Long Term Care Covid-19 Commission Mtg.

Michael Hillmer (Assistant Deputy Minister,
Capacity Planning and Analytics
on Tuesday, December 8, 2020

Long Term Care Covid-19 Commission Mtg.
Michael Hillmer (Assistant Deputy Minister, Capacity Planning and Analytics on 12/8/2020

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

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14   --- Held via Zoom, with all participants attending

15   remotely, on the 8th day of December, 2020,

16   2:00 p.m. to 3:23 p.m.

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 1   BEFORE:

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 3   The Honourable Frank N. Marrocco, Lead

 4   Commissioner;

 5   Angela Coke, Commissioner;

 6   Dr. Jack Kitts, Commissioner.

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 8   PRESENTERS:

 9   Michael Hillmer, Assistant Deputy Minister,

10   Capacity Planning and Analytics, Ministry of

11   Health;

12   Jennifer Bridge, Director, Health Analytics and

13   Insights;

14   Kamil Malikov, Director, Health Data Science;

15   Aileen Chan, Director, Health Data.

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17   PARTICIPANTS:

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19   Alison Drummond, Assistant Deputy Minister,

20   Long-Term Care Commission Secretariat;

21   Derek Lett, Policy Director, Long-Term Care

22   Commission Secretariat;

23   Lynn Mahoney, Counsel to the Ministry of Health and

24   Long-Term Care;

25   Roopa Mann, Counsel, Crown Law Office, Civil;
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1   Amy Leamen, Counsel to the Ministry of Health and

2   Long-Term Care;

3   Judith Parker, Counsel, Crown Law Office, Civil;

4   Rose Bianchini, Angela Walwyn, Senior Policy

5   Analyst, Long-term Care Commission Secretariat;

6   Stephanie Figliomeni, Counsel, Ministry of the

7   Attorney General;

8   Angela Walwyn, Senior Policy Analyst, Long-term

9   Care Commission Secretariat.

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1   I N D E X

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3   **The following list of undertakings, advisements

4   and refusals is meant as a guide only for the

5   assistance of counsel and no other purpose**

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7   INDEX OF UNDERTAKINGS

8   The questions/requests undertaken are noted by U/T

9   and appear on the following pages/lines: 24:25,

10   25:14.

11

12   INDEX OF ADVISEMENTS

13   The questions/requests taken under advisement are

14   noted by U/A and appear on the following

15   pages/lines: None.

16

17   INDEX OF REFUSALS

18   The questions/requests refused are noted by R/F and

19   appear on the following pages/lines: None.

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 1   -- Upon commencing at 2:00 p.m.

 2                 COMMISSIONER FRANK MARROCCO (CHAIR):

 3   Hi, Mr. Hillmer.

 4                 MICHAEL HILLMER:  Good afternoon,

 5   Commissioner Marrocco.  How are you today?

 6                 COMMISSIONER FRANK MARROCCO (CHAIR):

 7   Fine, thanks.  And you?

 8                 MICHAEL HILLMER:  I'm well, thank you.

 9                 COMMISSIONER FRANK MARROCCO (CHAIR):

10   Thanks for coming back.

11                 MICHAEL HILLMER:  Yeah, my pleasure.

12   I'm excited to be here.  Commissioner Kitts,

13   Commissioner Coke, nice to see you again.

14                 COMMISSIONER ANGELA COKE:  Nice to see

15   you.

16                 COMMISSIONER JACK KITTS:  Good to see

17   you, Michael.

18                 MICHAEL HILLMER:  Okay.

19                 COMMISSIONER FRANK MARROCCO (CHAIR):

20   You're waiting for anyone, or no?

21                 MICHAEL HILLMER:  I see my colleague

22   Jenn Bridge, Kamil Malikov.  Perhaps one other, but

23   I think we could get going while we wait for my

24   third colleague to join.

25                 COMMISSIONER FRANK MARROCCO (CHAIR):
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1   Up to you. If you want to wait, we'll wait.

2   MICHAEL HILLMER: Oh, I see she's just

3   joined now, so I think we're all here.

4   COMMISSIONER FRANK MARROCCO (CHAIR):

5   All right. Well, you know, you know the drill. I

6   won't repeat it. We're ready when you are.

7   MICHAEL HILLMER: Okay. Well, maybe

8   we'll get right into it, and then I gather you've

9   hit your stride in terms of questioning.

10   So the same as last time, interrupt any

11 time you like, and we can follow any radicals that

12 emerge, and we'll both pursue them until we get to

13 the bottom.

14   COMMISSIONER FRANK MARROCCO (CHAIR):

15 Okay.

16   MICHAEL HILLMER: So we understood our

17 task to be these two questions, looking at key

18 performance indicators covering a range of

19 different topics, and then we've taken two tracks

20 on that. One, giving you a bit of an overview of

21 what we did in what I'll call pre-COVID times and

22 then what we're doing in COVID time.

23   And then Number 2, really, we took

24 about what -- how we're using different data sets

25 to help various decision-makers understand the

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1   extent of resident well-being, outbreaks, spread of

2   outbreaks, and where there might be limitations in

3   current data sources.

4   So I think you've met some of my

5   colleagues before, but I'll just reintroduce them

6   to you at this point because I'll be passing off to

7   them at certain points when I reach the edges of my

8   knowledge and understanding. So I'll introduce

9   Jenn Bridge who is the director of health and

10 analytics and insights branch.

11   COMMISSIONER FRANK MARROCCO (CHAIR):

12 How do you do?

13   MICHAEL HILLMER: Okay. Kamil Malikov

14 who is the director of the health data science

15 branch, and Aileen Chan who is the director of the

16 health data branch. So I'm really collectively

17 representing the data analytic portfolio of the

18 division.

19   So I'm going to maybe move on to the

20 next slide, please.

21   So I think you had an overview of the

22 division last time particularly in context of

23 COVID. So this presentation plus my speaking

24 remarks goes a little more into the pre-COVID

25 times.

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1   And so as you can see, we routinely

2   report a range of key performance indicators to

3   support program and policy development,

4   Accountability Agreements, internal dashboards, and

5   ad hoc requests, you know for --

6   One very specific example: The last

7   long-term care commission that I was involved

8   with/supporting was headed by Justice Gillese, and

9   I was looking into the murders committed by

10   Elizabeth Wettlaufer.

11   And we took on a specific piece of work

12   to support both the Ministry of Long-Term Care --

13   at that point, it was one Ministry -- now Ministry

14   of Long-Term Care and the Chief Coroner's Office to

15   monitor homes for potentially unexpected resident

16   deaths. And we're in the midst of putting that

17   into operational action in collaboration with the

18   Chief Coroner's Office.

19   And so I thought I might just start

20   with a couple remarks about what we do in pre-COVID

21   times. And so we support a number of portfolios.

22   We manage the Ministry's various websites. We

23   oversee the data holdings, the provisioning of

24   data, calculating and reporting on various

25   long-term care indicators.

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1   And so I think you've got an overview

2   of the "longtermcarehomes.net" website that's used

3   to communicate with the homes. We oversee that and

4   are responsible for the posting.

5   We maintain various client profile

6   databases to document how many people are on the

7   wait list, what the waiting time is on that wait

8   list, what the occupancy is of homes, staffing

9   levels -- I know that's a particular interest of

10 yours -- and then, as I mentioned, many key

11 performance indicators.

12   So maybe I'll talk a little bit about

13 some of the data we maintain to support the

14 Ministry of Long-Term Care. So one key dataset --

15 it's called the "client profile database." And

16 what it does is it's a dataset that includes bed

17 classification and bed type, and it has,

18 essentially, demand and placement information at

19 the client level. So it's used by Ontario Health

20 and the placement coordinators to help understand

21 which homes have open beds.

