as a whole, all of these -- I'm just
20 giving you examples -- the access to different
21 types of homes as per public interest tests.

22 Under the legislation, the licensing
23 team, me especially as the director, I have to
24 weigh all of those things. So not just the need
25 for beds, but whether or not we are in a position

1 where we can safely licence beds and expect that
2 these beds will continue to be in operation in a
3 safe way over a period of time.

4 So a few things have to be taken into
5 consideration. The need for beds is one,
6 absolutely, that's one of the public interest tests
7 that is done.

8 But, also, the safety of residents.
9 The ability to operate to a certain level on the
10 part of the licensee. Compliance, history of
11 compliance of the organization. All of those are
12 taken into consideration.

13 COMMISSIONER MARROCCO: You said that
14 the LHIN controls the list.

15 MS. HYLTON: They hold the list, yes.

16 COMMISSIONER MARROCCO: What does that
17 mean when you say "they hold the list"?

18 MS. HYLTON: When an individual is
19 looking to apply to be put on the waitlist for
20 long-term care, essentially, that application goes
21 to and is processed by the local health integration
22 network.

23 So there are 14 of them across the
24 Province. And other than Regulation 7910, the LHIN
25 has its rules set out in terms of how to organize

1 and manage the waitlist.

2 Essentially, they are responsible for
3 the waitlist, so they do the assessment of
4 applicants. They determine whether or not that
5 applicant meets the criteria to go on the waitlist
6 for long-term care. And if the individual does,
7 they place that individual in the appropriate
8 category of the waitlist.

9 COMMISSIONER MARROCCO: But how does
10 the individual get into the facility, to the home?
11 Who decides that?

12 MS. HYLTON: So there is choice made by
13 the individual. So the applicant.

14 So they can choose to be on up to five
15 waitlists at any particular time. So they can
16 choose five different homes. Well, they can choose
17 many homes, but they can only be on five waitlists
18 at a time. So this is what they would communicate
19 to the LHIN.

20 Typically, the LHIN would go to the
21 person's home, or visit the person or their family
22 in hospital or in an appropriate place, and conduct
23 an assessment. Those homes would be identified.

24 So, for example, most applicants tend
25 to identify homes that are close to where they

1 live, or where their families reside. They have
2 the opportunity -- some homes provide virtual
3 tours. Prior to COVID, I know family members would
4 physically visit homes, and they would indicate to
5 LHIN which homes they would like to be on the
6 waitlist for.

7 I know sometimes LHIN recommends homes,
8 depending on the person's situation. So an
9 individual who perhaps might need specialized care
10 like dialysis, the LHIN will likely recommend a
11 home that provides that level of care; not all
12 homes provide specialize services. And so that
13 individual, if they agree -- consent and choice are
14 foundational to the placement process of long-term
15 care. If they agree, they can be put on the
16 waitlist that ultimately they decide whether or not
17 they go into the home.

18 The LHIN brokers with the home, once
19 the application is made. The home has the
20 opportunity to also decide "yes" or "no", based on
21 their ability to care for the individual.

22 COMMISSIONER MARROCCO: Okay.

23 MS. HYLTON: I do know that, Sheila
24 Bristo, again, the operations division, I just
25 happen to have background around this, but this

1 day-to-day information perhaps more detail on
2 placement, is certainly within the operations
3 division portfolio.

4 COMMISSIONER MARROCCO: All right.

5 So go ahead.

6 MS. HYLTON: All right. So slide three
7 captures, essentially, the four types of either
8 licenses, or approvals on the part of the Ministry.

9 So this is related to any facility
10 looking to provide long-term care services. So for
11 a municipal or First Nation home, they are not
12 licensed. They receive an approval, and that is
13 issued by the Minister. It has no fixed terms, and
14 it cannot be transferred to another entity.

15 So the Minister is responsible for
16 approving, for example, the City of Toronto to
17 provide LTC services up to the tune of ex-number of
18 beds, or ex-number of homes. So that is in the
19 realm of the Minister.

20 So the other three, so the orange, the
21 yellow and the black, speak to licenses that are
22 issued by me as director under the Act.

23 So most homes in the Province are
24 operated under a typical long-term licence, which
25 lasts for up to 30 years. And this is issued,

1 again, by me as director under the Act and it can
2 be issued to a for-profit or not-for-profit entity.
3 They are transferable, but within limits.

4 So for example, the legislation allows
5 for beds to be transferred between sectors. So
6 between -- or within sectors, rather. So within
7 the for-profit sector, operators at for-profit
8 operator may decide to transfer its licence to
9 another for-profit, perhaps in the event of wanting
10 to get out of the business or do something else.
11 We certainly see that movement as well within the
12 non-profit realm.

13 The Ministry under the legislation,
14 really limits the movement of beds from the
15 non-profit arm of long-term care, or the non-profit
16 part of the sector to the for-profit by limiting
17 transfers from not-for-profit over into the
18 for-profit sector. Only when a non-profit home is
19 going through a receivership exercise can that be
20 allowed for. But, essentially, non-profit beds
21 stay within the non-profit sector.

22 COMMISSIONER MARROCCO: You said there,
23 you do see quite a lot of movement did you say?
24 What does that mean exactly?

25 MS. HYLTON: So that means you have

1 operators who are choosing to do things depending
2 on the strategic plan for the organization. So we
3 have companies deciding either to get out of the
4 business, or looking to grow their footprint within
5 the business. So oftentimes you will see beds
6 being purchased.

7 So operators might decide to purchase
8 beds from a smaller operator who might want to get
9 out of the business and take over a home. And so
10 that would involve a licence transfer, because the
11 previous licensee would be essentially handing over
12 their licence to another organization to continue
13 operating those beds.

14 So that is the type of movement, and we
15 see that quite often in long-term care.

16 COMMISSIONER MARROCCO: Are you seeing
17 that kind of thing only in the for-profit sector or
18 do you see it in the not-for-profit sector as well?

19 MS. HYLTON: It's in both, absolutely.
20 But I would say certainly my time in long-term care
21 most prevalent within the for-profit realm.

22 COMMISSIONER MARROCCO: What do they do
23 then? They don't want to be in the long-term care
24 home business, if you like, what is driving that?
25 What do they do then after, they've got a building,

1 they've got land; do you have a sense of that?

2 MS. HYLTON: Yes, yes. And that is one
3 example of a circumstance under which a licence
4 transfer could happen. But under that example,
5 historically I can tell you within the last two to
6 three years, I have certainly seen smaller,
7 for-profit operators make the decision, or consider
8 strongly stepping away from the business.

9 I have met with -- I can recall at
10 least two or three for-profit operators, operating
11 single homes, oftentimes in nonurban areas. So
12 perhaps rural parts of the Province, and they tend
13 to be smaller homes. As a general response, when
14 asked, you know, why? What's the impetus behind
15 this change? Many of them have operated the homes
16 for years, and they themselves are looking to
17 retire.

18 Two, I've heard quite a bit about the
19 change of demographics of LTC applicants coming in.
20 So the level of care, the level of service to be
21 provided, quite different from what it had been
22 historically.

23 An operator has mentioned to me
24 recently, when they got into the business,
25 long-term care residents were driving and parking

1 at the home, and they were able to walk to Tim
2 Horton's by themselves.

3 The demographic in long-term care has
4 changed drastically within the last few years. So,
5 you know, the majority of LTC residents are living
6 with dementia, so they require more care.

7 A third reason we have certainly heard,
8 it's very much the need for more staffing support
9 and the challenges from a staffing perspective.
10 Especially depending on where you're located in the
11 Province.

12 So very much hearing smaller,
13 for-profit operators speak to their challenges in
14 either recruiting or retaining staff on a long-term
15 basis, attracting staff and different types of
16 staff, depending on where they're located.

17 So those are some of the reasons why we
18 know some operators are looking to leave.

19 COMMISSIONER MARROCCO: Thank you.

20 MS. HYLTON: Just speaking to the last
21 two slides. So beyond a long-term licence, the
22 Ministry has the ability under the legislation to
23 issue two temporary licenses.

24 The one captured in the yellow flag
25 here is what we refer to as a temporary licence.

1 This can be issued up to five years; this is not
2 issued in an emergency situation, but typically is
3 issued where there is an opportunity to open up
4 capacity in an identified location for a specified
5 period of time, oftentimes to deal with an
6 important, but not necessarily urgent or an
7 emergency situation.

