Long-Term Care COVID-19 Commission

Via Zoom
on Tuesday, September 15, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 15th day of September, 2020, 3:04 p.m. to 4:35 p.m.

BEFORE:

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

PRESENTERS:

Michael Hillmer, Assistant Deputy Minister for the Capacity Planning and Analytics Division

Jennifer Bridge, Acting Director, Health Analytics and Insight Branch, Ministry of Health and Ontario Ministry of Long-Term Care.

Kamil Malikov, Director, Ontario Ministry of Health and Ontario Ministry of Long-Term Care.

PARTICIPANTS:

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

Dawn Palin Rokosh, Director of Operations With the Long-Term Care Commission.

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

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

Ida Bianchi, Counsel, Long-Term Care Commission Secretariat

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

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

Judith Parker, Crown Law Office Civil.

Roopa Mann, Counsel, Crown Law Office Civil.

PARTICIPANTS (continued):

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

Lynn Mahoney, Counsel, Gowlings

ALSO PRESENT:

Judith M. Caputo, Stenographer/Transcriptionist

-- Upon commencing at 3:05 p.m.

COMMISSIONER MARROCCO: I'd like to thank you folks for coming. I'm sure what you'll have to say will be of great assistance to us.

So without any further adieu, let's get started.

MR. HILLMER: I understand that the presentation will be projected and -- thank you.

COMMISSIONER MARROCCO: It's taken care of.

MR. HILLMER: Wonderful.

So what follows is a general overview of what our division does, and then we get into some specifics in terms of the kinds of information supports we provided during the -- and continue to provide during the pandemic specific to long-term care.

So I wanted to offer all of you as Commissioners, the licence to interrupt and digress and interrogate as necessary. I'm quite happy to have that happen, so I'll get started.

Next slide, please.

So the Capacity Planning and Analytics Division is one that provides -- that has access to a whole range of health data and has the skills and

expertise to combine that into dashboards, analyses, and information products to guide decision-making, policy formulation, performance management, situational awareness.

We also have a fairly sizeable investment in health and human resources, and provide expertise in planning and program development and operations in health and human resources.

Next slide, please.

You can see the branches here. I won't dwell on it other than to say that we do have centres of excellence for health data collection, combining that into dashboards and indicators in the Health Analytics and Insights Branch.

The Capacity and Health Workforce Planning Branch is the one that does the broad system-based planning and the health and human resource funding and program delivery.

And then our Health Data Science Branch focuses on methodologies, like forecasting predictions and simulations.

COMMISSIONER MARROCCO: Did the Health Data Science Branch do some forecasting in terms of the COVID-19?

MR. HILLMER: Absolutely. There are some slides where we'll get into that, and we can certainly dive into that in more detail.

COMMISSIONER MARROCCO: When did they start doing that?

MR. HILLMER: Kamil, I would ask you to respond to the timing.

We continue to do it, but when it started, Kamil?

MR. MALIKOV: April 20th.

COMMISSIONER MARROCCO: Thank you.

MR. HILLMER: Okay. Maybe we'll go right to the next slide.

So this is a schematic of some of the major sectors throughout the healthcare system. And what's highlighted beside each green box is the kind of information that we have access to as this division.

So, for example, in hospitals, we have a fairly rich picture of the patients served, the procedures offered, the administrative infrastructure and funding associated with all of that.

Of note, for long-term care, we have quite a rich resident-specific profile. In fact,

in some ways, long-term care is -- the residents of long-term care are perhaps the most finally grained and richly characterized of any sectors, population because of the assessments that are done.

So we know the cognitive status; the functional status; whether you're leaving food on the plate; your paying status. All of that we get after the fact about, you know, a quarter-and-a-half after the fact, but it does allow us to paint quite a rich picture of long-term care residents.

Other sectors we don't have as much, but what we are able to do is link it altogether and tell interesting stories, following patients and residents through time and space. And geography, because of this ability to link across the individual health card number.

So some of this is foundational information, some of which I'm sure you've seen before. But just to show you some of the ways in which we present it, and I think is relevant to your inquiry.

Obviously homes are operated by different types of providers. One fact that we found, and external academics have found, is this real distinction between the older designed homes

and the newer designed homes, and how those are not distributed across the different ownership types; that's the graph on the right.

The older homes really have about a 50-50 split on the for-profit designation, and are not represented as highly in the other two ownership categories.

That has relevance for some of our risk categorization going forward, so just to keep that in mind as we go forward.

We'll keep going, please.

So one example of what we're able to tell you about long-term care residents in Ontario is the types of health conditions that they have. And not surprisingly, dementia sits right at the top with quite a high proportion, two-thirds of residents have dementia. And then you can see the other kinds of conditions.

These aren't mutually exclusive. Residents would typically have a half dozen of these conditions or more. They're generally the frailest, oldest members of our province.

So we'll keep going.

I wanted to show this to you, so that you'd have a baseline understanding of the number

of people that die in long-term care homes every year in Ontario. And by and large, it's around 21, 22 thousand residents will die every single year.

And you can see the monthly variation, lowest in the summer and then it starts to move upwards in the fall as respiratory season starts.

This kind of data comes from the fact that we are able to link across different kinds of data sets. Because one piece of information that might come out in other discovery sessions that you're doing is, Ontario doesn't have a very quick or contemporaneous death registration system. So we don't necessarily know who has died in the population in a timely manner.

So for long-term care residents, what we end up doing is linking across our different data sets whether it's the registered persons database, which is essentially the list of everybody with a health card number in the province, with hospital data, long-term care data. And from that, we're able to paint a fairly accurate picture of who has died in the sector, in a much more timely way than the vital statistics process can offer.

We'll keep going.

So this was a schematic that was presented early on in the pandemic that painted a typical patient journey. This is based in the community, but it's really just to share for illustrative purposes.

So that we work closely with program and policy colleagues who create documents like this, to help guide their programming. But then what they let us do is, design a surveillance and performance management framework.

So that we might look at the virtual option category and say, "well, we need to have good data coming from the tele-health operator; from primary care claims; and from the website, telling us how many people did the self-assessment."

And we would comb through our data holdings and determine whether we had that. If we did, what was the appropriate way to construct the indicator? If we didn't, we'd try to source that data. And the same goes for long-term care.