22   And then, in turn, we use it to

23 provide -- you know, when you hear the familiar

24 statistic of 36 or 37,000 people on the wait list

25 and this is how long they've been there, we're

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1   using the client profile database to do that.

2   And we, out of that, create what's

3   known as the monthly long-term care home system

4   report which is used by the Ministry of Ontario

5   Health and long-term care homes. And it's sort of

6   a snapshot of the number of beds, number of

7   residents, wait lists, things like that.

8   And so the other key data that sits

9   within Aileen Chan's portfolio is a system that's

10   known as the "Ontario Healthcare Financial System."

11   It's a series of standardized cost centres.

12   And, essentially, what we ask of the

13   long-term care homes is that they take their

14   general ledger and translate it to our standard

15   cost centres. Commissioner Kitts would be familiar

16   with this because he would have had to do this on

17   behalf of the Ottawa Hospital. And so the homes

18   will submit across a whole range of cost centres

19   including staffing information, pharmacy, food

20   services, et cetera, et cetera.

21   And what we, then, do is translate that

22   into a series of indicators that sit within our

23   healthcare indicator tool. It's a tool that is

24   available to the broader health public sector.

25   They can access it and do comparative

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1   reports. You know, how much did home X spend on

2   overhead versus home Y, things of that nature.

3   FTEs associated with certain cost centres compared

4   across regions, homes, things like that.

5   COMMISSIONER FRANK MARROCCO (CHAIR):

6   Mr. Hillmer, if I can -- that -- I was concerned --

7   you know the four envelopes of money?

8   And in my experience, there often are

9   questions of interpretation about how these funds

10   can flow and not flow. And depending upon which

11   side of the line you're on or which side of the

12   field you're on, you have either a liberal or a

13   conservative interpretation of what you can do and

14   what you can't do.

15   Would it be possible -- is there any

16   monitoring done of how, for example, for-profit

17   homes are moving those funds? Is that data

18   supplied to you in any way?

19   MICHAEL HILLMER: That's a good

20   question. In terms of the financial reporting,

21   there are -- we put the standards out as the

22   Ministry, and we expect the individual institutions

23   to adhere to those.

24   So it's, you know, not unlike the CRA

25   where it's an honour system. We expect you --

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1   there is a -- particularly in the hospital

2   sector --

3   Aileen is reminding me that reporting

4   is not mandatory, so I probably will defer to her

5   in a moment.

6   But in the hospital sector, we do

7   compare audited financial statements against what

8   is submitted in the Ontario Healthcare Financial

9   System. I believe we do not do that in the

10   long-term care home sector, but I'm going to pass

11   it over to Aileen to maybe dive into your question

12   a bit more and give you a bit more insight into

13   that financial reporting.

14   MS. CHAN: Hi. Good afternoon. In

15   terms of the reporting, it's done two times during

16   the year, one for Q2 and one for year-end. And as

17   Michael mentioned, because the reporting is

18   mandatory, compared to the hospital sector, the

19   compliancy rate for long-term care homes is not as

20   high.

21   And as Michael mentioned, you know, the

22   cross-walking of the financial statistical

23   reporting against the financial statement, I don't

24   think, is done on a regular basis. So that --

25   we'll have to confirm that with FMB, but that's my

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1   understanding.

2   COMMISSIONER FRANK MARROCCO (CHAIR):

3   If there was a requirement that every home had

4   three months or two months or whatever -- but let's

5   just say, for the purposes of this discussion,

6   three months of personal protective equipment --

7   would you be able to monitor the expenditure to see

8   whether -- to get some sense of whether this was

9   being observed or not?

10   MICHAEL HILLMER: So it's a good

11 question. I was -- I was thinking about your ask

12 coming up to today, and pre-COVID, we had very

13 little line of sight into any given institution's

14 personal protective equipment and their infection

15 control.

16   It's just -- it was something we

17 expected facilities to do in terms of the Long-Term

18 Care Homes Act. You know, it's named as a specific

19 requirement that a home have an infection control

20 plan, and they would be inspected against it. But,

21 you know, we, as provincial data stewards, would

22 not have that kind of information nor were we

23 typically asked for it.

24   You know, we now track PPE and

25 inventory a lot more closely. We use what was

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1 historically known as the Daily Bed Census tool

2 which we've now rebranded as the "health data

3 collection service" because we are collecting a lot

4 more information than just bed information, like

5 PPE inventories and other things which I'll get

6 into.

7   So it's a long-winded answer which I

8 will summarize to say that we could. We would

9 either need to ask specifically for, you know,

10 inventory and expenditures associated with it, or,

11 if there was an appropriate Ontario healthcare

12 financial standard cost centre associated with PPE,

13 then we could track it that way as well.

14   But we didn't -- we don't typically

15 track inventory down to that particular level. It

16 would sit in higher-level cost centres -- you know,

17 sundry items, you know, diagnostics. You know,

18 that's kind of the level of category.

19   COMMISSIONER FRANK MARROCCO (CHAIR):

20 (Indiscernible).

21   MICHAEL HILLMER: Yeah, exactly.

22   So, you know, theoretically,

23 absolutely. And then the nature of how it's

24 reported becomes, you know, "what lever are you

25 going to use?" "Are you just going to ask the

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1 homes --"

2   You know, as Aileen mentioned, that's

3 what we do with financial reporting. Or in the

4 terms of the recent testing directive, that came

5 out under a minister's directive in which case it

6 has, you know, the legal ramifications that go

7 along with them in a search directive.

8   COMMISSIONER FRANK MARROCCO (CHAIR):

9 Or ask their -- if they have a professional

10 accountant on staff, ask that person to certify, or

11 ask their auditors to certify that this is what

12 they spent on PPE?

13   MICHAEL HILLMER: Sure.

14   COMMISSIONER FRANK MARROCCO (CHAIR):

15 You kind of know if you're not -- if you're

16 spending that amount of money, "that's probably

17 three months' supply," or "that can't possibly be

18 three months' supply," that sort of a check. I

19 think I understand it's possible if it was going to

20 be done.

21   MICHAEL HILLMER: Yeah, absolutely.

22 You know, one of the themes of today's presentation

23 is, you know, really anything is possible.

24   COMMISSIONER FRANK MARROCCO (CHAIR):

25 Yeah.

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1   MICHAEL HILLMER: It's like my -- like,

2   my contractor says to me "we can do anything you

3   want. You just have to be willing to pay for it."

4   And the cost always is the burden to the homes in

5   terms of what they need to do to be able to collect

6   and submit it and then our ability to make

7   meaningful use of it. That's kind of my analogy of

8   the contracting world.

9   And so maybe I'll just -- I'll segue a

10 little bit, and then I'll get into the specifics of

11 the presentation which are a little more focussed

12 on COVID reporting.

13   COMMISSIONER FRANK MARROCCO (CHAIR):

14 Okay.

15   MICHAEL HILLMER: So because we knew

16 that staffing --

17   Oh, yeah, please, Commissioner.

18   COMMISSIONER JACK KITTS: Just a quick

19 question before you go on because I -- and maybe I

20 should know this, but I really don't, so...

21   In Health Quality Ontario where

22 hospitals and, I think, others submit quality data,

23 is the long-term care sector part of that

24 submission?

25   MICHAEL HILLMER: It is a great

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1   question. I was going to cover that a little bit,

2   but I'll do it now.