8 So we see this across the Province,
9 especially in areas where ALT pressures are higher,
10 or alternative levels of care, hallway healthcare
11 pressures are high. Or, where there is simply
12 capacity available where an operator may not be
13 entrusted in a long-term arrangement. And so we
14 issue a temporary licence to cover beds for up to
15 five years.

16 The temporary emergency licence,
17 similar, but has different construct. The
18 emergency licence is issued in an emergency
19 situation, it can be issued to last for up to one
20 year, and this is really where the Ministry steps
21 in to allow for beds to be licensed to deal with an
22 emergency.

23 So we have issued temporary emergency
24 licenses for a host of reasons, certainly within
25 the heights of Wave 1 of the pandemic. But prior

1 to that, in my history here, I have issued
2 temporary emergency licenses to deal with floods,
3 to deal with fires, those types of emergencies
4 where we may need to create space very quickly in a
5 location to facilitate getting residents either
6 moved from another home, or another location on a
7 very urgent basis.

8 COMMISSIONER KITTS: Can I just ask, in
9 the temporary licence and temporary emergency, is
10 it implied that the physical structure exists,
11 you're just transferring the licence? Or do you
12 have to build a ward? Can you just give me an idea
13 how long that takes?

14 MS. HYLTON: Yes. So both temporary
15 emergency and temporary licenses oftentimes are
16 associated with existing structures. Most times
17 they are beds that actually exist in a home that is
18 already operating, but perhaps there's more space
19 or a floor that was never licensed on an emergency
20 basis. Oftentimes it's almost room created within
21 an existing home.

22 So we have a situation that -- and this
23 is certainly what happened this year during the
24 pandemic. Homes have other needs that are created
25 to support either family members of residents, or

1 even residents depending on the situation. So lots
2 of homes have what we would call a palliative care
3 room. So it's a room that is built to really
4 accommodate a resident who might be at the end
5 stage of life, and may want to, for privacy
6 reasons, not be in a shared space, as an example.

7 But temporary emergency licence could
8 be issued to cover that need, that palliative care
9 room for a specified period of time, maybe to move
10 someone into that room for up to a certain period
11 to deal with an emergency. So they're existing
12 spaces.

13 I think we can move to the next slide.
14 Slide four speaks to just some base principles as
15 it relates to the licensing framework. The licence
16 provides the licensee, one, with the right to
17 operate a long-term care as per the legislation and
18 as it is defined under the legislation.

19 It also facilitates funding on the part
20 of the Ministry. So once we issue a licence, there
21 is funding that is associated with an issued
22 licence, either on a temporary basis or over that
23 up to 30-year period for a long-term licence.

24 And then thirdly, a licence provides
25 the operator with the ability to monetize the

1 licence. And this goes back to my comment around
2 the potential to transfer or to sell, really, again
3 subject to ministry approval, but under the Act
4 there is room for licenses to be transferred or to
5 be sold and, certainly, the licence has a value.

6 If someone holds a licence that doesn't
7 expire for another 15 years compared to someone
8 with a licence that expires in two years, the
9 value, you can imagine, is quite different. If
10 another entity is looking to purchase, it would
11 likely want a licence that has a bit more time tied
12 to it. Because there's that dedicated Ministry
13 funding and perhaps give them time to make
14 decisions about that home prior to a very -- a
15 pending licence expiry.

16 The licence framework also enables what
17 we call a due diligence process. Again, this
18 speaks to determining competency on the part of the
19 licensee to actually operate the home. Really with
20 a focus of maintaining a certain standard of care
21 for residents and maintaining a safe level of
22 services across the board.

23 So at the core of our framework, we
24 look and assess the competency of the applicant or
25 the licensee, and we do that as mentioned before,

1 in a variety of ways. We speak to the public, by
2 way of a public consultation. We conduct a
3 financial review, looking at the financial health
4 of the licensee, the organization.

5 We also seek external feedback. So we
6 speak with a local health integration network,
7 they're connected with operators on the ground and
8 other healthcare operators. So they tend to know
9 entities that are seeking approval for licenses, or
10 seeking a licence.

11 We also speak to compliance. The
12 licensing arm of the Ministry works hand-in-hand
13 with the compliance branch. So we look at
14 experience, not only on the part of that particular
15 home, but the licensee as a whole.

16 So oftentimes in long-term care you
17 will have a single licensee with responsibility for
18 thousands of beds, or hundreds of beds and multiple
19 homes.

20 So from a licensing perspective, we
21 take into consideration, not only the history of
22 that home, but also the history of the licensee.

23 COMMISSIONER MARROCCO: Were there
24 requests for emergency licenses during the first
25 wave of the pandemic?

1 MS. HYLTON: Yes.

2 COMMISSIONER MARROCCO: How long would
3 it take to issue, assuming you decided to issue an
4 emergency licence?

5 MS. HYLTON: A matter of days. A
6 matter of days. A little later on in the
7 presentation I will speak to that. But in the
8 course of one month, we issued licenses to
9 69 homes, that was for the creation of 97 more beds
10 or spaces within the period of one month.

11 And so we had, I would say, there's a
12 bit of -- there was us coming into the Ministry by
13 way of an application form that was created and
14 sent out to the centre, but there was also work
15 proactively done on the part of Ministry of Health,
16 Ministry of Long-Term Care, local health
17 integration network, Ontario Health and their
18 regions to also try and identify spaces.

19 So temporary emergency licenses
20 absolutely were issued throughout that period and
21 especially at the beginning, and that was done
22 within the period of one month.

23 COMMISSIONER MARROCCO: If you have a
24 situation where you have too many people in the
25 face of a pandemic -- too many people housed in,

1 say, one room. And so you want to create extra
2 capacity, surge capacity; are you creating
3 additional beds, or are you really just moving the
4 same number of beds into a larger space, however
5 you would do that. And if so, would you need a
6 licence to do that?

7 MS. HYLTON: So, no, you wouldn't need
8 a licence to do that.

9 So the home, given their responsibility
10 under the Act, can make the decision within their
11 current licence to move people around to ensure
12 their safety.

13 Where licenses have been issued, it
14 really is to add capacity to a home. So speaking
15 through the 97 that were licensed, so the 69 homes
16 that received licenses, this was really to create
17 more space within a home. So if a home had room
18 available where they needed to isolate, for
19 example, we didn't necessarily need to create or
20 issue a licence for the existing number of beds in
21 the home.

22 If they wanted to add capacity to the
23 home, for whatever reason, it could be for
24 isolation, it could be for privacy reasons,
25 whatever. Those circumstances would have warranted

1 the need for a temporary emergency licence. So it
2 was really to add capacity to the home. But homes
3 do have the flexibility to move folks around in
4 keeping with the legislation and maintaining
5 certain base access.

6 So, for example, if an operator were to
7 move someone within the home to another space, no
8 new licence, they're just making the decision, that
9 operator is still expected under the Act to meet
10 certain obligations, i.e., you know, access to
11 things like a call bell system, safety measures
12 related to constraints, bed rails, those would all
13 still be expected to be upheld, even if that
14 individual was moved to a different space.

15 COMMISSIONER MARROCCO: All right.
16 Commissioner Coke.

17 COMMISSIONER COKE: I'm just curious
18 what situation you've had where you haven't
19 approved or issued a licence; is that something
20 that happens often, or do you have to work with
21 people so they meet the requirements?

22 MS. HYLTON: We have had situations
23 where we have not issued licenses. For the most
24 part, we tend to work with proponents.

25 One, to make sure they understand

1 exactly what a licence means, and in terms of
2 responsibility on an ongoing basis.

3 We do get inquiries all the time,
4 because I think generally speaking, the public
5 seems to have its understanding of what long-term
6 care means and the responsibilities. But very few
7 people actually take the time to read the
8 legislation and appreciate the responsibility that
9 comes withholding a licence.

10 I can tell you there have been a
11 handful of circumstances during my time in the
12 Ministry, where a licensee simply did not meet the
13 cut. So if there were concerns from a financial
14 perspective, as an example, certainly compliance,
15 we have had instances where we've had a licensee,
16 perhaps an existing licensee, request a licence to
17 open up more beds, perhaps in another area.

18 I have had the ability, with support
19 from compliance to say "no". Because if their
20 compliance history doesn't check out, if we're not
21 satisfied, we're not comfortable, we absolutely
22 have leverage to say, "no"; or, "not at this time
23 given your compliance history". Or, "given our
24 concerns related to your ability to properly manage
25 the home financially speaking".