So we'll get into some of the data that we have, and where some of its strengths and weaknesses lie. But just to kind of give you a general insight into how we try to construct our

oversight of programs from a data and an indicator perspective.

Next slide, please.

So some of the core data sources we used for tracking COVID-19, and this is inclusive of the general population as it is the long-term care population.

So the Integrated Public Health Information System, "iPHIS" as we affectionately call it, and now being replaced by the Case Contact Management System, "CCM", which is implemented in 31 of the 34 public health units is what we consider to be the authoritative public health information data source.

So by legislation, the Health Protection and Promotion Act, early on in the pandemic, COVID-19 was declared a reportable disease, such that any positive case had to be entered as an individual line entry by a public health unit into this data system.

So you'll find a record entry for every positive case; the person's name, their health card number. We don't see their name, we do see a health card number, so we can link it. You get demographics, source of acquisition of the -- best

known ascertainment of the source of acquisition. And importantly, you get the public health unit's understanding of whether it was associated with an outbreak or not.

So you could imagine yourself having contracted COVID-19 as part of a workplace. So your positive case would be entered into this data system, and then the field investigator would call you and start to determine how your case came to be. And they might find out that you worked in a call centre, and there were five of your colleagues who were also possible.

At that point, they would declare your case to be part of an outbreak, and they would apply a code within the data system to say that not only are you an individual positive case, but you're also associated with an outbreak. And this applies to long-term care homes as well.

So the field investigators go through this process. It's a little easier in the long-term care home because of the fact that you're a resident there. But it's important for you to know that you can both be an individual, and as part of a higher order outbreak.

The Daily Bed Census is a key data

source for us because -- Commissioner Kitts will know this well -- we don't have, generally, real-time hospital or clinical information systems at the regional level.

You know, as CEO of the Ottawa Hospital, he would have known on a daily basis what was happening, but the systems don't always talk well to each other. So when we want to know things like the number of people hospitalized with COVID, we actually had to send out a specific survey to the hospitals through this Daily Bed Census summary asking each hospital to tell us how many people were hospitalized with COVID-19.

COMMISSIONER MARROCCO: Are they obliged to respond?

MR. HILLMER: That's a good question, Commissioner.

We did not put a formal obligation into, you know, a contractual instrument, or a funding instrument.

But through what I would classify moral suasion, we get basically on any given day, 100 percent, give or take. And for those that don't, we follow up with, you know, a series of friendly, progressively not friendly letters.

COMMISSIONER MARROCCO: Was your experience that there was a good response, or -- I heard 100 percent, but there was a good response?

MR. HILLMER: When we launch information requests from -- particularly, the hospital sector, we find the compliance to be excellent.

And when it's not, it's usually because there's a very good reason. It might be a small northern hospital that is underresourced and maybe can't do a Saturday submission, because nobody in the department is working that day.

So I would say this is true of the hospital sector. In my general experience, the long-term care home sector is more variable, just because it's a more heterogenous sector than the hospital sector, and you have smaller homes right up to big corporate chains who have the back office capable of reporting daily.

COMMISSIONER MARROCCO: Thank you.

MR. HILLMER: ICU submissions were an important marker for us for the severity of COVID. So there is critical care information system that monitors all admissions, discharges and a range of other characteristics relating to the ICU system.

We were able to get a sense from that system daily.

The other absolutely critical information system is what's known as the Ontario Laboratory Information System. It is a record of almost every lab test offered in the province, and so not only is it a record that the test happened and what it was, but the value as well. And again, the health card number so it can be linked.

So what it offers over the public health information system, is that it gives you all -- it gives you all the people tested, and whether they were positive or negative. What it doesn't offer is -- it's not as good at telling you the location of that individual within a particular retirement home or long-term care home.

So we're always having to triangulate or mix the appropriate sources of data to tell us what we hope will be the best answer to a particular question.

COMMISSIONER MARROCCO: Does that include -- so that's all labs, public and private?

MR. HILLMER: By and large, yes.

There are a few exceptions to that. But, yes, I would say that the simple answer to that is, yes. And we can probably do a bit of a

follow up for you to kind of characterize what's not included. But what's important is all COVID tests are in there.

COMMISSIONER MARROCCO: Right, okay. Regardless of what lab you went to, whether it was public or private or...

MR. HILLMER: Yeah. So the public health labs are the public ones, and they get entered. And again, the Dynacare, or you know, another private provider would be in there as well.

Next slide, please.

So moving on to the more unique long-term care data sources. I've already covered the public health.

So the MLTC inspector's data set, we colloquially will call that the "daily tracker". This was a data set initiated earlier by colleagues in the Ministry of Long-Term Care where inspectors would call homes daily and ask about the number of people with staff residents with COVID-19, the number of deaths. There would be a range of other important information, at least from an analytical perspective, like details on human resources shortages.

You know, can you fill shifts within

the next 48 hours? How many regular staff are you using? What's your supply of personal protective equipment?

So all of those are potential mediators of spread within your facility, both entry into the facility and spread within the facility. So we continue to use that as a key source of data to understand who is infected within a facility.

I've mentioned the continuing care reporting system, that's the information system where the assessments are entered, and so we get really detailed clinical information.

Its weakness, of course, is that it's not timely. We don't get it until, you know, a couple of quarters after the fact.

The coroner's data is there. So we use this data to try and determine what, you know, this idea of how many excess deaths were there above and beyond what's normal and above and beyond COVID itself.

So you might have seen really nifty analyses published in the New York Times or Financial Post where they tried to do an excess death analysis. As I mentioned, we can't do that in Ontario for the general population until years

after the fact.

But Dr. Huyer implemented a system in the middle of April, where he asked each home -- each home is obligated by law to tell when a resident has died, but what he implemented in the system is, please tell us when somebody dies, whether that person had COVID; was likely to have died of COVID, but you just didn't get the test done in time; or not related to COVID.

So we have, from mid April to close to the end of June of everybody who died, characterized by those three criteria. Because, again, we know who has died from the public health data, but we don't know who died who didn't have COVID. So you don't have that full picture. So again, trying to triangulate the full picture here.