3   So each hospital, long-term care home,

4   and primary care organization needs to submit a

5   quality improvement plan to Health Quality Ontario,

6   now Ontario Health. And we will help calculate

7   some of the indicators that go into the quality

8   improvement plans. And for hospitals, it was

9   mandatory through the Excellent Care For All Act

10   and for homes.

11   The mandatory nature was manifested in

12   the Accountability Agreements, and then Ontario

13   Health then reviews them. And, really, the purpose

14   is to lay out a set of improvement goals and have

15   some data and indicators to measure against those

16   goals, and then you resubmit the next year.

17   COMMISSIONER JACK KITTS: Okay. Thank

18   you.

19   MICHAEL HILLMER: So I've highlighted

20   some of the systems we used pre-COVID for -- and we

21   continue to use financial staffing and occupancy.

22   And, of course, the occupancy data we had was

23   generally two months out of date because that's

24   just the nature of the way the system worked. And

25   we need much more current occupancy.

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1   So since the last time we talked, we

2   have launched a weekly occupancy survey of all

3   long-term care homes. I think it's been running

4   for about five weeks now. So we get a weekly sense

5   of the beds occupied, the beds not available

6   because of various infection control processes.

7   And we've been getting a completion rate of, in any

8   given week, about -- close to 600 of the, you know,

9   620-odd homes.

10   And we've determined that the occupancy

11 now sits on a weekly basis around 87 percent, and

12 that's of total beds available. And then when you

13 account for the beds not available for different

14 isolation procedures, the occupancy sits around

15 94 percent of the beds actually available. So

16 that's been a new development.

17   And then just last week, we launched

18 the testing survey to go along with the Minister's

19 directive where homes in the grey, red, and orange,

20 zones of the provincial COVID framework need to be

21 having their staff and caregivers and students and

22 others tested every seven days and then, for the

23 yellow and green zones, every 14 days.

24   So we've just launched that and have

25 one week's result of that, and that's -- both of

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1   those -- the testing is so that the Ministry can

2   understand how homes are doing in terms of reaching

3   the 100 percent target as laid out in the

4   Minister's directive and to support, where

5   necessary, if it's low.

6   And then the occupancy monitoring is to

7   support both understanding of how homes are doing

8   with -- we -- you know, that no new residents can

9   be admitted to the multi-bed rooms so as to oversee

10   that process and then, also, to support where homes

11   might have beds available, more realtime

12   operational decisions so that, you know, somebody

13   in a hospital that needs placement could

14   potentially find an open bed in a home much more

15   quickly than we could previously offer up.

16   COMMISSIONER FRANK MARROCCO (CHAIR):

17   Mr. Hillmer, when you're calculating the occupancy,

18   you have a room with four beds in it but only two

19   people because they're not putting more than two

20   people in the room. Is that half full or full?

21   MICHAEL HILLMER: We ask specifically

22   about the multi-bed rooms as well. So when we do

23   the occupancy, it's just, you know, residents

24   divided by total beds. And then for the adjusted

25   occupancy, residents divided by beds available.

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1   But we also ask about how many people

2   are in -- how many rooms have three people in them

3   and how many rooms have four people in them.

4   Because, of course, there are still people in those

5   rooms who are still residents, so we have some

6   sense of, you know, what the occupancy is of those

7   multi-bed rooms.

8   COMMISSIONER FRANK MARROCCO (CHAIR):

9   Okay. So the 87 percent could be one or the other?

10   MICHAEL HILLMER: Well, the 87 percent

11   is at the -- that's at the province level. So, I

12   mean, we have it right down to the home level, too.

13   And on any given home, we can tell you

14   the occupancy level plus how many people are still

15   in those -- how many -- how many people are still

16   in those multi-bed rooms, you know, that are over

17   the target of two.

18   Okay. The last thing I'll mention

19   before getting onto the rest of the presentation

20   are -- I know you had some questions about resident

21   well-being and, you know, how we measure that and

22   some of our other performance-monitoring work.

23   So one of our main sources for resident

24   well-being and monitoring what's happening in the

25   home is the Continuing Care Reporting System, the

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1   CCRS, which contains all the interRAI assessment

2   data which is a really rich clinically-collected

3   source of data that happens when a resident is

4   admitted to a home.

5   It's -- I don't know -- like, hundreds

6   and hundreds of clinically-directed questions that

7   are asked about functional status, mobility, status

8   of pain, status of appetite, chronic diseases,

9   et cetera, et cetera.

10   And so there are these elements in

11   there that get at resident well-being like pain and

12   appetite and things like that. So as I said, it's

13   collected when the resident is admitted and then

14   quarterly and then upon any change in --

15   significant change in clinical status.

16   So I don't think you would call it a

17   true measure of resident well-being, but it does

18   get at some aspects of that. And so we use that

19   data source to report on things like number of

20   transfers of residents to the emergency department,

21   potentially avoidable emergency department visits,

22   acute hospital discharges for long-term care

23   residents.

24   Those all sit in either the

25   Ministry-LHIN Accountability Agreement or the

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1 Long-Term Care Sector Accountability Agreements

2 that Ontario Health maintains with the homes.

3   Yeah. Please, go ahead, Commissioner

4 Coke.

5   COMMISSIONER ANGELA COKE: So I'm just

6 trying to understand. So the acuity level, is this

7 where they get the data that would go into the case

8 mix index for funding?

9   MICHAEL HILLMER: I'm going to ask my

10 colleague Kamil Malikov to tackle that. He's got

11 quite a bit of knowledge in that regard.

12   KAMIL MALIKOV: The acuity level is

13 basically based on the Rag (ph) three grouping

14 which is based on the -- basically, what kind of --

15   So the acuity level goes with that

16 count as well, yes, for -- to give you a short

17 answer.

18   MICHAEL HILLMER: But -- so, Kamil, is

19 the assessment data used to generate the acuity

20 level that goes into the --

21   KAMIL MALIKOV: Yes.

22   MICHAEL HILLMER: Yeah, okay.

23   KAMIL MALIKOV: So this was used for

24 that, but it's used not by us. It's used by a

25 different branch which has their funding formula.

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1   COMMISSIONER ANGELA COKE: Okay. Thank

2   you.

3   MICHAEL HILLMER: I think the simple

4   answer is "yes."

5   COMMISSIONER ANGELA COKE: Okay.

6   MICHAEL HILLMER: So we use the CCRS

7   for a lot of those key performance indicators. And

8   clearly, as you've noted, Commissioner Coke, it's

9   used for other purposes as well.

10   And I think the important thing to

11   remember with the assessment data is that its

12   primary purpose is to guide care planning at the

13   home level. It just also happens to have all these

14   other uses because it's so rich and covers so many

15   aspects of residents' status and care provided to

16   them.

17   And so the other kind of indicators

18   that we would typically measure on behalf of these

19   agreements would be things like, you know, wait

20   times for determination of eligibility to be placed

21   in long-term care homes -- we measure median at the

22   90th percentile -- the long-term care home refusal

23   rate, so the number of times the home has rejected

24   an application because of their inability to meet

25   the needs.

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1   So that, hopefully, gives you a bit of

2   an overview that we would -- of how we used

3   different data sources to monitor various aspects

4   of performance in pre-COVID times.

5   COMMISSIONER JACK KITTS: Michael, in

6   your data sources, is there a source that

7   reports -- and, again, like hospitals -- on the

8   overall resident, family, or power of attorney

9   experience in the home? Was that one measure or

10 indicator?

11   MICHAEL HILLMER: Commissioner Kitts,

12 do you mean sort of like the Picker surveys that

13 get done --

14   COMMISSIONER JACK KITTS: Yeah.

15   MICHAEL HILLMER: -- in a hospital

16 sector?