1 So there are instances where we say "no".

2 COMMISSIONER COKE: Thank you.

3 COMMISSIONER MARROCCO: One last
4 question.

5 Does the local Medical Officer of
6 Health figure into this process?

7 MS. HYLTON: Not formally. Part of our
8 external consultation or taking feedback
9 externally, allows for any member of the public to
10 be able to provide their feedback, or their advice,
11 by way of them either writing into the Ministry or
12 speaking to us online or virtually. Or, by way of
13 a public meeting depending on the nature of the
14 transaction.

15 We do not formally seek input from a
16 local medical officer of health, so...

17 COMMISSIONER MARROCCO: But they do
18 have a responsibility if there's an infectious
19 disease in their area?

20 MS. HYLTON: Yes. Local public health
21 units would absolutely have a responsibility in
22 terms of supporting homes, or providing guidance to
23 homes, and they may have their ongoing relationship
24 with homes, even outside of a pandemic, yes.

25 COMMISSIONER MARROCCO: So if you have

1 a home, and you have -- let's say it's too crowded.
2 Can the local Medical Officer of Health make an
3 order that they separate them? That's probably a
4 crude way of putting it, because you can't separate
5 them if you don't have the facility to separate
6 them. But can the local Medical Officer of Health
7 make an order that binds the home?

8 MS. HYLTON: To be frank with you,
9 Justice, I am not the best person to answer that
10 question. I don't know the specifics in terms of
11 realm of responsibility at the public health unit
12 level or more locally.

13 I do know, though, that certainly we
14 saw this throughout the heights of Wave 1. Public
15 Health, Ontario Health, as well as the compliance
16 arm of the Ministry, have all worked together to
17 really assess what's happening within a home.

18 I know that there were IPAC teams
19 created that visited a couple of homes. Again, the
20 operations division, perhaps best poised to speak
21 to this. But they had visited homes, made an
22 assessment; made recommendations; and some of those
23 recommendations, I know there have been instances
24 where relocation did come up as a recommendation
25 or, you know, changes to some basic infrastructure

1 within the home to facilitate better IPAC.

2 But I do know that there have been
3 combined efforts between public health, Ontario
4 Health and the Ministry of Long-Term Care on the
5 compliance side.

6 COMMISSIONER MARROCCO: Thank you.

7 COMMISSIONER KITTS: Just to follow up
8 on that. So the LHINs are in the field, and they
9 are Ontario Health. And they play a role in
10 asking, I guess for licensing or requesting beds
11 and licensing. So Ontario Health is involved.
12 Your capital branch is in the Ministry of Health;
13 am I correct.

14 MS. HYLTON: No, it's in the Ministry
15 of Long-Term Care it moves in 2018.

16 COMMISSIONER KITTS: So there's Ontario
17 Health and Ministry of Long-Term Care. Is the
18 Ministry of Health involved in these decisions
19 around licensing and expansion of beds as well, or
20 is it clearly the Ontario Health and Ministry of
21 Long-Term Care?

22 MS. HYLTON: For the most part, it is
23 Ontario Health/LHINs given their responsibility
24 under the Act. LHINs especially, their
25 responsibility under the Act to support the

1 licensing assessment contribute to my decision
2 making as director, as well as their responsibility
3 to -- their responsibility to manage the waitlist.

4 LHINs also factor into the public
5 interest text, again, part of the licensing
6 assessment framework. Those tests are conducted by
7 the Minister. But LHINs also contribute to the
8 evidence, or the information provided to the
9 Minister to make a decision related to the public
10 interest tied to a licence transaction that
11 ultimately comes to me as part of my body of
12 evidence.

13 So LHINs Ontario Health, is very much
14 critical to the licensing structure within the
15 Ministry of Long-Term Care. We do interact with
16 the Ministry of Health on a regular basis. I can
17 give you an example, where we're talking about
18 temporary licenses, so that yellow flag on the
19 previous slide.

20 Sometimes those temporary licenses are
21 coming about as a result of pressures being felt
22 within the Ministry of Health and given their
23 responsibility for, you know, all other healthcare
24 services.

25 The Ministry of Health is very much, I

1 would call a canary on the mine, in terms of
2 identifying pressures in the system and identifying
3 where there are blocks, be it long-term care or
4 home care.

5 So we have to work in tandem with the
6 Ministry of Health. For example, when I talk about
7 issuing temporary licenses to alleviate hallway
8 healthcare pressures in an area, that is very much
9 informed by the Ministry of Health.

10 COMMISSIONER KITTS: Okay.

11 MS. HYLTON: I will jump to the next
12 slide, thank you. So the next slide speaks to the
13 two decisions essentially that are made to
14 facilitate a licence transaction.

15 The first two rows that you see there
16 are decisions made by the Minister, and these are
17 what we call the public interest test under the
18 legislation.

19 So number one, the Minister needs to
20 decide, come to agreement that there is a need for
21 beds in the area. Again, this is where the LHINS
22 factors in, or Ontario Health factors into that
23 body of evidence that goes to the Minister.

24 Secondly, the Minister also has to
25 consider the impact of concentration of ownership

1 as well as sector balance in the system.

2 So going back to first principles
3 around for-profit, not-for-profit existence within
4 a sector. So really wanting to ensure that there's
5 a balance in terms of having for-profit,
6 not-for-profit operators; and also paying close
7 attention to what I would call how big of a share
8 of the pie does 1, 2, 3, 4 operators have across
9 the Province.

10 The Minister has to pay attention and
11 make decisions as she's dealing with each licensing
12 transaction related to those two things:
13 Concentration ownership and sector balance.

14 The last two rows here speak to the
15 decision and determination essentially that I have
16 to make. I do that based on, again, reviewing past
17 conduct, operational financial competency of the
18 proposed licensee.

19 I also then take into consideration the
20 public feedback, via consultation. That can either
21 happen virtually, in writing, or in person via
22 public meeting related to licensing proposals.

23 I should note that these apply to all
24 transactions, except for the temporary emergency
25 licence. The temporary emergency licence does not

1 require all of these steps. For example, on the
2 part of the Minister given the speed with which we
3 tend to make these decisions. We certainly bear
4 that in mind, but we also know they are
5 time-sensitive and very much short term.

6 The max temporary emergency licence is
7 up to a year. On average, we tend to licence in an
8 emergency situation for about three, three to
9 six months.

10 If we can just go to the next slide.

11 The next slide speaks to the review
12 process, and a bit of a recap of what I just spoke
13 to. The left-hand side speaks to the public
14 consultation, the Minister's determination, and
15 essentially my determination.

16 And again, that feeds into the
17 decision-making process. And there are two
18 decisions. It could be to issue a licence or to
19 facilitate a transaction, such as a management
20 company coming in. And those are decisions that
21 are approved by me or determination made by me.
22 Then a Minister would approve specific to municipal
23 and First Nation homes.

24 COMMISSIONER MARROCCO: In the past, in
25 2019, were there instances where licenses were

1 actually suspended?

2 MS. HYLTON: Licenses were not
3 suspended, but the suspension piece would be part
4 of the suite of compliance tools managed by the
5 operations division.

6 So dating back to 2019, there was no
7 suspension of licenses. What was in place from a
8 compliance perspective, dealing with challenges
9 specific to homes, you know, the compliance branch
10 has a range of tools to choose from, increasing in
11 severity depending on the nature of the situation.

12 I do know that they have ceased
13 admissions to homes. So we rarely do away with a
14 licence or suspend a licence. Typically what
15 happens on the compliance side of the Ministry is
16 that they would cease admissions. So they would
17 limit the number of people who are able to come
18 into a home that has a direct impact on a home from
19 a funding perspective. They could also leverage
20 other tools, like issuing compliance orders or what
21 they would call a mandatory management order.

22 So a whole set of tools available for
23 compliance to go in and say, "licensee, we're not
24 comfortable with how things are operating". Or,
25 "we are not satisfied, you are not meeting the

1 requirements under the Act. We require you to do
2 X, Y, Z".

3 And that leads all the way up to the
4 potential to essentially cancel or revoke the
5 licence. Revocation, though, happens rarely within
6 the Ministry. I know it happens quite rarely. But
7 there are a host of other tools before revocation
8 that have been employed. And I know that at least
9 one home comes to mind for me, from a compliance
10 perspective last year.

11 COMMISSIONER MARROCCO: Okay, thank
12 you. I should tell you, Ms. Hylton, I'll probably
13 take a short break around 11:15 or so.

14 MS. HYLTON: All right. So the next
15 slide speaks directly to the two areas of licensing
16 that were activated during the pandemic.