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COMMISSIONER COKE: Let me just ask a question.

Is somebody, I guess if they died strictly of COVID and it wasn't the COVID that led to some other issue. Do you know what I mean? It could be related death, but not directly.

MR. HILLMER: 100 percent, Commissioner Coke.

This is one of these things that's --

this is probably, you know, unless you were doing kind of a deep forensic exercise, there's going to be some miscategorization.

So by and large, if you were testing positive from COVID and you died, you were classified as having died because of COVID.

I mean, I think there are some scenarios where that wouldn't have been the case. I think it's that "probable" category that's less precise.

But I think the point you make is exactly right. And having done the excess death analysis, that later on Minister Fullerton had several of those same kinds of questions. And some of them are, at the end of the day, unanswerable.

What we do is rely on the -- you know, there's some clinician insight going into the categorization. But, you know, in long-term care with the number of deaths that happened, and the inherent uncertainty that comes with being precise about that, I would say there's probably some, on the margin, some cases that were categorized in the "probable", that might have been in the "not related" and vice versa.

COMMISSIONER COKE: Thank you.

MR. HILLMER: That's something that we'll have difficulty answering with a high degree of precision, because of the challenging clinical presentation of COVID. And again, it's an inherently imprecise exercise unless you get right down into a true forensic investigation.

COMMISSIONER MARROCCO: Commissioner Kitts.

COMMISSIONER KITTS: Michael, thank you for this.

I'm trying to figure out sort of the key metrics measurement before COVID and then how things might have changed post or during COVID.

Are you going to come to that, or is this appropriate to ask the question now?

MR. HILLMER: No, please go ahead, Commissioner.

COMMISSIONER KITTS: So we've heard about long-term care performance reports, I think maybe done by inspectors in the long-term care sector.

I'm just wondering, what were the key metrics that you captured, and from what data sources pre-COVID to determine whether a long-term care home was performing up to speed or not, pre-COVID?

MR. HILLMER: I think that's a great question.

So I think you've hit on a key distinction in that the inspector and, you know, in compliance with the legislation was something that -- so the results arising from the inspector process and the complaints process, those are all data systems and processes, you know, I'll use air quotes here, owned by the Ministry of Long-Term Care.

We access them from time to time to assist them with their analysis. So we would, in order to help the Ministry of Long-Term Care, we monitor a whole range of indicators related to institutional characteristics, which are inherently static. Like the number of homes, the number of beds, you know, some aspects of financial health and HR health. We monitor the wait list, the number of people on the wait list.

Once you're in the home, we use primarily the Continuing Care Reporting System to characterize a whole range of health and functional status indicators. So, number of chronic conditions; you know, proportion of residents requiring support with activities of daily living.

And then, you know, those are all ones we do as a matter of course. And we've got, you know, our long-term care dashboard that people can access to get some of these statistics.

And then a whole range of more ad hoc analysis. So, you know, a colleague might ask us about polypharmacy, and we would do that analysis, but maybe not repeat it. Or, can you please tell us, you know, the number of -- oh, sorry, I've overlooked an important one, and I'll ask my colleagues to fill in here.

But transfers to hospital is a big one for us, we monitor that routinely. Not only because it sits in the Ministry LHIN Accountability Agreement, but it's a good marker of quality that we want to have our eyes on. Falls is another big one.

And at this point, I'd ask my colleagues to jump in to help round that answer out, because I will not do it justice.

MS. BRIDGE: Some other things are just sometimes wait times would be, you know, to get into LTC, but not actually about patient condition, but wait times to go in is another thing that is, you know, monitored sometimes as well.

COMMISSIONER KITTS: I'm just sort of trying to understand if the key metrics that we were following in long-term care were robust, or detailed enough, or not too high level, to perhaps predict which homes might have more difficulty with a pandemic than others.

Do you think that the data was there, or it was captured that could show that, or was it just too high level?

MR. HILLMER: I think it's a good question, Commissioner. I will offer an informed, hopefully informed response to the question.

I think -- what we've observed so far, because I think there are two aspects to the answer.

One is, what's the probability of infection entering the home? And then once it enters, what's the probability it's going to spread?

And we found clear correlates of what determines whether it enters the home. And we get into that a little bit later, but just to kind of answer your question. We did have the data beforehand. The data that we found to -- let me back up.

The biggest determinative of whether COVID enters the home we found was the rates of community COVID. And I think that was something that might have been self-evident, but we were only able to verify it after the fact. And verify it with some level of precision. And you can even see it in the -- you know, in some of the mobility data that's presented later on in this presentation.

So I think in terms of constructing a probability of COVID entering the home before COVID struck, I think the data existed, I just don't think the knowledge to construct the analysis existed necessarily.

In terms of spread, I'll answer that two ways. We found the case fatality rate hovers around 30 percent, you know, so of those cases that have COVID, how many people die, you know, three out of ten.

This seems to be consistent with other jurisdictions as well. So it seems as if, as an individual in a home, once you have COVID there's not necessarily a whole lot -- a therapeutic approach can do to help you, it's about 30 percent.

The correlates have spread, though. We did have that data, and that's why I highlighted

the design standard. The design standard is essentially a proxy for crowdedness. And the older homes have more of these multi-occupant rooms, shared bathrooms, much harder to cohort individuals.

You know, the much newer designs have these, you know, pods that are -- have some physical separation from other pods, so cohorting becomes -- infection control as a discipline becomes much easier in a newer home.

COMMISSIONER KITTS: Yes.

MR. HILLMER: So we had those data. I mean, us as a division, we didn't analyze that data from an infection-spread perspective. So I hope I'm answering your question.

COMMISSIONER KITTS: No, it is a difficult question and I think you've covered it nicely.

It looks like the more detailed metrics appeared during the crisis where a much sharper focus on design standards, compliance with public health practices, PPE, IPAC and staffing, those are not necessarily followed routinely as metrics might predict which homes would do better in an outbreak or not. They're new since COVID; is that correct?

MR. HILLMER: I think that's fair to say, Commissioner. We would have never had any information on PPE for any sector.

We had some information on staffing, but it came in, generally, as part of quarterly or annual submissions. And it wasn't necessarily granular. Like we didn't necessarily know, there are this many PSWs providing these many hours of care.