17   COMMISSIONER JACK KITTS: Yes.

18   MICHAEL HILLMER: I'm personally not

19 aware, but I'd ask if any of my colleagues would

20 know of something similar, you know, kind of

21 LTC-satisfaction type survey or question.

22   I'm getting some messages here that my

23 colleagues are not aware either.

24   COMMISSIONER JACK KITTS: Okay.

25 U/T   MICHAEL HILLMER: I would, though,

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1   offer up that we could just do a quick poll and

2   then maybe get an answer back to you based on a bit

3   more comprehensive poll in case I'm overlooking

4   something.

5   COMMISSIONER JACK KITTS: Yeah, that

6   would be -- that would be fine.

7   But, also, for the staff, too, with

8   staff engagement or a staff experience survey as

9   well.

10   MICHAEL HILLMER: Yeah, not that I know

11   of, Commissioner.

12   COMMISSIONER JACK KITTS: Yeah, you can

13   get back to us on that. That's fine.

14   U/T   MICHAEL HILLMER: Okay.

15   COMMISSIONER JACK KITTS: Yeah, thank

16   you.

17   MICHAEL HILLMER: Yeah.

18   COMMISSIONER FRANK MARROCCO (CHAIR):

19   How timely is the data collection, from your

20   perspective?

21   MICHAEL HILLMER: It's a good question.

22   Some of the collections that we talked about that

23   we're running now around, you know, weekly

24   occupancy and testing of staff are very timely, but

25   I think they're the exception to the rule.

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1   You know, take the CCRS system, the

2   assessment data. We, as the Ministry, don't end up

3   with that data until two orders have passed. So we

4   don't have any ability to understand, you know,

5   what's happening with residents at a really

6   granular level until, you know, half a year has

7   gone by, essentially.

8   So that's not that timely, and we've

9   already mentioned that the previous occupancy

10 monitoring was two months out of date. So we've

11 had to stand up these new data collection efforts

12 because of the need to understand this information

13 in a much more timely way.

14   So I would say, in general -- you know,

15 and Aileen mentioned the financial reporting that

16 would happen twice a year. That might be okay for

17 financial reporting. But, again, if you're trying

18 to understand something like your first question

19 around run rates, probably not timely enough.

20   COMMISSIONER FRANK MARROCCO (CHAIR):

21 M-hm. Okay.

22   COMMISSIONER ANGELA COKE: Can I just

23 ask another question?

24   MICHAEL HILLMER: M-hm.

25   COMMISSIONER ANGELA COKE: Are you

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1   involved in sort of the analysis about future

2   demand given demographic trends and other data

3   that's available?

4   MICHAEL HILLMER: We do support those

5   kinds of analyses and, again, I might ask -- it

6   would typically be Kamil's area that did a lot of

7   this kind of work/support.

8   You know, whether it's bed -- you know,

9   the placement of new beds as part of the expansion

10   or to understand how many more people might not be

11   able to be served because of the growth pattern.

12   So I don't know if, Kamil, you could

13   just give maybe a quick overview of how you go

14   about that work.

15   KAMIL MALIKOV: For long-term care, we

16   didn't do any particular forecasting analysis so

17   far. The analysis that we were doing was basically

18   on comparing the -- or making an analysis on the

19   impact of the opening of new beds in the long-term

20   care and how that will impact the availability of

21   beds in other sectors, not specifically on how many

22   beds will be required in the LTC sector in, let's

23   say, ten years or next year. That was not part of

24   what we were doing so far.

25   COMMISSIONER ANGELA COKE: Okay. And,

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1   sorry, I have one other unrelated question.

2   In terms of all the data that you do

3   have, is that open data that's available for others

4   to access and use?

5   MICHAEL HILLMER: Typically, no, with

6   some exceptions. So you take the assessment data,

7   I mean, that's the very essence of personal health

8   information. So we can't make that available.

9   Although another development that has

10   happened since we last talked is we've actually put

11   a lot more data into the open catalog that now

12   drives a series of new visualizations on the

13   Ministry's public-facing page. So there are some

14   new long-term care visualizations around --

15   Maybe, Jenn, you could remind me. I'm

16   just drawing a blank on what they are. But those

17   are now part of the open-data catalog.

18   COMMISSIONER ANGELA COKE: Okay.

19   MICHAEL HILLMER: So we know that

20   there's a big push to put more data out there. But

21   by and large, it's all too sensitive with personal

22   health information. And if we were to put it out,

23   it would have to be aggregated like what we have in

24   the catalog right now to support --

25   Because there's a big push right now to

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1 get out all the information at a public health unit

2 level that has -- that are the key criteria for the

3 COVID response framework so that -- you know, in

4 Ontario, you could go and plug at the public health

5 unit and get a sense of, you know, where their

6 geography sits in terms of, you know --

7   Is the positivity over X percent, and

8 would that put me in lockdown, and what is my test

9 turnaround time in my local region?

10   That kind of information is now getting

11 out there. So it's actually kind of a step forward

12 in transparency which is really nice.

13   COMMISSIONER ANGELA COKE: Okay. Thank

14 you.

15   MICHAEL HILLMER: Okay. Now, I'm going

16 to transition to -- thank you, to Slide 4.

17   So I know one of your specific

18 questions was around some of the datasets and what

19 they get used for. So I'll maybe just go over this

20 slide because I think it's a good anchor slide for

21 some of the subsequent things that we're going to

22 show.

23   The case and contact management

24 solution, this is the new Public Health Information

25 System. It used to be called iPHIS, and now the

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1   majority -- I think 33 of 34 public health units --

2   are now using the CCM solution.

3   And we use that for staff and resident

4   COVID case outcomes. We calculate long-term care

5   case fatality rate, hospitalization, ICU transfers,

6   case doubling rate. So that is a very valuable

7   data set to understand what's happening to

8   long-term care residents and staff.

9   The MLTC daily COVID-19 report, we get

10   outbreak status and progression of case counts, but

11   this is also a place where we get PPE and staffing

12   supply information from. This is where the

13   inspectors -- the LTC inspectors are contacting the

14   homes directly and inputting information on cases

15   and other aspects into a database that we have

16   access to. You can see some of the example

17   indicators we get from that.

18   The Laboratory Information System, we

19   use that to calculate testing volumes, positivity

20   rates for the homes and sectors. Also a really

21   important metric is the test turnaround times for

22   homes.

23   The other source of staffing

24   information -- because I know this was a big

25   interest of yours -- is the Health Professionals

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1   Database, and this is a database that's generated

2   out of agreements with the various regulatory

3   colleges. And they will submit, annually, to us

4   information on their members -- number of members,

5   locations, work demographics, things like that.

6   And so we're able to tell you the

7   number of long-term care health professionals in

8   the sector by occupation from that database. It's

9   not timely, but it is good system information.

10   And then, finally, the other piece of

11   information -- Ontario Health maintains an

12   operational daily tracker where they assign a

13   red/yellow/green status to homes in their different

14   OH regions, and we use that information as part of

15   our surveillance system to highlight homes at risk

16   for the IMS team members.

17   All right. Let's keep going to

18   Slide 5. I think I've covered this, just to say

19   that one of the specific parts of your question was

20   do we understand who is on the floor at a given

21   time. And I think the answer to that is we don't.

22   We have an understanding of FTEs over

23   time periods. We don't really understand, on any

24   given day or shift, who is working. And so what we

25   do know is that the homes will indicate through the

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1   daily tracker if they -- the percentage of regular

2   staff being used. That's a measure we use to

3   understand their staffing stability. If they're

4   using a low percentage, that means they're using a

5   lot of agency staff which isn't desirable.