17 So number one, temporary emergency
18 licenses, as I've mentioned. Between March 22nd
19 and April 3rd, a total of 97 cases were licensed in
20 69 homes across the Province.

21 These beds were licensed, really, at
22 that point in history, to support work happening on
23 the part of the Ministry of Health, as well as in
24 the Ministry of Long-Term Care really to prepare
25 for what was expected to be an influx of COVID-19

1 intakes, potentially in hospital and, therefore,
2 wanting to make sure that hospital beds were
3 available for the expected influx.

4 Typically outside of the pandemic,
5 outside of the circumstance this year, hospitals
6 across the Province more so in different areas,
7 deal with hallway healthcare pressures. Hence the
8 government's commitment to address hallway
9 healthcare.

10 Many people who wait in hospital are
11 waiting for long-term care beds to become
12 available, beds of their choice. Most people tend
13 to prefer to wait until a bed of their choice comes
14 up, as opposed to going to any bed that is
15 available.

16 And so part of the issuance of
17 temporary emergency licenses, March to April of
18 this year, was really to facilitate opening up as
19 many spaces as possible, in a state where at that
20 point in history, to facilitate movement of folks
21 out of hospital safely and into long-term care
22 homes.

23 Those beds were also made available for
24 folks who are coming in from community at the time.
25 So you can either enter a long-term care via a

1 hospital or a community. There were limited people
2 looking to move into long-term care, but still some
3 certainly at that point in history.

4 So the beds weren't specific, or only
5 for folks coming in from hospital, but the majority
6 of folks at the time were, because folks were
7 asking the LHINS to hold on placing them, they
8 prefer to stay at home until things settle down.

9 COMMISSIONER MARROCCO: The temporary
10 licenses, you said that they were issued between --
11 you pick the period, March 22nd to April 3rd -- I'm
12 sorry.

13 MS. HYLTON: It's March 22nd to
14 April 23rd.

15 COMMISSIONER MARROCCO: Oh, 23rd. And
16 when would the -- this occurred because the -- a
17 particular home requested a temporary emergency
18 licence or some facility requested it?

19 MS. HYLTON: So we had two things
20 happening at the same time.

21 One, we had either homes or Ontario
22 health regions and LHINS coming to the Ministry to
23 indicate that there were spaces available in homes.

24 So we had information coming into the
25 Ministry with requests coming in. And the Ministry

1 also took a proactive approach and reached out to
2 either homes. For the most part, we reached out to
3 local health integration networks, to LHINs and to
4 OH regions.

5 So we had both things happening at the
6 same time. I can tell you, for example, in certain
7 parts of the Province, the OH region would've
8 reached out to either my ADM, my deputy, or even
9 myself, to say, "we have space available" or, "we
10 know of a home where space is available; would you
11 be willing to provide a temporary emergency
12 licence?"

13 And then in other instances, we placed,
14 and I think at the end of the day we ended up
15 calling all LHINs just to cover our bases.

16 We did just formalize this approach and
17 it's captured a little later on in the deck,
18 there's even a screenshot of what was put forward.

19 There was what was called a "Temporary
20 Emergency Capacity Form" created. This was put out
21 to long-term care homes across the Province, so
22 providing them with an opportunity, because not
23 everyone was coming to the Ministry. We wanted to
24 allow for an equitable process, and the homes had
25 the opportunity, or felt they could safely open

1 beds through this emergency capacity form.

2 This provided a route for homes to
3 write in to the Ministry and indicate, you know,
4 the type and number of beds they were willing to
5 operate on a temporary basis. And this was
6 accompanied by a memo from the Minister out to the
7 sector.

8 So this enabled information coming in,
9 but the Ministry also reached out to LHINS and to
10 OH region.

11 COMMISSIONER MARROCCO: And this
12 March 22nd, is there a reason why that was when
13 this first started to happen or not?

14 MS. HYLTON: So I can say, Justice,
15 that middle of March, so just around the March
16 break period, this is when the government was
17 preparing to eventually make that declaration of
18 emergency on March 17th, so that was a pivotal
19 weekend. I think the 13th was a Friday.

20 So we started, Margaret and I on this
21 call, and my licensing team. We started to
22 proactively reach out in conversations with the
23 Ministry of Health. This is when the command table
24 was certainly getting off the ground and a host of
25 measures were being considered to support the

1 Province as a whole in terms of responding to the
2 pandemic.

3 So ensuring that hospitals were
4 equipped, that they had room to match the potential
5 influx I know was one of the priorities. And
6 looking at opportunities to make sure the hospital
7 had space certainly had an impact on long-term care
8 and long-term care licenses.

9 So that was all coming to fruition that
10 middle week, in the middle of March, that's the
11 March 13th weekend. Declaration happened on
12 March 17th, Declaration of Emergency by the
13 Premier.

14 And so we had started our work really
15 that weekend. So given the number of days it tends
16 to take to process the application, verify
17 information, by March 22nd, we had gotten into a
18 groove where we can start to actually issue
19 licenses.

20 COMMISSIONER MARROCCO: And nobody
21 sounded the alarm before March 22nd, or March 16th
22 or 17th, whenever the declaration, or State of
23 Emergency -- or whatever you want to call it -- was
24 made?

25 MS. HYLTON: Related to additional

1 space in long-term care? Not formally. I do know
2 that the Ministry of Long-Term Care certainly prior
3 to March 13th. My colleague director in the
4 compliance area, Stacey Colameco and I were paying
5 very close attention to what was happening in
6 Seattle and DC, and very much keeping an eye, given
7 the impact of long-term care.

8 And so I know, given the role of
9 compliance and inspection in the Ministry, the
10 compliance team had proactively gone to the
11 Ministry of Health, gone to the Public Health arm
12 of the Ministry of Health, really to ensure that
13 long-term care was being thought about, was being
14 considered given what we anticipated would come to
15 the Province of Ontario. So that started prior to
16 March 13th.

17 As it relates to issuing temporary
18 emergency licenses, nothing formal, I would say,
19 prior to that weekend. Because I think that's the
20 weekend where decisions were being made about how
21 to support hospitals, especially, what are the
22 expectations of long-term care homes, where are
23 there opportunities potentially to open up spaces.
24 It was really around that weekend that those formal
25 decisions started to be made.

1 COMMISSIONER MARROCCO: As you're
2 paying attention to what's going on in Seattle, and
3 in British Columbia as it relates to long-term care
4 facilities; what's the concern? What concern are
5 you responding to when you're doing that?

6 MS. HYLTON: I know from a compliance
7 perspective, really paying attention to infection
8 control measures. That, in particular, I can
9 recall, you know, as part of internal discussions
10 wanting to make sure that long-term care homes were
11 prepared, or taking the necessary precautions.

12 So things related to supplies, PPE.
13 These were some of the things that were being
14 discussed early on. And really making sure, and
15 for sure within the Ministry of Health, really
16 making sure that homes were starting to think about
17 or make arrangements for or access for things like
18 PPE.

19 Those were the early kind of Ministry
20 of Long-Term Care discussions and then those were
21 formally brought to the Ministry of Health and that
22 wandered to command table. That then started to
23 meet on a regular basis, and then eventually
24 long-term care became a standing item on managing
25 that, as far as I know.

1 I did not sit at the command table, but
2 I understand that LTC became a formal agenda item
3 there, you know, being discussed on a regular
4 basis.

5 COMMISSIONER MARROCCO: And so when was
6 the concern about personal protective equipment and
7 so on? When was that first articulated by the
8 Ministry of Long-Term Care to the Ministry of
9 Health. From your perspective. I appreciate, you
10 know, in terms of what you know. I'm not asking
11 you to pronounce on behalf of the entire ministry
12 every phone call. But from your perspective, when
13 was that first brought to the Ministry of Health's
14 attention.

15 MS. HYLTON: From my perspective, and I
16 want to make sure that I am not misrepresenting in
17 any way, given that I would not have been the
18 person to place the call. Those conversations were
19 very much led by compliance at the time under the
20 operations division.

21 I would suspect that these
22 conversations started to happen early, earlier in
23 March, or earlier than middle of March when the
24 declaration of emergency was made. I know that
25 week leading up to March 13th, that Friday, that

1 certainly was a critical turning point, I would say
2 within the Ministry of Health, Ministry of
3 Long-Term Care as we started to organize ourselves
4 to respond to the pandemic.

5 So not necessarily sure I can commit to
6 anything prior to that week, but I do know that
7 that was a critical turning point. And I know
8 that, you know, senior officials within the
9 Ministry were certainly talking and being briefed
10 throughout the course of that week, leading up to
11 that Friday.