We always understood the resident characteristics in quite granular detail. Again, as a division, we never had any line of sight into infection prevention practices.

So of those three, sorry, of the four if you include design standards, really only did we have some line of sight into the staffing that we would, you know, sometimes characterize as part of reports and dashboards.

COMMISSIONER KITTS: That's good, thank you, Michael.

MR. HILLMER: Yeah, my pleasure.

Okay. Let's keep going. I think I've covered this, in that this is just getting into some of the more details of how we used the coroner's data, and how it ended up being a really

valuable data source for us, and provided a great characterization.

You know, you'll have to forgive me. Sometimes, as somebody who gets excited about data analytics, I use words like "great" when we're talking about ways to capture death. And that's by no means other than to say, I like a good data system and it excites me. Please don't take any offense from that.

So we'll keep going, because now I think we move into part of the presentation where we start to get into some of the information products we've launched.

So early on in the pandemic, we launched an online interactive mapping and report tool. And you can see the different aspects of the sector and pandemic that we monitored. And, you know, a whole range of people were able to sign onto this and use it to check in daily; we updated it daily.

And on the right you'll see a map that shows the -- you know, the "L's" are long-term care homes; the "Rs" are retirement homes; and the green circles are representations of ICU and acute capacities. So that, you know, we always launch

these in collaboration with program planners and people who have other levers at their disposal.

So this was something that our colleagues wanted to be able to see, to understand, you know, where there are gaps, where there was a high concentration of homes, and not much acute care or ICU capacity. Just one kind of snapshot example from this dashboard, and we continue to update this dashboard until this day.

Next slide. This is another dashboard that we designed in collaboration with the Ontario health regions. And there is a specific dashboard for each of the five regions. And then within, there are these subdashboards that show different aspects of the health system, always related to some aspect of the pandemic response.

So the "surgical" tab was to help them understand what procedures were in arrears, and how progress was being made to make up the gap that had happened during the shutdown; what the PPE supply was.

This "COVID" tab is just a whole series of regional-specific information. The number of people in your region with COVID, again, updated daily with the number of active cases, number of

long-term care cases.

So the regional structure had a daily situational awareness arising from these dashboards.

Next slide.

So early on in the pandemic we were -- you'll see this in the early versions of the command tables scorecard. If you haven't seen, you'll be getting as part of your document submission process.

We constructed this one-page snapshot of what was happening in the home sector in terms of cases and deaths and the rate of change. We didn't continue to do this because it ended up being incorporated into different other aspects of the Command Table Scorecard, but we wanted to just show you what some of the command table members were seeing specifically here.

Next slide, please.

So this gets to your question earlier, Commissioner Kitts, around predicting and forecasting -- actually, Commissioner Marrocco you made this point as well, of what's happening in the home sector.

So within the general population, it's

relatively easy to make a prediction about what's going to happen with an epidemic. And, you know, these kinds of techniques are used by disease epidemiologists all the time, and people like Dr. David Fisman or, you know, others like that will apply a curve that just makes certain assumptions about the number of people infected; the number of people who recovered; the number of people who die. And they follow a kind of predictable ascent and descent process.

What we did here was that we used that same idea, but essentially treated each home as a person, and tried to predict when that home would move into outbreak status. And that map, that little tiny map there is what lies behind each of those dots as the very nifty forecasting methodology that predicts the individual risk of the home entering outbreak.

And then from that, we're able to say, "okay, these are the numbers of homes that are going to move into outbreak and when". And then once they've done that, we kind of make a separate prediction of the spread within the home itself.

And once that process runs through -- if you can go to the next slide, please -- we're

able to say, you know, "here is the upper and the lower boundary of the number of homes that will move into outbreak".

So we ended up, as Kamil said, starting close to the end of April, presenting this weekly as part of the Command Table Scorecard.

The red line is the number of homes that went into outbreak. And then we realized we were sort of undercounting, because homes can re-enter outbreak. And so that's why you see the higher yellow line to reflect the fact that homes went into outbreak multiple times potentially.

Yes, thank you, next slide.

There's a follow up to that, showing the number of cases and deaths. And we did this to both, you know, showcase just what could be expected. And I think at the early parts in early April, you know, the high and the low bounds were giving kind of the limits of possibility to the decision makers at the command table, but also as the pandemic progressed, it offered opportunities for reflection on our further directives required.

You know, should we introduce more restrictive measures around mobility? Should we, you know, further shut down homes? I'm speaking

hypothetically here but, you know, this was the -- this was the general purpose for which these forecasts were created and hopefully were used.

Okay, yeah, next slide.

So there was a big question around how did COVID get into the homes? And somebody was introducing COVID into the homes. And, of course, I think that seems self-evident.

But what this analysis shows is that there's a high degree of predictability and correlation between when COVID rates go up in the community, and then what happens subsequently within the home sector.

And so if we want to focus in on the top left in the Ontario quadrant. The orange line is rates of community COVID, non-long-term care COVID in the communities in Ontario. And then what's happening in the long-term care home sector.

And you can see the rate of ascent and the patterns closely mimic each other. Even so much so that that subsequent community spike was associated with a long-term care spike as well. And this is borne out in each region as well.

And so on the right, you can see, you know, it's about 20 days, depending on the region

from when the rates of community COVID go up to when you can expect a spike to happen in the long-term care home sector. And this is through the first wave of the pandemic.

We are now monitoring closely to see if all of the hard work that has been done through public health assessments, and supply of PPE, and training on best practices of infection control, we'll see this pattern borne out again. And we're actually seeing it in real-time now, because we do have a few hot spots that we're watching closely in Ottawa, Peel and Toronto.

And so, you know, just for example, Ottawa is sitting right now between 20 and 25 cases per 100,000. And we're using a rule of thumb that we'll talk about a little more when we get to the risk matrix of alerting homes when they're in a community that is 10 cases per 100,000 or above, based on this analysis.

So we're really trying to take the lessons learned from this analysis and build it into empirical thresholds that are linked to specific actions. It's not just about monitoring the data, it's about knowing that the data then leads to something specific happening.