6   They indicate if they're able to fill

7   their shifts within the next -- it's 48 or

8   72 hours, and then a binary question of, you know,

9   do you have any critical staff shortages right now,

10   and that's up to the home to decide what that

11   means.

12   But then those answers trigger specific

13   responses either from the IMS structure or from

14   Ontario Health who then endeavor to work with the

15   home to be able to fill any gaps that they're

16   indicating through those daily trackers.

17   But, again, it doesn't really tell us

18   who is working at any given time. And I think I've

19   already mentioned that resident well-being -- we do

20   capture some aspects of that through the assessment

21   data we receive as part of the CCRS data system.

22   COMMISSIONER JACK KITTS: Michael, is

23   this new since COVID, or has this always been a way

24   of monitoring long-term care homes?

25   MICHAEL HILLMER: These are forevermore

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1 pieces here before COVID. I would say that the

2 exception to that is we didn't ask homes on a daily

3 basis about, you know, their use of agency staff.

4   That's a new piece since COVID, and the

5 resident well-being, everything that's in that

6 category was -- that was all collected before COVID

7 and continues to be collected.

8   The other piece -- I know that

9 Dr. Stall was in front of you for some exchange,

10 and I don't remember if he mentioned the work that

11 we collaborated on looking at psychotropic drug use

12 during the pandemic. We collaborated with him to

13 look at the prescriptions of antipsychotic drugs.

14 The use of those drugs in the long-term care

15 population is controversial.

16   Homes will use them to help address

17 when residents with dementia have really bad

18 psychological symptoms of their dementia. You

19 know, they can -- they can be very aggressive and a

20 lot of yelling, and antipsychotics are effective at

21 dealing with those symptoms, but they have really

22 deleterious side effects, the worst of which being

23 they can hasten mortality in a quicker way than if

24 you don't use them.

25   So Dr. Stall looked at the prescribing

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1   of these drugs plus a few sedating drugs to

2   understand, you know, did the isolation and stress

3   of the pandemic lead to an increase in prescribing

4   of these drugs. And it looked like it did. There

5   was a small but noticeable increase in the

6   prescribing of these drugs.

7   I mean, I think there are probably

8   some -- you know, it's a balanced story because I

9   think the homes were faced with another very

10   challenging situation in Wave 1 where they would

11   have had a lot of residents who were experiencing,

12   you know, high levels of distress because of COVID

13   and isolation.

14   But I just -- I bring it up because it

15   is one other ways you can use a data source --

16   like, claims for drug prescriptions to be able to

17   surveil something like resident well-being and

18   mental health. And it's -- it was a -- it was a

19   nice piece of work that shone a light on something

20   that isn't really available in other data sources.

21   I'll keep going to Slide 6. Thank you.

22   So we just wanted to give you a general

23   sense of the sequence here where, you know, the

24   long-term care -- this is in relation to the

25   long-term care inspectors' database, the daily

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1   COVID trackers. But this could equally be the OLIS

2   system or the CCMS system where the data is

3   collected. We end up receiving it through our

4   databases. We have a series of standard reports,

5   which I'll get into in a moment, and then we

6   provide those reports -- one of our major audiences

7   is the IMS Table -- providing these reports to IMS

8   for situational awareness and intervention as

9   required.

10   So I'll keep going onto Slide 8, I

11 think.

12   So now I get into some examples of the

13 IMS reporting and how we're using some of those

14 datasets to provide awareness in the platform for

15 action. So this table on the left, we provide to

16 IMS members at every meeting. IMS meets three

17 times a week. It's just a general overview of how

18 many homes are in outbreak and the nature of that

19 outbreak.

20   So you can see we try to provide a

21 sense of, you know, how many are big outbreaks, how

22 many are small outbreaks, how many fit into the

23 different categories of our surveillance system,

24 and we've got this new -- relatively new statistic

25 that we use here where we say, you know, how

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1   many -- how many outbreaks are increasing or

2   decreasing or are plateaued.

3   And we show that as a measure of -- you

4   know, hopefully more homes end up with a decreasing

5   trend. And that's a -- you know, a measure of

6   success of, you know, different interventions and

7   the pandemic itself within the sector.

8   So this is -- you know, maybe Jenn --

9   no, that's okay. The same goes for both of these

10   slides.

11   Maybe, Jenn, you could just describe

12   the underlying data a little bit for those two

13   slides.

14   JENNIFER BRIDGE: No problem. So in

15   terms of the datasets that, you know, we're using

16   for the trending here, we are largely relying on

17   the daily tracker, daily report, that is filled out

18   from the inspectors and submitted to the Ministry

19   of Long-Term Care.

20   The other way that we're also

21   categorizing it is based on -- you know, we're

22   using this to also look at an alert status that

23   we're tagging the homes with it. I don't know if

24   you want to go to the next slide, please, but we

25   can talk about that.

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1   So we take a few data sources to get --

2   we take a few pieces of information together, and

3   we worked on this, you know, consulting with the

4   Ministry of Long-Term Care and others to arrive at

5   an alert system that will help to identify homes

6   that may be at increasing, you know, risk of

7   outbreaks or risk of issues that they can

8   understand, like where it escalated and where it

9   falls on the spectrum.

10   So the first one is the "vigilance"

11   one. So we look at community rate, so if the rate

12   is at 10 per 100,000 cases of COVID in the

13   community. The other factors that go into all of

14   these are whether there's VMOs or MMOs that have

15   been issued and the outstanding orders.

16   There's also an operationally stable

17   aspect of this. So another piece of data that we

18   bring in to create these different levels is

19   whether or not a home has been classified as red,

20   yellow, or green by OH in the regions.

21   They take into consideration, you know,

22   whether the level of the home in outbreaks and

23   staffing -- you know, like, their staffing

24   considerations and that kind of thing. And they

25   assign it, you know, a status of red, yellow, or

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1   green.

2   And other things that we'll take into

3   consideration are whether there's additional risk

4   factors, like, yeah, design factors if it's older;

5   if it's crowded; also some historical factors about

6   whether something's been, you know, in a red status

7   for more than five days, historically.

8   So if a home is, you know -- is not in

9   a community with a high rate -- less than 10 per

10   100,000 rate of COVID and it doesn't have any VMO

11   or MMO outstanding compliance orders and it's got a

12   stable rating from OH and local partners, then --

13   like, a green rating, then we'd call that -- just

14   be vigilant with this home. Things are looking

15   good, but it's just learning to be vigilant and

16   keep up the good practices.

17   If the home tips into a community where

18   there's 10 per 100,000 but it doesn't have any

19   outstanding compliance orders and it's still

20   considered operationally stable, it's considered

21   "early warning." So everything is operationally

22   good, but now you're at risk because of what's

23   happening in the communities, so keep an eye on it.

24   An "alert" status is if they go into --

25   three -- less than three -- three or less cases --

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1   home is in outbreak unless three or less cases.

2   Then its gone into alert automatically and/or it

3   may have one or more outstanding compliance orders.

4   It's considered operationally at risk by OH and

5   other partners, and it's -- but -- or it's early

6   warning, and it has a risk factor that -- it --

7   either older design chain, crowded, historically

8   had issues with outbreaks.

9   And then the "high alert" is if there's

10   more than three cases in outbreak and at least one

11   of those cases is a resident and/or it's already

12   been flagged operationally at "high risk" or as a

13   "red" status by OH and local partners.

14   So based on that, we also create some

15   categorizations, and we tag all the homes with what

16   level of alert status they have and provide that as

17   well and report how those fall out in terms of the

18   homes that are in outbreak and the homes that are

19   not in outbreak.