12 COMMISSIONER MARROCCO: And so these
13 discussions and briefings related to the -- and you
14 correct me if I'm wrong -- related to the need to
15 be conscious of an outbreak in long-term care
16 facilities?

17 MS. HYLTON: Yes, the potential. Given
18 what we observed happening in other parts. So
19 BC, as an example. So it was really, you know,
20 preparing ourselves from a national standpoint.
21 Ontario has the largest footprint of long-term
22 care. We have the most number of beds.

23 So we certainly were looking at what
24 was happening in other long-term care sectors, and
25 being cognizant of the strong or high potential for

1 outbreaks within Ontario, just given how big of an
2 LTC footprint we have here in the Province.

3 COMMISSIONER MARROCCO: And then the
4 discussions around hospitals, and the adequacy of
5 hospital facilities would be -- as far as long-term
6 care is concerned, be trying to move long-term care
7 patients out of the hospital into a long-term care
8 facility because of the anticipation that hospital
9 was going to be under pressure from people who were
10 being admitted due to COVID-19.

11 MS. HYLTON: Yes.

12 COMMISSIONER MARROCCO: So you're faced
13 with a risk associated with the spread of the
14 disease in a long-term care facility, and also a
15 pressure to receive people into the long-term care
16 facility who have been moved out of the hospital to
17 make room for the anticipated surge of patients as
18 a result of the pandemic; have I captured that or
19 no?

20 MS. HYLTON: Yes, you have. The only
21 qualifying statement I would make is that the
22 97 beds licensed were not exclusive to
23 hospital-based LTC applicants.

24 But certainly part of the
25 decision-making related to opening up capacity

1 within long-term care homes was to try to offset
2 what was anticipated to be potential pressures on
3 long-term care facilities. Given, again, what the
4 Ministries were seeing beyond Ontario. And,
5 really, trying to prepare our hospitals locally to
6 manage the potential influx of COVID-19 cases.

7 COMMISSIONER MARROCCO: Yes, Mr. Kitts?

8 COMMISSIONER KITTS: Just to follow up
9 on that. I keep getting a notice my internet is
10 unstable, so forgive me if I've missed this.

11 But I'm just going back to, I think you
12 said that the increase in temporary emergency
13 licenses began in March 22nd and ended in
14 April 23rd, which allowed us to increase the beds
15 in long-term care by 97 spaces in 69 homes; do I
16 have that right?

17 MS. HYLTON: Yes.

18 COMMISSIONER KITTS: So the direction
19 at that time was to create space in long-term care,
20 so that the hospitals could decompress and have
21 more beds, because that was where the expected need
22 would be; is that correct?

23 MS. HYLTON: It was not exclusive to
24 hospital pressures, but certainly part of the
25 decision-making was to ensure that if someone did

1 not need to be in hospital, they could be routed to
2 an appropriate setting.

3 And for some of those hospital patients
4 at the time, they were waiting for long-term care.
5 But those beds, the 97 beds were not exclusive to
6 hospital patients only. There were still
7 applicants from the waitlist in community asking
8 for long-term care. So it was agreed to deal with,
9 I would say, emergency admissions into long-term
10 care.

11 COMMISSIONER KITTS: So the capacity
12 was created to admit more patients, not to
13 decompress the long-term care homes like the
14 hospitals?

15 MS. HYLTON: Right. Yes, that's right.

16 COMMISSIONER KITTS: Was it April 23rd
17 when that sort of thought process got reversed and
18 said, "we need to now decompress the long-term care
19 homes"?

20 So was it at that time that it sort of
21 reversed and said, "we need to create space in
22 long-term care for long-term care".

23 MS. HYLTON: Yes. I think a couple of
24 things kind of came together within that first
25 month. So kind of moving towards April 23rd.

1 We started to see, obviously being
2 reported in the media, that the Ministry on the
3 ground, hearing from Ontario Health regions on the
4 ground as well, and directly from licensees,
5 starting to hear about the major challenges now
6 faced by long-term care homes.

7 Now I should note the decision-making
8 around issuing temporary emergency licenses, we
9 were very careful. We worked directly with Ontario
10 Health regions, LHINs and the operators. The
11 Ministry was very careful in terms of making
12 decisions around issuing licenses only for homes
13 that were not in outbreak, that would not have been
14 an option. We would not have opened up spaces in
15 homes that were in outbreak.

16 But, yes, within the course of the next
17 month, there was certainly that -- I would call it
18 rapid evolution of the spread of COVID across the
19 long-term care sector in Ontario. And I think by
20 way of, one, the Ministry recognizing that more and
21 more homes were going into outbreak.

22 And two, really that the interest on
23 the part of the sector as well as LHINs really
24 being dried up, folks understood that long-term
25 care, very much critical in terms of managing the

1 spread of the virus within the homes, and even
2 outside and to other facilities, given movement of
3 long-term care residents to hospitals.

4 So by the time we got to April 23rd,
5 those two things came together really to, I would
6 say halt any further issuance of any temporary
7 emergency licenses for those particular reasons.

8 COMMISSIONER MARROCCO: Thank you. Go
9 ahead.

10 All right. It's 11:11, from your
11 perspective, is this an appropriate place to stop
12 for a few minutes or no?

13 MS. HYLTON: Perhaps I can just close
14 with this slide.

15 So this slide, on slide eight, just
16 gives you a bit of an overview from a visual
17 perspective. This is a timeline that shows, again,
18 the licensing arm of the pandemic response. So the
19 first bar, that yellow bar on top speaks to -- on
20 the left-hand side, speaks to what happens in mid
21 to late March going into April. And again, the
22 focus there at the time, was really looking at the
23 ability to open up stages within homes where it was
24 safe to do so.

25 Going beyond that, by the time we got

1 to the month of May, given the evolution within the
2 sector, within such a short period of time, working
3 in tandem with the compliance branch of the
4 Ministry, we moved into approving management
5 contracts. And management contracts, I'm happy to
6 speak to that in a bit more detail after the break.

7 But this was an opportunity to
8 facilitate greater support for specific homes on
9 the ground, either by way of a voluntary
10 arrangement between a hospital and an operator, or
11 what we call a mandatory management order; one of
12 the tools within the toolbox of the compliance
13 branch, where they can require an operation,
14 depending on the circumstance, to bring in another
15 entity to manage the day-to-day operations of the
16 home, if the compliance branch is not satisfied
17 with what's happening.

18 So we had three management contracts
19 that were approved by me, by way of a mandatory
20 management order being issued by the compliance
21 branch. So those were the three homes, River Glen
22 Haven, the bottom red bar, the first home there.
23 So that's the May 29th was River Glen Haven.

24 Downsvew and River Glen Haven was
25 supported by South Lake Hospital. So they went

1 into South Lake to manage the operations of the
2 home under a management contract.

3 Then we had Downsview long-term care
4 home on June 1st, with Humber River stepping in to
5 manage.

6 Camilla Care on June 4th, that did not
7 come by way of a mandatory management order, but
8 more of a voluntary agreement between the hospital,
9 Trillium and CNM, who is responsible or holds the
10 licence for Camilla Care, so that was June 4th.

11 And the third mandatory management
12 order tied to the June 5th management contract
13 between Forrest Heights Home and St. Mary's
14 Hospital.

15 The rest, including Camilla Care, going
16 to June 17th, those were voluntary arrangements
17 where hospitals stepped in to these specific homes
18 to manage for a specified period of time.

19 COMMISSIONER MARROCCO: And in this
20 process that you've described in this chronology on
21 page 8; is the local Medical Officer of Health
22 engaged at all in these decisions; from your
23 perspective?

24 MS. HYLTON: From the licensing
25 perspective, not formally. My responsibility to

1 approve a management contract between two parties,
2 in this case it would be one of the hospitals and a
3 specific LTC home, we do -- we do not engage the
4 Medical Officer of Health.

5 COMMISSIONER MARROCCO: Even in this
6 type of situation?

7 MS. HYLTON: We would not, from a
8 management contract arrangement perspective. The
9 Ontario Health regions are certainly integral to
10 this and would have been part of our discussions
11 between the hospital, the operator to formalize a
12 contract and get this off the ground.

13 From a compliance perspective, I don't
14 want to speak for the operations team, but I know
15 that there have certainly been very close contact
16 between public health, the compliance branch of the
17 Ministry, looking at specific homes and,
18 especially, in cases where they have had to use
19 such ancillary tool as a mandatory management
20 order.