So I'll maybe keep moving on to the next slide. This is a slide that gives you a lot of information. And it was a specific analysis that Deputy Steele asked for, because he would always get the number of homes in outbreak. And I think what was hidden from him was, what was underlying that? How many homes are entering and exiting outbreak status? And, what's the extent of the outbreaks? Are individual homes getting worse, or better? And so we continue to do this.

And what it shows is, you know, these are all the number of homes that are in outbreak status right now. And the intensity of the colour represents how many people were infected in the home, staff and residents. And the homes that are written down in red, are in a repeat outbreak. Then the ones shaded in blue, are these older standards. And then you can quickly see, you know, which have kind of come and gone; or which are new; which are getting worse.

So he really liked this presentation of data. And so it now ends up in the scorecard every week as well.

And then just knowing that Commissioner Kitts is from Ottawa, we do unfortunately have one

Ottawa home that has upwards of 20 people infected in it right now. So that's kind of what I meant by we're trying to, you know, link what we've learned to be as real-time in our surveillance framework as we can be.

Next slide, please.

So this was an analysis we did -- there was a lot of interest from -- you probably have heard of the Central Coordination Table by now, the "CCT". You know, kind of the uber command table, where the secretary cabinet and other senior execs sit.

The Deputy was interested in this, and this whole idea of, you know, above and beyond people dying with COVID, was there excess death happening in the long-term care home sector. We were able to do this analysis by combining all these different data sources, and particularly relying on the coroner's data.

So you'll remember I started the presentation with that kind of historical mortality pattern. So we know in any given week what the five-year average of people dying in any given time period.

So you can see, you know, this

represents kind of mid-April until the end of June, which is exactly corresponding to the coroner's data collection.

And so right at the beginning, in mid-April, you know, that's roughly, you know, 300 deaths a week. And then we're able to categorize, okay, well, the next category of people dying are the ones with confirmed and probable COVID deaths. In that case, it's the red.

And then kind of the non-COVID deaths that are potentially above and beyond what would normally be expected, is kind of that -- I don't know what you'd call it, but like an orange dotted colour. And you can see it in, at least in Ontario's case during this period, seems to be small, and gets smaller as time goes on.

So, you know, we tentatively concluded that for better or for worse, the number of people dying in homes above and beyond normal, were largely related to COVID. And by the end of June, had largely returned to the historical patterns that we've observed over the last five years.

COMMISSIONER MARROCCO: Why was the coroner's timeframe selected or followed?

MR. HILLMER: Yeah, it's -- selected

for analysis or why did he put it in place for those time periods?

COMMISSIONER MARROCCO: Why did you choose the same time period?

MR. HILLMER: That's a good question, Commissioner Marrocco.

We can only do this analysis with the data arising out of the coroner's data set. Because we don't know from any other data set the people dying unrelated to COVID.

So his data was the only data that told us the total number of people dying in homes on any given day during that period. Otherwise, we would have just been able to show you the red part of that graph, not the yellow or the orange, because of the way the data categorization worked.

So every day, every home submitted to the coroner, the total number of people who died, and then categorized by not related, probably related, and definitely related to COVID.

So it's one source of data, should another spike in cases happened, that I would advocate for it to be started up again. And the reason -- I mean, Dr. Huyer can speak for himself, but I think by the end of June, the number of COVID

deaths were very small. So collecting data is always a process, you know, done by overseers. And at that point, again, I don't want to put words in his mouth, but I think that balance had tipped, because the number of COVID deaths was very small.

COMMISSIONER MARROCCO: Was there any reason why the data couldn't be reported directly to you?

MR. HILLMER: No, there is no reason. He does, within the Coroner's Act, have a -- there is a legislative obligation for homes to report deaths within some time period of them happening to the coroner. So he leveraged that legislative obligation to bring the additional characterization. You know, we can either work with him or just ask directly.

But the simple answer is, there is no reason, other than we would just need to figure out the best way to make it happen.

COMMISSIONER MARROCCO: Could you compel the production of the information?

MR. HILLMER: I don't know the technical answer to that. So I would have to get back to you after conferring.

I mean, there are different ways to

compel. You can make it an obligation of funding, that's often how we compel. And then other pieces of legislation can compel directly. But maybe I'd get back to you specifically on that.

COMMISSIONER MARROCCO: That's fine, yeah.

MR. HILLMER: Okay, thank you.

Commissioner Kitts, it looked like you had a question.

COMMISSIONER KITTS: I was just going to ask whether going back to the epi curve, which starts, I think, on the 4th of April, where there are very few deaths, who would help fill in the first week of April if that was important?

MR. HILLMER: Sorry, I didn't quite catch the question, I apologize.

COMMISSIONER KITTS: So the question here is why did we start on the 14th of April?

And I think if you go back to the epi curve that you showed, it was just starting to rise in the early, first week of April. So I doubt that the number of deaths would have been very large.

MR. HILLMER: Yeah, I mean, I think we show it on the right here, where you can kind of see the, you know, the component omitted.

And I think it was just the timing required to get the system up and running on the coroner's piece. I mean, he'll be able to answer probably more precisely as to the reasons, but I -- my educated response/speculation would be, it just takes time to get the data systems up and running and that was as quick as they could do it.

COMMISSIONER KITTS: Okay. Thanks, Michael.

MR. HILLMER: Okay. Now we're going to give you an overview of how we're trying -- yes, next slide, please -- how we're trying to help our long-term care colleagues understand risk. And this is the product of what we learned through the first phase of the pandemic. And I'm going to hand it over to my colleague Jen Bridge to walk you through how this system works and how we try to use it.

MS. BRIDGE: Thank you, Michael.

So this is something that we had proposed in late -- proposed in mid to late July in working with our colleagues in the Ministry of Long-Term Care and understanding their needs.

And it was in response to the Deputy really wanting to have an understanding of, you

know, what can we do that might help us before we get to a point where there's problems. Help put some homes on the radar that could be at risk, so that we know who they are, and start to think about what do we want to do about this.

And so we came up with a framework that we could filter the homes through to try and look at increasing risk. And most of these things are, you know, dealing with things that we knew from the evidence was telling us are important to look at.

Like Michael had already spoken about that rate of 10 per 100,000 cases; we know that crowdedness is an issue; older homes that are part of a chain can put you at higher risk.