20   MICHAEL HILLMER: Okay. Well, let's

21   keep going.

22   JENNIFER BRIDGE: Okay. All right.

23   And then this is just another way that we have been

24   reporting the data that Michael had spoken about.

25   We've been starting to look at patterns

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1 to help categorize homes. Have they been showing

2 some increasing trends? So the cases continually

3 increase, and we'll provide a list of the homes

4 based on whether they're having that increasing

5 trend.

6   Or is the home not increasing, that

7 there's something that you need to keep an eye on?

8 For example, it's a new home that's come into

9 outbreak in the last few days, or is this home in a

10 decreasing trend, has it plateaued?

11   So it's also a way to help, you know,

12 the Ministry and partners understand, you know,

13 potentially what some of the trends are with the

14 homes at a home level and be able to, you know,

15 supplement some of the work that they're doing when

16 they're learning about the homes and help them

17 determine if there needs to be some follow-up

18 conversations or any types of supports given.

19   And then the next slide -- actually,

20 this would be every Friday --

21   I'll hand this over to Kamil, but every

22 Friday, we also provided IMS a higher-level

23 reporting that gives more of a sense of how trends

24 have been going compared to Wave 1 and other things

25 that might be happening beyond a home level, so at

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1   a higher level.

2   But, Kamil, I'll let you talk to the

3   reporting that you provided.

4   KAMIL MALIKOV: Thank you, Jennifer,

5   and thank you, Michael.

6   Yes. You can see, on the first line,

7   the graph or the case fatality rate in the LTC

8   residents. It compares the point of time case

9   mortality in the second wave to the similar point

10   of time in the first wave so that we can have a

11   head-to-head comparison.

12   And those --

13   MICHAEL HILLMER: Kamil, I might just

14   interject for one moment to say we've defined the

15   second wave as September 1st onwards.

16   KAMIL MALIKOV: Yes. Thank you,

17   Michael. I forgot to mention that.

18   And that date was determined not only

19   by us but also confirmed by the research community

20   and the members of the Modelling Consensus Table

21   that advises government on the measures to -- and

22   provides evidence to support the measures for the

23   outbreak management or pandemic management.

24   So the light blue bars present the

25   first wave, and the dark bars represent the --

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1 well, the other bars represent the -- the purple

2 bars represent the second wave.

3   And you can see that for all age

4 groups, the case fatality at a given time point was

5 below the first wave.

6   A similar analysis we're doing for the

7 LTC homes and resident outbreak in Wave 1 and

8 Wave 2, it's the right graph on the first row.

9   The size and the number of the homes in

10 the first wave -- the size of outbreak and the

11 number of homes in the outbreak is much smaller in

12 the second wave compared to the first wave.

13   At the bottom of the row on the left

14 side, you will see the forecast that we're

15 producing for cases of LTC residents and death of

16 LTC residents. You can see the trend that,

17 initially, the cases were quite stable and closer

18 to the best=case scenario forecast.

19   But recently, sometime mid-October,

20 they started rising up at a faster speed -- rate

21 than the forecasts, and now they're approaching the

22 worst-case scenario. Similar but not exactly the

23 same trend, you can see the deaths which start to

24 escalate a little bit later.

25   The middle graph is the -- the middle

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1   table is the table coming from Jennifer's team, and

2   I will let her talk to that table later. I will

3   proceed with the two right-side graphs on the

4   bottom row, and they both represent the percentage

5   of homes with PPE shortages or percentage of homes

6   with the staff shortages.

7   And, again, you can see that the

8   situation is much better in the second wave

9   compared to the first wave both in terms of the PPE

10 shortages and the homes with the staff shortages.

11   Jennifer, back to you.

12   COMMISSIONER JACK KITTS: And before

13 you leave that, can I just ask a question about the

14 PPE shortage?

15   KAMIL MALIKOV: Sure.

16   COMMISSIONER JACK KITTS: So if I'm

17 looking at the graph, in the first wave -- I'm not

18 sure what I'm reading there with the peaks. Like,

19 its number of long-term care homes, the highest

20 seems to be 19 in that peak. What does that mean,

21 that 19?

22   KAMIL MALIKOV: It means that 19 homes

23 reported a shortage of PPE.

24   COMMISSIONER JACK KITTS: And what does

25 the -- on the day of the outbreak or --

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1   MICHAEL HILLMER: Oh, yes.

2   KAMIL MALIKOV: Yes.

3   MICHAEL HILLMER: They've been -- so

4   Wave 1 would be end of February/beginning of March;

5   and Wave 2, September 1st.

6   So they're just equalized. So number

7   of days since those start points for either wave.

8   KAMIL MALIKOV: Yeah, thank you,

9   Michael. Exactly. It's the number of days from

10   the beginning of the outbreak -- or from the

11   beginning of the wave.

12   COMMISSIONER JACK KITTS: So if we take

13   the -- where there's an orange for the second wave

14   and a blue for the first wave, let's say at 37 or

15   38, whatever's in there, what does that mean?

16   KAMIL MALIKOV: It means that only one

17   or two homes in the second wave reported PPE

18   shortages, and so much -- many more LTC homes

19   reported PPE shortages in the first wave.

20   The orange represents the second wave

21   and number of homes reporting the PPE shortages,

22   and the blue bars represent the number of homes

23   reporting PPE shortages in the first wave.

24   COMMISSIONER JACK KITTS: So that's

25   striking. Similarly, the next graph, then, is the

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1   staffing, and the shortage of staffing in the

2   second wave is strikingly less than the first wave

3   again, right?

4   KAMIL MALIKOV: Yes, exactly.

5   MICHAEL HILLMER: And this -- sorry,

6   this resonates with us. It has face validity on

7   the PPE front because we know so much work was done

8   with PPE supply and that there are the, you know,

9   provincial tables that exist to address any

10   organization that have shortages right away.

11   And there are -- the other part of my

12   portfolio that we don't really cover in this

13   presentation is health human resources. And, you

14   know, there are a variety of measures that have

15   been put in place around staffing.

16   So we take this as some measure of

17   success for some of these initiatives put in place

18   over the summer and early fall.

19   COMMISSIONER JACK KITTS: Yeah. Thank

20   you.

21   KAMIL MALIKOV: Thank you.

22   COMMISSIONER FRANK MARROCCO (CHAIR):

23   So based on these, it's really just a number of

24   deaths that is approaching Wave 1. Have I got that

25   right, or am I misreading that?

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1   MICHAEL HILLMER: No, it's a good

2   question. So there are a couple of ways we look at

3   that. So on the top right, the graph comparing the

4   number of outbreaks and the severity of outbreak --

5   so each dot represents a home in outbreak on any

6   given day, and then the colour of the dot is the

7   intensity of the outbreak.

8   So if the dot is red, it means there

9   are upwards of 160 cases associated with that

10 home's outbreak. And so at the height of Wave 1,

11 there were 100 to 130 homes in outbreak, many of

12 which had 80 or 100 or more residents infected with

13 COVID.

14   So far, in Wave 2, we've seen -- and

15 just so you're connecting different data sources

16 here, you'd say, "well, aren't there over 100 homes

17 in outbreak right now," and this graph only shows

18 80?"

19   This particular graph is only resident

20 cases. So this is all about cases, this graph. So

21 we say, you know, these are the number of homes and

22 the cases associated with the outbreak. So far not

23 nearly as intense as Wave 1.

24   The graph to the left is about

25 mortality. And, again, so far, the case fatality

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1 rates in Wave 2 are, in each age category,

2 considerably lower.