21 The extent to which public health was
22 involved in the three I mentioned, the operations
23 branch would perhaps be best poised to speak to
24 that. I would not necessarily have been privy to
25 those conversations.

1 But from a licensing perspective, our
2 job is essentially to facilitate bringing a
3 management company in. Once that has been
4 identified as either being required through an
5 MMO on the part of the compliance branch, or
6 identified by the two parties, the hospital and the
7 operator, essentially coming to the Ministry with
8 this request.

9 COMMISSIONER MARROCCO: Okay. Yes,
10 Commissioner Coke.

11 COMMISSIONER COKE: So these mandatory
12 management orders, or voluntary orders, they have a
13 specific timeframe, or what are the conditions
14 under which this ends?

15 MS. HYLTON: Yes. So the management
16 contracts do have a specific timeframe. So many of
17 these, if not all of them were approved for about a
18 90-day period. So this month of September was
19 actually a critical month in terms of the contracts
20 coming up for expiry.

21 So, yes, they do have a specified
22 timeframe that's typical for a management contract.
23 Management contracts exist outside of this COVID
24 response. We have management contracts in the
25 system all the time, there are some operators who

1 hold the licence, but always have an operation
2 managing the home. So this is typical.

3 The management contract is not limited
4 to 90 days. In this circumstance, given the
5 reasoning behind bringing in the hospitals and for
6 all ten, they were related to dealing with the
7 pressures of the pandemic outbreaks in the home,
8 that specified period of about 90 days was
9 identified for each.

10 So I do know that there is work
11 underway now on the part of the compliance branch
12 to connect in with the hospitals, connect in with
13 the homes, gauge how the homes are doing and really
14 make some decisions that will obviously come to me
15 in licensing, about whether or not there's a
16 continued need for the hospitals to continue to
17 manage. Or, if the licensee can regain day-to-day
18 management and take over day-to-day management of
19 the home.

20 COMMISSIONER COKE: Thank you.

21 COMMISSIONER MARROCCO: I guess one
22 final. You said a number of these contracts were
23 coming due in September; were they extended?

24 MS. HYLTON: We're literally going
25 through that process now. I know that a few of

1 them, especially through the voluntary approach, I
2 don't have the list of all of them in front of me
3 as I am getting them on a day-to-day basis from my
4 team now. But the expectation, and I think there
5 may be even communication that has gone out from
6 the operations branch. Many of them will not be
7 extended, by virtue of the Ministry on the
8 operations side, given the interactions, the
9 requirements for plans, operational plans by the
10 management company and the operator. The
11 compliance branch feeling that they are in a
12 position to be returned in terms of operation back
13 to the home.

14 So I suspect that many of them, if not
15 perhaps all, I would be able to confirm that by
16 about Monday when I see the full list. But I know
17 so far what I've seen, quite a few of them will
18 expire and the hospitals will leave the home and it
19 will be returned to the operator.

20 COMMISSIONER MARROCCO: Okay.

21 We'll take ten minutes.

22 -- RECESS TAKEN AT 11:19 --

23 -- UPON RESUMING AT 11:30 --

24 COMMISSIONER MARROCCO: Okay.

25 All right, I think we're ready to go.

1 Ms. Hylton, go ahead.

2 MS. HYLTON: These last few slides in
3 the licensing deck speak to the priorities of the
4 licensing arm of the division and of the Ministry,
5 that at least properties were established initially
6 in 2018, so they are a work in progress but we've
7 certainly seen some movement.

8 If you jump to the next slide, this
9 slide just provides a bit of background and some
10 context for the transformation and the change in
11 priorities since 2018. We have processed just shy
12 of 3,000 licence related transactions since this
13 legislation has come into force. So dating back to
14 2010.

15 We have quite a bit of experience now,
16 given almost 3,000 transactions. We've heard from
17 stakeholders about their experience with the
18 process, certainly concerns cited related to how
19 intensive the process is from a timing perspective.

20 We have very much heard concerns around
21 transparency. So operators or applicants wanting
22 more information about where they are in the
23 process, or whether or not things are moving
24 forward.

25 Really wanting more confidence around

1 timelines, given the responsibility of elected
2 officials like our Minister, as part of this
3 process, you know, timelines and committing to
4 timelines can sometimes be challenging externally,
5 and so we certainly heard feedback in that respect.

6 We've also heard quite a bit about
7 scope. So you know, this one-size-fits-all model
8 where we have the same type of rigor afforded to a
9 transaction that might cover the transferring of a
10 handful of beds, compared to the building of a net
11 new home and really applying the same rules or
12 expectations; quite a bit of feedback from the
13 sector in that respect.

14 And that has made for, I would call it,
15 somewhat diminished stakeholder confidence in the
16 system over the last few years. The work we have
17 undertaken since 2018, and it's captured on the
18 next slide, that really speaks to the efforts made
19 by the Ministry given the feedback received and
20 articulated. And we are definitely seeing a
21 difference and hearing quite positive feedback from
22 this sector.

23 The temporary emergency licence is an
24 example of, you know, the fruition of changes made
25 as a result of the transformation. It allows for

1 us to do things quickly, and to be responsive to
2 the sector. For example, in an emergency situation
3 like what we have lived through.

4 This slide just identifies our five key
5 areas of focus, as we strive to transform the
6 licensing arm of the Ministry.

7 So number one, the licensing piece of
8 the development story. So we want to facilitate
9 the building of new beds, the redevelopment of
10 older capacity. And there is a heavy dependance on
11 licensing, because even if these buildings are
12 built, if they don't meet the actual standards,
13 they will not receive a licence. So facility
14 development of LTC capacity is critical.

15 And so really looking to identify
16 synergies and optimize licensing and development
17 functions to make for a smoother experience for our
18 operators, very much critical from a licensing
19 perspective.

20 We've looked quite recently at the
21 legislation and made changes to the legislation
22 related to the public consultation part of the
23 licensing process.

24 So the ability now, and we have
25 certainly leveraged this through the experience

1 over the last few months. But the Ministry is now
2 only since last year, able to facilitate the
3 comprehensive public consultation for a transaction
4 where it is required by leveraging technology. So
5 the internet or doing things virtually. Whereas
6 before, we were literally required to go out in
7 person to host meetings. And lots of members of
8 the public either would not be able to physically
9 get to a meeting at a specified time, and would
10 have wanted to be able to capitalize on technology.
11 So that's another change made.

12 The other three speak to refinement
13 that support or review of licensing transactions.
14 So, for example, our financial reviews which I
15 mentioned is an important component of my
16 determination for a licence transaction.

17 We have made significant changes to
18 that process. Really making sure we are adequately
19 capturing the information that's needed. And the
20 Ministry leverages a third party Deloitte at this
21 point, to support the review of financial
22 information related to an organization. And so we
23 send information, advice, recommendations, as it
24 relates to the financial health of an organization
25 before we issue a licence.

1 So we've made changes there with the
2 support and the feedback from Deloitte, given what
3 they've observed.

4 Lastly, we have identified and started
5 work on process, as well as program improvements to
6 the licensing arm of the Ministry. So, for
7 example, really looking to optimize the review
8 process, maximize value, maintaining integrity in
9 the system.

10 So we have identified within the last
11 year -- under Margaret's leadership, my team has
12 been able to pinpoint every step of every licensing
13 transaction, and really leverage leading principles
14 to be able to identify, question, change, modify or
15 accept, really with an ear to, what is adding
16 value? What is inherently supporting the
17 expectations that the Ministry and the operator as
18 per the legislation? And really wanting to build
19 and maintain integrity of the licensing system. So
20 significant changes certainly on the way in that
21 respect.

22 And as it relates to our program itself --
23 COMMISSIONER MARROCCO: Ms. Hylton,
24 just a second. Commissioner Coke?

25 COMMISSIONER COKE: I'm just curious.

1 In addition to this business process improvement
2 that are underway, do you feel you have adequate
3 resources and capacity within your own area? Is
4 that a challenge in any way?

5 MS. HYLTON: Absolutely. The rapid
6 development of the development program in
7 particular, given the emphasis on building new
8 beds, to redeveloping capacity, there are direct
9 implications for licensing. That's why that's flag
10 number one on this slide. And you can see a direct
11 connection then between needing sufficient
12 resources to be able to manage and handle the
13 workload, the experience of the pandemic, the
14 ongoing day-to-day transactions for the existing
15 homes, those don't stop, those are always
16 happening.

17 So, absolutely, I think resources have
18 been and continue to be a challenge for the
19 licensing team and certainly the capital division
20 as a whole.