So what we did is we thought, okay, the very first thing we know is being in a community with greater than 10 per 100,000 active cases, you want to be alerted to that. So the first step was, okay, let's start with these homes. You are already in a bucket.

The next thing is, okay, whether or not you're in that bucket, there's also these other risk factors that we know about that could put you -- that we want to maybe alert you to, because these homes, there's something about them, the way

they're structured, that could be, you know, putting them at higher risk on top of that.

And, you know, we've looked at also a couple of other things we included in there, just because of historical reasons was, if they're in outbreak, or repeat outbreak, or if they've been -- you know, what they called red status, which was a designation that came out of the IMS table that was the response to the outbreak in Phase 1.

So if the home was red, they had, you know, low PPE, there were staffing issues, and it was a home that they really needed to get into and do something about. So that historical data is there as well.

So taking that, we say, okay, if you're already in an active community, if you're a part of a chain, so if you have more than 50 percent of C/D beds, that's usually an indication that you're an older home. If you have more than one repeat outbreak since March 29th. If you were ever designated a red status by the IMS response for more than five days.

And there's also a crowdedness index, which is an index that comes out of McMaster University that takes a look at the number of beds

in the home and takes a few other factors into consideration and then gives it a rating of low to high crowdedness.

So if that index for the home, if that particular home has a rating of greater or equal to three, then that's also a flag.

And then we created four categories. So the next slide we'll show you how we grouped these homes based on this. But before I get into how we grouped them, is there any questions?

(No response).

Okay, thank you. Going to the next slide.

So taking all of that into consideration, and we spoke with our colleagues at MLTC and, you know, did some work trying to figure out, okay, how do we want to bucket these? You know, for slightly increasing risk. So we came up with three groups that when you're in a high risk community, and then one group if you're not in a high risk community.

So the grey area on your left with the three groups, if you were all in that area of greater than 10 per 100,000, and you didn't have any of those other risk criteria, those four risk

criteria that we've outlined on the previous slide, you would be called "Group 1". And then we would have a list of homes that were in this Group 1.

And then Group 2, this would be if you were in a high risk community that has 10 or more per 100,000, and you had any one of those other two criteria. So you were crowded, or you were older in a chain, or any combination of those other criteria, then you were in Group 2. So you're in a high risk community, and you have a couple of other things that you may want to pay more attention to.

And then Group 3, same sort of thing, but now you have three or more of those four criteria. So there's extra things on there that you may want to pay attention to.

But we know that some of the structural, or other risk things that were on there, you just don't have to be in a high risk community to have some risk factors. So we also create this fourth group which is, okay, if everything is looking good in your community, but you have three or more of these other sort of structural criteria, or historic criteria, we're going to give you a flag as well, and that's Group 4.

So what we've been doing is running on a weekly basis the homes according to these lists for Ministry of Health and Long-Term Care, and so that they can see where these homes are on these risk factors.

I don't think that -- Commissioner Marrocco, I think you're on mute.

COMMISSIONER MARROCCO: Does it follow that this would describe the necessarily the risk that the home is in?

Like take Group 4, for example. They've got other criteria, they just don't have very many people in their community that are sick, thank goodness. So I mean, is that a comment about the home or a comment about the community?

MS. BRIDGE: No, excellent point. And so this about kind of that early detection, so it's trying to, you know, trying to help the Ministry of Long-Term Care say, okay, there's some things about these places that you want to, you know, whatever you want to do, you may want to try -- what can you do to sure up before things happen. And if you had to prioritize, here is a way that you can maybe do your priorities, or decide on certain actions.

So with the Group 4, the reason we did

this is just to let them know that, okay, maybe if they don't show up on the radar because something is happening in their community, just know that these are the homes right now. That there may not be something happening in your community, but let's say if you wanted to say we have to -- for home communities, where maybe there aren't any urgencies, but, you know, if you had to prioritize some homes, that maybe you wanted to just, you know, hey, how is your IPAC? How are all these things?

Like these are just homes that might be at a higher risk if something were to start coming into the community. So it's just a way to try and segment it for them, so they can maybe think of some actions they want to take.

COMMISSIONER MARROCCO: That anticipates, I guess, my question.

Having identified them, what do you do with that?

MR. HILLMER: Yeah, maybe -- I'll take this one, Jennifer.

MS. BRIDGE: Okay. Thanks, Michael.

MR. HILLMER: I think in the time you spent with the Deputy Minister, he was alluding to

some of the recovery and stabilization work.

One very specific aspect of that is an operational playbook that's being developed. And I think you will probably either get some testimony on that, or the document itself. And what it does is, it lays out very specific actions in response to certain signals.

So, for example, if you're a home in a community with that rate of COVID, you would get an alert that said, you know, "ensure your active screening protocols are working. That your staff have had recent training on donning and doffing of PPE", etcetera, etcetera. "If you're a home that has declared a critical staffing shortage, here are the very specific actions and which organizations will take them on".

And so I think that is a direct response to what happened through Wave 1, where a lot of those things happened, but now it's a chance to mechanize them into a, you know, a series of "If Then" statements.

So, you know, hopefully, some of my MLTC colleagues who are authors of this playbook can tell you more about the specific actions, but our role is to try to help them connect these data

signals to those specific actions.

COMMISSIONER MARROCCO: Are the specific actions mandated or voluntarily?

MR. HILLMER: It's a good question, Commissioner. And I think I probably would leave the answers to my colleagues. Because I am uncertain of the answer right at this point.

COMMISSIONER MARROCCO: Does anybody know the answer?

(No response).

Okay. Maybe you can get back to us. Because I'm trying to, you know, I'm just, I guess, imaging a situation where somebody is essentially noncompliant, has created kind of a risky situation, the risk materializes in Wave 1. If Wave 2 is -- you know, as you were saying, well, you would want to make sure of this, make sure of that. You don't know that they're going to be anymore faithful to that than they were previously; that's the thrust of where I'm coming from.

MR. HILLMER: No, it makes total sense Commissioner. I'd offer two reflections on that, just to give you general categories of methods to enforce compliance.