3   There are two caveats when comparing

4 case fatality rates. One, in Wave 1, it's possible

5 not everybody was tested. So your denominator

6 might be a little bit lower, so your case fatality

7 rate might be higher, whereas the testing

8 capability in Wave 2 is much higher, so we're

9 probably detecting more cases which might lower it.

10   And then the other one is the sooner

11 you look, after a case is diagnosed by default, the

12 case fatality rate will be lower because that case

13 may not have had the chance to die yet. So the

14 sooner you look for case fatality rate, the lower

15 it's going to be. And the longer you wait, the

16 higher it's going to be. Still, you know, these

17 are dramatic differences between the waves.

18   COMMISSIONER FRANK MARROCCO (CHAIR):

19 M-hm. Right.

20   MICHAEL HILLMER: So these are deaths.

21   COMMISSIONER FRANK MARROCCO (CHAIR):

22 And there's a dramatic -- that's what I was asking

23 about because there's a dramatic -- there's a

24 difference in the rate of people dying as well.

25   MICHAEL HILLMER: Right.

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1   COMMISSIONER FRANK MARROCCO (CHAIR):

2   It's positive. It's better in the second wave than

3   in the first wave if you look at this graph.

4   MICHAEL HILLMER: Right. We have a few

5   other graphs that we show the IMS Table and the

6   deputy and others. There's about 10 pages. We

7   call it our "Wave 1 versus Wave 2 analysis," and it

8   just provides different perspectives on Wave 1

9   versus Wave 2.

10   And you see it -- the same pattern when

11 we look at infection rate, which is, you know, the

12 number of residents infected divided by the total

13 number of residents. That is considerably lower in

14 Wave 2.

15   The case doubling rate, by and large,

16 is not as -- the rate -- the cases are not doubling

17 as quickly as they did in Wave 1, so all of these

18 are measures that --

19   As many cases and unfortunate deaths as

20 there have been in Wave 2, it appears Wave 2 is not

21 nearly as intense or severe or lethal as Wave 1.

22   Okay. Maybe we'll move on.

23   So you'll see some similarities here.

24 We also provide routine snapshots of the sector to

25 the Health Coordination Table which meets once a

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1   week, and you can see here we show a map of Ontario

2   with -- the intensity of the red colour is the

3   community COVID rate. We've shown pretty

4   conclusively that the probability of outbreak is

5   very much a function of the rates of COVID in the

6   surrounding community. And the map bears that out?

7   Those communities with the highest rates have the

8   most outbreaks.

9   And then we provided a very similar

10   snapshot in terms of the tally of outbreaks and the

11   cases and deaths amongst residents and staff on the

12   graph in the lower right.

13   And then I think I'll end by showing

14   you a screen capture of the weekly occupancy report

15   that we send to several sources. One is to the

16   operations division of Ministry of Long-Term Care.

17   We send it to Ontario Health for their operational

18   planning and placement, and we provide a snapshot

19   to IMS every week as well.

20   COMMISSIONER FRANK MARROCCO (CHAIR):

21   Is there any reason, Mr. Hillmer, why the local

22   medical officer of health or the chief medical

23   officer of health isn't on that list? How should I

24   read that?

25   MICHAEL HILLMER: It's a good question.

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1 The chief medical officer of health has a

2 membership at the IMS Table, so the CMOH office is

3 covered there.

4   The local medical officers of health --

5 that's a good question. My understanding of the

6 cascade, particularly as it relates to IMS, is that

7 it's typically --

8   The CMOH member who's at the table,

9 Dr. Yaffe, will take any item that is of relevance

10 or action required by the local medical officer of

11 health and engage directly with that public health

12 unit and that medical officer of health.

13   COMMISSIONER FRANK MARROCCO (CHAIR):

14 So in terms of availability, the chief medical

15 officer of health is designated and has access to

16 the information and is expected to distribute it to

17 the local medical officers involved as they see

18 fit; is that right?

19   MICHAEL HILLMER: I think that's

20 correct. And, I mean, the first part of it around

21 the availability to the CMOH office is absolutely

22 correct.

23   And then what typically happens is when

24 either a local medical officer of health needs

25 support from the provincial office or the CMOH

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1   designate needs to engage -- as you've suggested,

2   as they see fit -- because it's deemed to be an

3   issue in the public health domain...

4   COMMISSIONER FRANK MARROCCO (CHAIR):

5   Okay.

6   MICHAEL HILLMER: So this is something

7   you can look at at your leisure. I just wanted to

8   highlight that this is now something that we have

9   every week and does provide a good, timely snapshot

10   of bed availability, occupancy, and..

11   You know, for example, while provincial

12   occupancy sits at 87 percent, you can see the

13   number of homes that are at 100 percent, you know,

14   still range in the two dozen mark. So it's not an

15   even 87 percent occupancy across the province.

16   But the number of homes less than

17   85 percent -- or between 85 and 94, that's now over

18   half. So the directive not to admit to those

19   multi-bed rooms has clearly had a big impact on

20   occupancy over time.

21   COMMISSIONER FRANK MARROCCO (CHAIR):

22   Do you do median -- do you calculate a median as

23   opposed to an average?

24   MICHAEL HILLMER: That's a good

25   question. When you have an uneven distribution,

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1   you should always go with the median. That's a

2   good flag to a bunch of statistical wonks like us.

3   We should probably report that as well, so we'll

4   probably start doing that.

5   COMMISSIONER FRANK MARROCCO (CHAIR):

6   Okay. Well, I certainly defer as far as

7   statistical expertise. I would not put myself

8   forward as anyone with any great knowledge in that

9   area.

10   MICHAEL HILLMER: It is why we show the

11   categories at the bottom, to give you a sense of

12   that distribution. But it is absolutely a good

13   flag.

14   And now we have similar reports for the

15   testing compliance, as I've mentioned before that.

16   We just have one of those because it just launched

17   last week. So --

18   COMMISSIONER FRANK MARROCCO (CHAIR):

19   It would be possible, really, marshalling this

20   information to have a very intense response

21   throughout the system where it's required.

22   Like, this -- if this information is

23   timely, then you should be able to coordinate your

24   response to the most -- in the near -- the places

25   that need it the most and very quickly identify

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1   those places.

2   MICHAEL HILLMER: That's exactly the

3   intent, Commissioner. There's always a mantra that

4   we use that -- timely information that is used will

5   bring benefit, A, because it's available and

6   timely; B, as soon as it starts to get used, its

7   quality improves because everybody understands its

8   purpose and can see that it's being used. And I

9   think this occupancy is a good example.

10   Some of the other reports that we

11   showed you based on the Public Health data or OLIS

12   comes in daily are able to show changing trends

13   very quickly. And then when that's matched against

14   the on-the-ground operational knowledge or of

15   either Public Health units or Ontario Health, you

16   can marry the two very effectively.

17   The one caveat I put to you is that

18   this kind of collection, if it's not being

19   extracted from source systems, can be onerous on

20   the homes. We're putting a lot of burden on the

21   homes asking them to report.

22   And so, you know, in a -- in a perfect

23   world, that was all digital. If our healthcare

24   system was all integrated and digital, we would be

25   able to extract occupancy information right from

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1   the home's source systems. But we can't because

2   that integration doesn't yet exist, so we are left

3   in the position of having to ask the homes

4   directly.

5   So that's always my caveat there that

6   we always --

7   COMMISSIONER FRANK MARROCCO (CHAIR):

8   If it did exist, you could simply put it in the

9   agreement that you were signing -- that you have

10   the right to extract that information and use it in

11   an anonymized. Wouldn't track to the individual.