21 I do know that by virtue of
22 establishing our division, the capital's division,
23 and that's happened quite recently within the last
24 three months, I think that is a step in the right
25 direction for the Ministry. And so securing

1 adequate resources is absolutely something we
2 advocate for on a frequent basis, but it is
3 critical to get the job done.

4 COMMISSIONER COKE: Thank you.

5 COMMISSIONER MARROCCO: Is there
6 anything in the licence that allows you to insist
7 that an existing facility change itself in response
8 to improved medical knowledge, for example, or
9 something -- you know, something of that nature.

10 MS. HYLTON: If an entity holds the
11 licence, if there is an existing licence, it would
12 really be through the compliance arm of the
13 Ministry where those expectations or requirements
14 would be made.

15 It wouldn't necessarily necessitate a
16 change in the licence, but there is certainly the
17 option of revoking the licence if those changes
18 aren't made, or made to the satisfaction of the
19 compliance branch. And they, therefore, see
20 concerns of the ongoing operations of a home that
21 already has a licence.

22 There is always room, especially when a
23 licence is being issued, or reissued. There is
24 always room, and we work with our legal team
25 internally, if there are any requirements or

1 stipulations we would want to put on a specific
2 licence.

3 But, typically, if someone holds a
4 licence, the compliance arm would really be that
5 route to hold them accountable to making those
6 changes. And then as it relates to issuing or
7 reissuing, we have the option to put in
8 stipulations. But before we go there, the
9 Ministry's first response likely would be not to
10 issue the licence.

11 So we would want the confidence in the
12 design, in the delivery of the services, we would
13 need the confidence from the compliance branch. So
14 our first step likely would be not to issue the
15 licence, as opposed to issuing the licence with an
16 expectation that changes are to come.

17 COMMISSIONER KITTS: Quick question.

18 From the time you decide to, let's say
19 offer a licence to a new person to build a
20 long-term care home. If your transformation is as
21 successful as you predict, how long would it be to
22 go from, "we want to give a licence" to opening
23 that new home's doors?

24 MS. HYLTON: That's a great question.
25 There are several steps in between. And licensing

1 is one part of it. There is the development arm of
2 that transaction as well.

3 So generally speaking, it takes about
4 36 months after an operator has identified land and
5 secured financing. Physically get the building
6 built and to be ready to turnkey to take occupancy.

7 We issue a licence only when they are
8 ready for occupancy. But prior to that, so as they
9 are moving through the process, they are under
10 construction, or they are trying to secure
11 financing, etcetera, there are reassurances the
12 Ministry can provide, what we call a licence
13 undertaking. And he can do that, perhaps even
14 within a couple of months, if the operator has
15 things in order.

16 So we can provide what we call an
17 undertaking. In some respects it's a promise of a
18 licence in the event the operator, by the time they
19 get to occupancy, have met the necessary criteria.
20 For example, they have built the building to our
21 standards. They have received the necessary
22 municipal approvals, etcetera.

23 But that promise of a licence, which
24 many of our operators look forward to, because they
25 know the licence won't come until the building is

1 ready, that can be issued sometimes as early as a
2 few months if we have the necessary documentation.
3 As captured earlier, to conduct the public interest
4 tests. To be able to gauge the public feedback,
5 etcetera. So that can be done in a matter of
6 months.

7 COMMISSIONER KITTS: So 36 months is
8 the, I guess, the building time. So am I to assume
9 that it's probably all in about four years?

10 MS. HYLTON: I think that is fair. I
11 would say, as I want to double down on this, I know
12 my team would be in my ear here.

13 A lot of that window as it relates to
14 development, a lot of that is dependent on the
15 operator.

16 Securing financing, it is one thing to
17 hear from government in terms of approval or an
18 allocation of new beds, or approval to move forward
19 with the development project. But the time it
20 takes the operator to secure land, to firm up or
21 hone in on financing, to tender the project, all of
22 these steps -- to execute an agreement with us in
23 government, all of these steps happen before
24 construction starts. I have seen quite a bit of
25 variation there.

1 So operators who are very organized,
2 seem to be able to do that certainly within a year
3 I would say. So 12 months I think is reasonable.
4 Hence me saying four years is fair.

5 But I have also seen that take a lot
6 longer. Sometimes it is beyond the control of the
7 operator. Or they have opted to lobby for a
8 particular piece of land and wait out the
9 municipality, you know, wait out a whole bunch of
10 things before they move forward with construction.

11 So a lot of it is dependent on the
12 operator.

13 COMMISSIONER KITTS: Thank you.

14 MS. HYLTON: Slide 13 just gives you a
15 bit of overview of some of our improvements to date
16 as per the rural map before.

17 Number one, there's multistream
18 licensing review on the left-hand side towards the
19 bottom of the page, speaks to us applying this risk
20 based multistream licensing model.

21 So this again, very much tied to the
22 development arm of our organization, and the
23 licensing component being an enabler.

24 So back to the previous question
25 related to how long it takes before a licence can

1 actually be issued or an undertaking.

2 One of the things we have done as part
3 of our improvement or our slate of improvement, is
4 to really look at operations from a risk-based
5 model. Is there operators who have strong
6 compliance history? They have history, operating
7 long-term care history with construction. We have
8 quick access to their financial information, we're
9 able to move forward in a couple of months with
10 issuing a licence, a licence undertaking as an
11 example. Whereas some operators, especially if
12 you're net new, you do not have strong compliance
13 history, we would not necessarily advance those as
14 quickly, because the Ministry would want to take
15 its time, do our due diligence internally, allow
16 the Minister sufficient time, etcetera, to make the
17 decision.

18 The last two here to speak to again are
19 other examples in terms of changes we've made so
20 far. Improving transparency has been one of my
21 priorities here. Modernizing the system actually
22 is my priority, but improving transparency is near
23 and dear to my heart, given my experience working
24 outside of government.

25 And so we have leveraged our

1 connections with operators to use the opportunity
2 to sit with them at the outset, walk them through
3 our processes, document our processes, create
4 documentation to go up online so it's readily
5 available for folks to understand the steps, if
6 they are looking to undertake a licensing process
7 to appreciate the documentation that is required
8 beforehand.

9 It's important to me and to my team, to
10 the Ministry, that operators understand not only
11 the responsibility that comes with holding a
12 licence, but the steps that are required to get
13 there.

14 I certainly don't want this to be
15 deemed as impossible, or difficult. We have a
16 responsibility on the part of the Ministry to
17 licence operators who we feel can provide a certain
18 level and quality of care. And so we want to
19 ensure that we are being transparent in terms of
20 our expectations and can help proponents and
21 applicants plan.

22 Lastly, as I mentioned, the legislative
23 change related to the public consultation. Another
24 example of a recent change made to the project.

25 So these are examples, there are a few

1 more we can speak to, but these are some tangible
2 examples that are already in place.

3 The last slide -- sorry.

4 The last slide of this deck -- and I
5 will close off here for licensing -- but this
6 speaks to another critical priority I mentioned
7 before, this is about sustaining capacity. And
8 again, going back to the almost 26,000. So just
9 over 26,000 beds that are set to expire in 2025.

10 The Ministry, from a licensing
11 perspective, we are literally reaching out to every
12 licensee that holds a licence that will expire in
13 2025. We started this process earlier this year by
14 way of a survey. We surveyed the entire -- the
15 entire sector with a keen eye for asking specific
16 questions to those with 2025 expiries. We were
17 trying to get an appreciation for what their plans
18 were; the current state of their homes, etcetera.

19 We are now literally calling every
20 single licensee holding a 2025 expiry, if we are
21 not aware of their plans to redevelop, etcetera, to
22 make sure that we meet our requirement by 2022, to
23 provide notice to these homes as to whether or not
24 we intend to licence them beyond their expiry date.

25 So this is a critical piece of work for

1 licensing. And as identified before, there is a
2 potential here for loss of a significant number of
3 beds in the next few years.

4 If we aren't working in tandem with the
5 sector to be able to help them along to either
6 redevelop or to make plans for what happens beyond
7 2025.

8 COMMISSIONER COKE: Sorry, I just want
9 to understand. So if these are places that are not
10 able to come to the new standard by that time, they
11 wouldn't be licensed?

12 MS. HYLTON: Yes. Their licence will
13 expire. So regardless, they hold a licence that
14 expires as of 2025. So there are two main reasons
15 that are driving the potential for someone with a
16 licence expiry of 2025, not being able to continue
17 to operate after that time.