One is the -- I don't know if you've gone into the Section 22 capability that sits under the Health Protection and Promotion Act. Essentially a local Medical Officer of Health can compel, you know, a series of actions from independent operators of various sorts.

So, you know, a Medical Officer of Health could -- you know, let's say compliance with IPAC best practices is a part of the playbook, and it's been -- again, I'm speaking hypothetically here. But the power itself is real. You know, the local Medical Officer of Health is the one charged with assessing the IPAC readiness and could, if the home is not deemed to be compliant, order a Section 22 that has, you know, aspects of compelling it. And by no means am I a lawyer, so I won't go into more detail. But that is a power that exists under the Health Protection and Promotion Act.

And through Wave 1, you might have gone through this. And if you haven't, you will no doubt. Is that the different management orders that were put in place on certain kinds of long-term care homes, you know, they were the voluntary management orders, they were homes

partnered with hospitals and hospital administrative infrastructure came in to support and staff. And then there were the mandatory management orders which was, you know, a forced partnership. "Partnership" isn't the right word. You know, a forced management oversight model where local hospitals would come in and essentially take over administration of the home.

So those are forms of compelling that did and do exist. And we'll get back to you, and I -- my respectful suggestion would be to probably ask the, you know, for a copy of the playbook and perhaps a narrated overview of it. We'll certainly get back to you, but that might be the best way for you to get insight into that.

COMMISSIONER MARROCCO: And the decision to enforce the recommendations in the playbook, that falls to -- would fall in the conversation we were just having to the local Medical Officer of Health.

MR. HILLMER: If it was under the Health Protection and Promotion Act, you know, they maintain that compelling power.

I would say in general, you know, the decisions around -- I would have to be -- at this

point, I would be speculating and would not want to do that and give you any kind of incorrect information.

COMMISSIONER MARROCCO: All right.

MR. HILLMER: Maybe we'll keep going. I think now I'll take over again and just offer you a quick oversight of some of the more health human resource support programming that we had in place.

So my division oversees health human resource strategy and planning. And before COVID came about, we did have a plan to bolster the supply of PSWs. You're going to hear this loud and clear through your discovery process, that supply of PSWs is an ongoing issue before COVID and certainly during.

So many institutions through the pandemic expressed urgent HR needs, long-term care homes included. So we saw the creation of what we call the "Ontario Matching Portal", to assist institutions needing qualified HR personnel with those people who want to take on a shift. You can think of it as an uber for bringing supply and demand together.

We also did collect some additional health workforce information from hospitals and

long-term care homes, we continue to do so. And maybe I'll just tell you a little bit about the portal itself and what it does. So we will go to the next slide.

So as I said, it's based on a sales force platform, Deloitte Consulting created it for us. And it's got registration intake forms, where you as a provider can say, you know, "I'm a PSW and I'd like to work on these days in this geography". And then homes would register their need for shifts. And then in collaboration with Health Force Ontario, which is one of the arms of the Ontario Health Agency, they would support the matching of requests on the part of the worker and the organization.

And so just to give you some sense of what has happened to date. So there have been 25,000 people who registered, about half of them are regulated health professionals. As of just a couple of days ago, a thousand organizations had signed up. 40 percent are long-term care homes. Of the 1,500 requests for staff, half were made by homes, and close to 80 percent of the requests had approved matches.

And so we're looking to leverage the

existence of this portal moving into Wave 2. We've got some planned enhancements of it, so that it's easy to use. And we build awareness of it, because we think that ease of use and awareness are key drivers of uptake.

And we've got other ministries using it. You know, throughout the summer we were working with education to try and deploy custodians into homes. For example, retirement homes is another sector. And we really want to, you know, have this be the tool that organizations use to help them fill unfilled shifts.

And I think this is our last slide. Yes, it is. So I'd stop there, and I'm happy to entertain any questions or discussions you've got.

Yes, Commissioner Coke, please go ahead.

COMMISSIONER COKE: I'm just wondering if any of the data that you have, the health human resource data, does any of that help determine what is the right sort of mix of stuff that should be in these homes?

MR. HILLMER: I think what we have would be an input into that answer, but not in itself. I know that the long-term care staffing

study was just complete, and they made some recommendations to that regard.

And there's a fairly rich literature out there around the kind of mixtures of regulated, unregulated and types of and amounts of care.

What we've never done ourselves is connect it up. What we know about staffing, and then the kinds of outcomes seen, although I might ask my colleagues if they've been involved in any of that kind of analysis, that might get at what you're asking about.

MR. MALIKOV: I haven't done an analysis of that kind.

MR. HILLMER: Not to say that it couldn't be done, but it would be a separate kind of analytical project to figure it out.

COMMISSIONER COKE: Okay.

COMMISSIONER MARROCCO: Yes, go ahead Jack.

COMMISSIONER KITTS: Michael, that was a great presentation and very clear.

It seems that right now, there is a lot of very rich data that is both accurate and timely and reflective of what's happening. Am I correct in that?

MR. HILLMER: I would say "yes" to that with a few caveats that are, you know, as somebody who loves this kind of data, you never have enough, but you know you can't ask for everything or the people who run the organizations would do nothing else.

But I think -- and I might just say, some areas where I think a little bit extra information would be really helpful would be, we don't really have a good understanding on a near real-time basis of the number of residents being transferred back and forth between hospital.

And we also don't have a very good real-time understanding of occupancy of long-term care homes. You'll know this from your CEO days, we asked you every day what your occupancy was; and you told us.

COMMISSIONER KITTS: Yeah.

MR. HILLMER: That same level of insight doesn't exist in the long-term care home sector. Because by and large every home was 100 percent almost every day. But we know that's not going to be the case going forward, and occupancy is a big determinant of spread.

So I think some more routine

information on occupancy would be valuable. But, yes, I agree with your question as --

COMMISSIONER KITTS: And so for the data to be valuable and make a difference, it requires a level of leadership and accountability. And this may not be a fair question for you, but do you see the data being used at the right level by the leaders on the frontlines and being held accountable for improving the data?

MR. HILLMER: I can offer reflections from what I've observed.

I know that Deputy Steele absolutely is a, an adherent to using data to drive improvement.

Mat Anderson, who played a key role through Wave 1 and will continue to play in that role. You know him as well as I do, is certainly the same. I mean, his question is always, "so what? What's next? You've told me an interesting pattern here, what should I do with it?"

There are certainly many operators who are just, you know, caring passionate people who want nothing but the best. I've had a chance to become, you know, exposed to the Schlegel Organization throughout this. And this certainly would apply to them.

That being said, the homes exist on a continuum. And there's always opportunity for improvement, and so I would say that the answer to that is going to be variable. You know, if Jamie Schlegel sits on kind of one end of the continuum, there are no doubt people on the other end.

What I can't tell you is how tight that distribution is, what's the difference between best and worst. If I can use kind of crude terms like that, and that every -- and that distribution can always shift to the right towards the better, even if you're at the top of it.

COMMISSIONER KITTS: Okay, thank you.

COMMISSIONER MARROCCO: This is, I guess, related in a way.

Is the data that you've been showing to us, is that generally available to academics, to the public, to people interested in policy? How available is it?

MR. HILLMER: That's a really good question.

Our general practice around providing data is request based. So academics will ask us for information, and we'll provide it to them, based on how they specify they want it.

Canada, in general, it's not that easy to get a hold of data. You have to request it from the Canadian Institute for Health Information, "CIHI", you know, from us as a provincial government, Provincial Minister of Health.

One really neat development through the pandemic was the creation of the modelling and consensus table. It was started up by Professor Adalsteinn Brown, in the effort to provide government with really strong consensus at the estimates of spread and impact of COVID.

The table probably has a dozen academic members, and we provide them with a lot of the same information that we presented to you daily, and they've been able to do some pretty amazing things with it.

You know, that's a small group. And it is a big community out there, so I would say the answer to that question is "yes", but in a limited way. And if you're a member of the public, it's not that easy to find really good information beyond what we put on our website, which admittedly, could be a lot better visualized compared to what you see on a slick, you know, New York Times website.

So if you're an academic, you're well served. But you could be better served in the way that I described this modelling table, member of the public, that remains challenging.

COMMISSIONER MARROCCO: Is there any reason why the information would be somewhat closely held?

COMMISSIONER COKE: Can I add to that before you answer?

In terms of Open Data Directive, we have some policies and corporate policies that are in place that have a much higher requirement than the past to put this stuff out more openly.

So I'm just trying to understand what's your adherence to that direction that, you know, is quite a push at least when I was there.

MR. HILLMER: Commissioner Coke, thank you for bringing up the Open Data Directive.

For several years now, the entire Ontario Government has been under the guidance of the Open Data Directive, which states that data needs to show up in a easy-to-use format in a centralized place.

So, for example, the public health information actually is in the open data

repository. So as a lay person, you could go in and examine the number of cases, and where they are. And, of course, the limits on what shows up in the open data set is, is it of commercial sensitivity or somehow revealing an individual's identity.

So a lot of what we present is based on individual records, you know, which we can never release in that format. You know, the individual cases in the public health open data set are shown in age groupings, you know, 10 to 20 and at a fairly high geographic level. You know, so that you'd never be able to reverse engineer who that person was.

So in terms of holding things close to the chest, the first hurdle is, is there any way you're going to identify somebody? And if you're not, then we feel better about releasing it.

And then whether we release things or not, there's a whole, you know, political process that happens. You know, where a communications lens is put on it, and ultimately we advise and, you know, Minister's Office decide.

It's that process that kind of mediates what gets released and what doesn't. And we try to

provide the parameters of, you know, as Commissioner Coke has said, this falls under the Open Data Directive, it doesn't violate privacy, and provide our best advice as to whether it should be released on those parameters. And then they use their own calculus to decide whether it ultimately gets released or not.

COMMISSIONER MARROCCO: Thank you. Any further questions?

Well, Mr. Hillmer, is there anything further?

MR. HILLMER: No, I wanted to thank you for your interest and your attention. And I know that you're likely to have lots of follow-up questions, and as you get into your analysis there may very well be questions you have that we can help answer.

I wanted to make the offer to you that we're here to help, and I don't want you to hesitate in reaching out. Because the capability represented by my group is quite sophisticated, and we want to be able to aid you in reaching your end goal.

COMMISSIONER MARROCCO: I appreciate that. I'm sure we all do, we all appreciate the

offer. And we'll take you up on it, you can count on that.

This is our first run through to try to get some understanding of the environment that we're dealing in. And we all anticipate that we'll be back asking further questions. And so your offer is to the point and very much appreciated.

And I thank you for the presentation. As with all the presentations we've had, but yours included, has been very helpful to us and we appreciate it.

MR. HILLMER: It was our pleasure.

MR. MATHAI: Commissioner Marrocco, this is Sunil Mathai here.

I wanted to highlight for the Commissioners, I tried to jump in when you asked the open question to anybody that was on the call. As with things in the pandemic, my internet was giving me a problem so I wasn't able to jump in at the time.

I wanted to give you a highlight right now. The playbook that Michael has described, is the LTC Stabilization Action Plan, that you already heard bits about at a very high level during Deputy Steele's presentation.

We are trying to arrange with the secretariat now for a follow-up examinational briefing with Alison Blair and Olha Dobush, who is the Executive Lead, for Stabilization in the Long-Term Care Home Sector, and they'll provide more information on the stabilization plan, including the additional compliance monitoring that is part of that plan.

So you will hear that information. I wanted to let you know that on the HPPA side that Michael briefly addressed with you, we are also planning a foundational briefing with one of the counsel at MOH, who will give you kind of a 1-0-1 on the HPPA and the powers that are contained within it.

COMMISSIONER MARROCCO: Thank you for that information, it's appreciated.

MR. MATHAI: No problem, thank you.

COMMISSIONER MARROCCO: So good bye everybody and we'll regroup in a few minutes.

-- Examination adjourned at 4:35 p.m.

REPORTER'S CERTIFICATE

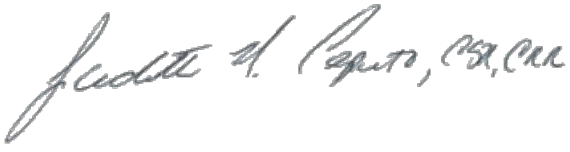
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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 16th day of September, 2020.



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