18 One is the fact that the licence will
19 expire. If you have an expired licence, you are
20 then not considered an active operating LTC home,
21 in the eyes of the Ministry and, therefore, would
22 not be funded.

23 The other critical piece here, are
24 changes and requirements on the part of the fire
25 marshal. These changes were communicated quite

1 some time ago, I think perhaps dating back to a
2 decade now to both retirement homes and long-term
3 care homes to meet specific requirements about
4 these sprinklers by the year 2025.

5 So the fire marshal would have
6 responsibility if a long-term care home by 2025 is
7 not sprinklered, in terms of being able to approve
8 their ongoing operations. And then coupled with
9 that, the Ministry also happens -- and it just
10 happens to be the same year -- we also have
11 licenses expiring in 2025.

12 So many of these licenses that are set
13 to expire, are not necessarily sprinklered at this
14 point. Part of why redeveloping these beds would
15 be such a critical piece, part of the redevelopment
16 process would mean that they are brought up to the
17 Ministry's standards, as well as the fire marshal's
18 standards.

19 Thank you.

20 COMMISSIONER KITTS: We understand that
21 most of these would be in the much older homes who
22 don't meet the design standards of the Ministry or
23 perhaps even the fire marshal, including Public
24 Health and IPAC.

25 Do you have an idea of how many can be

1 renovated to meet the design standards, versus need
2 to build new because the infrastructure is just so
3 old; do you have an idea?

4 MS. HYLTON: Well, it's a fair
5 question. I can tell you that what we've heard
6 from the sector, and the reason I don't necessarily
7 -- I won't give a figure here is -- we've heard
8 quite explicitly from the sector over the last year
9 especially.

10 The majority of homes that are housing
11 older beds that are set to expire will likely
12 redevelop a net new build, a greenfield project
13 anyway. So that the likelihood of renovating the
14 existing space, very low.

15 The figure given by the sector back in
16 January when we held consultations on development,
17 was in and around 90 to 95 percent of redevelopment
18 projects being greenfield projects. So that's,
19 essentially, all of them being greenfield.

20 So space, and the footprints seem to be
21 a critical driving factor, and the need to
22 modernize just a basic infrastructure for many of
23 these homes seem to be pushing the sector towards
24 building net new.

25 And this is one of the reason why we

1 know there's been limits in terms of how quickly
2 these homes, or these operations have moved forward
3 with redevelopment. They are limited in terms of
4 leveraging the existing homes, and so either
5 leading to find land, or to create a plan where
6 they can move their residents out for a period of
7 time, not gotten a home and build net new, all of
8 those are things they have to take into
9 consideration.

10 But generally speaking, we've heard
11 over 90 percent of these older homes to be
12 redeveloped would be as a result of net new builds.

13 COMMISSIONER KITTS: So if I just
14 quickly do the math, it takes four years to build a
15 home and open it. And we need to, looks like maybe
16 257 long-term care homes need to be built.

17 Plus we have to increase the base
18 number by 15,000 more beds. So that's a lot of
19 long-term care homes that need to be built.

20 MS. HYLTON: Yes, absolutely.

21 COMMISSIONER KITTS: In the next four
22 years.

23 (Experienced virtual connection
24 difficulties).

25 MS. HYLTON: I apologize, I didn't hear

1 the question.

2 COMMISSIONER KITTS: The question was:

3 Is there some concern about the ability
4 to transition to 2025 without a significant
5 shortage of long-term care beds in that transition?

6 MS. HYLTON: Yes. I think it's worth
7 saying here that the 257, with licenses coming up
8 for expiry in 2025, we know that some of these
9 homes will close, and we're hearing as they're
10 making their plans, or they do not intend to
11 operate.

12 What we have heard through our surveys,
13 and we're verifying this through the calls. The
14 majority of these operators, though, have expressed
15 interest in continuing to operate.

16 So they know they will either need to
17 redevelop, or bring their homes to a place where
18 they can meet certain base standards. For example,
19 the fire marshal standards. So the sector is very
20 much aware of that.

21 The realty, though, that you've
22 outlined is correct. The Ministry is tasked with
23 working with the sector to create a plan and
24 facilitate as best we can, maintaining capacity
25 given the 2025 date. Building net new, and

1 certainly working to address and try to meet the
2 demand or come closer to meeting the demand for
3 long-term care.

4 As the timelines are very tight, once
5 we get to the next deck, you will see that there
6 have been a host of successive attempts on the part
7 of the Ministry dating back to maybe almost
8 20 years ago at this point to facilitate
9 redevelopment of beds. So this did not start in
10 2018.

11 There are a host of challenges, as I
12 mentioned, perhaps finding land or securing
13 financing; but there are also, you know, there's
14 also onus on the part of the operators as well.
15 And we've seen some moves, some are starting to
16 redevelop, or they've already redeveloped. Some
17 have plans in place; and then there are others who
18 are yet to have their plans in place.

19 COMMISSIONER COKE: I'm just curious,
20 what extent are we offering up government land to
21 help with this process?

22 MS. HYLTON: That is a critical part of
23 our development program, and as part of our work
24 and we will -- we can certainly shift to this deck,
25 and you will see that captured here.

1 But back in 2018 coming into 2019, this
2 government -- and I must say under the previous
3 government, this was identified as well -- very
4 much promoted on the part of this government in
5 2018, interest in leveraging government surplus
6 lands to be able to facilitate the development of
7 long-term care facilities.

8 So you will see in the next deck, once
9 we transfer to that, that surplus land is a
10 critical part of the modernization of the
11 development program. Given the reality we know
12 operators are facing in terms of trying to find
13 land, especially in urban areas.

14 So the GTA, absolutely. The GTHA, I
15 would say in particular, areas of great concern.
16 And there are a host of other measures that the
17 Ministry have put in place.

18 Perhaps this might be an appropriate
19 time to speak to the other deck. But you'll see as
20 we go through that deck, other efforts made on the
21 part of government quite recently to try to incent
22 development and move folks forward as quickly as
23 possible.

24 MR. MATHAI: Commissioner, it's Sunil
25 Mathai here. I'm cognizant of the time, it's now

1 12 o'clock, which is the original time that we had
2 scheduled.

3 I think you're going to be as engaged
4 with the next presentation which is capital
5 development. And I'm just wondering, rather than
6 rushing through that deck in order to meet your
7 time schedule, I'm wondering if we should find some
8 time on Monday. I understand there's time
9 available between 3:00 to 5:00 or Tuesday between
10 9:00 to 11:00 a.m. That might be a better -- more
11 time to present on these issues? We're in your
12 hands on that. I just wanted to flag that as a
13 possibility.

14 COMMISSIONER MARROCCO: I was thinking
15 the same thing. Let me just ask the other
16 Commissioners.

17 Do you want to reschedule the second
18 piece, which deals with long-term care home
19 development framework?

20 Commissioner Coke?

21 COMMISSIONER COKE: Yes, I think we
22 should give it the time that it's due. So rather
23 than rush it.

24 COMMISSIONER MARROCCO: All right.
25 Commissioner Kitts?

1 COMMISSIONER KITTS: Yes, I agree
2 completely.

3 COMMISSIONER MARROCCO: All right. So
4 then Mr. Mathai, why don't we do it this way.

5 Ms. Drummond and yourself can work out
6 when you come back.

7 MR. MATHAI: Will do, thank you
8 Commissioners.

9 COMMISSIONER MARROCCO: Okay. Well,
10 Ms. Hylton, thank you very much for the first
11 presentation. As you can appreciate, we were all
12 engaged with it. And I believe we found it very
13 informative, and thank you for the straightforward
14 presentation. We look forward to the second act
15 when you come back, thank you.

16 MS. HYLTON: Thank you. Thank you for
17 having me.

18 COMMISSIONER KITTS: Thank you.

19 COMMISSIONER COKE: Thank you.

20

21

22 -- Meeting adjourned at 12:07 p.m.

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REPORTER'S CERTIFICATE

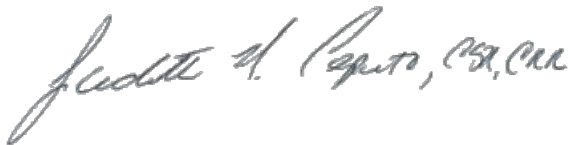
I, JUDITH M. CAPUTO, RPR, CSR, CRR,
Certified Shorthand Reporter, certify;

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

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

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

Dated this 21st day of September, 2020.



NEESONS, A VERITEXT COMPANY

PER: JUDITH M. CAPUTO, RPR, CSR, CRR

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