12   It would track in the aggregate. So that, legally,

13   you could get at it. It's a digital platform, if

14   the platform was there.

15   MICHAEL HILLMER: I agree with that

16   statement. This is an area -- I keep referring to

17   Commissioner Kitts. It's only because I know him

18   and his hospital well, and I know that he and

19   people like Alan Forster have been real pioneers of

20   using information to improve quality. And there's

21   a business case for it and a clear benefit that

22   comes from it.

23   But having it be digitally available is

24   really important because the collection activity

25   can be time-consuming and expensive.

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1   COMMISSIONER FRANK MARROCCO (CHAIR):

2 The only issue, then, I take it, is the input of

3 the data. Like, the data -- it will only be timely

4 if it's input --

5   If the homes are inputting the data,

6 they have to do it in a timely manner. And you

7 could actually monitor that. You could tell from

8 the data when -- to what it refers and when it was

9 inputted into the system. Am I correct in that?

10   MICHAEL HILLMER: You're absolutely

11 correct. The example here on this slide -- you can

12 see the number of homes submitting a very little

13 bit week to week. At the top row, November 25th,

14 it was 600 homes. December 2nd, it was 592 homes.

15 So we know exactly what homes submitted --

16   COMMISSIONER FRANK MARROCCO (CHAIR):

17 M-hm.

18   MICHAEL HILLMER: -- and who didn't.

19 And then we have follow-up mechanisms that we put

20 in place to be able to follow up.

21   When the information is integrated

22 within the normal operations of the home, that's

23 the sweet spot because then the homes find it to be

24 a valuable source of operational information. And

25 then, as you say, we can extract it from those

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1   systems that exist already.

2   And I think in the -- in some of the

3   other sectors in healthcare, we're getting closer

4   and closer to being able to do that but not -- it's

5   not pervasive yet everywhere.

6   COMMISSIONER FRANK MARROCCO (CHAIR):

7   M-hm.

8   COMMISSIONER JACK KITTS: I wonder,

9   Michael, you know, given -- this has been a great

10   session. It gave us a lot of insight into the

11   information you're gathering and how you're dealing

12   with it.

13   Is there anybody sort of looking at --

14   and you've been in meetings with me before. Like,

15   what are the vital few? What are the vital few

16   indicators that someone would look at and say

17   "okay. This is starting to go the wrong direction"

18   or whatever? Is there a table or a group -- I know

19   how busy it must be there, but -- looking at that

20   for long-term care that could be public-facing?

21   MICHAEL HILLMER: Could be

22   public-facing? That's interesting. Certainly the

23   group that does it right now is the IMS Table. And

24   their whole role is immediate operational response

25   to address, you know --

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1   What we always hope to put forward to

2   this group is the vital few, you know, separating

3   out signal from noise. So we're always trying to

4   innovate with the way we present information and

5   what we present to get to that point.

6   I'd probably defer to answer the

7   public-facing part just because I don't feel like

8   that would be my decision to make. I always serve

9   the audience that I have in front of me. And in

10   this case, IMS is the -- and the deputy and the

11   Minister, when they ask, are my kind of primary

12   audiences.

13   COMMISSIONER JACK KITTS: Yeah, I

14   understand. So thank you for that.

15   COMMISSIONER FRANK MARROCCO (CHAIR):

16   Well, I take it --

17   Is that the last slide, Mr. Hillmer?

18   MICHAEL HILLMER: I'm just going to

19   check.

20   Yes. The final slide in the appendix

21   just gives you an accounting -- or a crosswalk of

22   where -- of specific indicators and what

23   information source they came from because I know

24   that was of interest to you.

25   I guess I'd summarize by saying there

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1   is absolutely a wealth of data that can be used to

2   help manage COVID response. As we've discussed, I

3   think the weaknesses lie in our understanding about

4   the staffing and its role in outbreaks and the

5   spread of outbreaks and in the practice of

6   infection control.

7   You know, if I think of some of the

8   work we've done with Dr. Stall and others

9   characterizing how outbreaks happen and spread, we

10   have not been able to include the role of staffing

11   or infection control practices because they are not

12   captured in a systematic way.

13   So some ingenuity that balances off the

14   burden of collection with the value of information

15   would, I think, be positive and help give the line

16   of sight into, you know, which homes are doing well

17   and how those practices and patterns could be

18   replicated in homes that might not be doing as

19   well.

20   And, as always, happy to follow up if

21   you have any thoughts or questions following this

22   briefing.

23   COMMISSIONER FRANK MARROCCO (CHAIR):

24   Before we end, I just had one question. You

25   mentioned a couple of times that the gathering of

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1   this information or the collection, the input of

2   it, would be burdensome for the long-term care

3   homes.

4   And can you -- I guess anything you're

5   asked to do -- anything anyone is asked to do over

6   and above what they're already doing is burdensome.

7   But what are we talking about in terms of the

8   burden? What does it look like?

9   MICHAEL HILLMER: No, that's a good --

10   it's a really good question. So if we take the

11   occupancy data -- imagine you're a small long-term

12   care home, 50 beds. You have one administrator,

13   maybe one or two extra administrative staff running

14   your business in your care, and then the Ministry

15   comes knocking and says "by the way, we want you,

16   every week, to submit to us the answers to these

17   12 questions."

18   And depending on the sophistication of

19   the organization in the small example, they might

20   literally have to go count, you know, the number of

21   people in their multi-bed rooms and et cetera,

22   et cetera to fill out the questions.

23   If you're a big, sophisticated

24   organization with an electronic system, you

25   probably could ask your IT department to create an

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1   automatic query. And you'd just, you know, hit

2   "execute," and that automatic query generates the

3   questions, then somebody enters it into our

4   provincial website.

5   So the burden looks different depending

6   on who you are and your capabilities. So it could

7   literally be somebody who is going around and

8   counting, and that time is taken away.

9   And it's not any one collection,

10   Commissioner, that's particularly burdensome. It's

11   the layering that happens. I'll just -- I'll use

12   an example that I still find really relevant from

13   the late Dr. Reuben Devlin where he talked about

14   when he joined the Humber hospital, there was a

15   half a page of Ministry requirements that had to be

16   reported quarterly. And by the time he left his

17   CEO position, that had grown to 11 pages, and there

18   were people that had to be hired to support that

19   reporting.

20   And so that layering over the years led

21   to 11 pages, and there's a risk of that in the

22   long-term care sector as well because we're asking

23   about testing. We're asking about occupancy, the

24   inspectors are asking about various things. We

25   might want to know about infection control

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1   practices which would require a survey. So it's

2   sort of this pernicious default in health that we

3   don't tend to stop collection. We just layer new

4   things on, and that has a collective, cumulative

5   burden.

6   COMMISSIONER FRANK MARROCCO (CHAIR):

7   But would you agree you can't tailor what you are

8   prepared to ask for to the lowest common

9   denominator?

10   MICHAEL HILLMER: There are many

11   strategies to overcome the burden. You know,

12   working hard with individual -- working hard with

13   the sector to understand what does exist in their

14   systems and work to extract it automatically,

15   working hard to minimize the number of questions,

16   you know, be parsimonious, you know, sacrificing

17   granularity for ease -- I mean, there are many

18   different ways you can ease a burden. You can

19   change the frequency. You can --

20   Yeah, anyways, I think you're on the

21   right track in saying that, yes, there are

22   definitely ways you can address these things, and

23   tailoring and flexibility is certainly -- and

24   parsimony would be three principles I would bring

25   to any kind of value-versus-burden conversation in

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1   this regard.

2   COMMISSIONER FRANK MARROCCO (CHAIR):

3   Okay. Well, I don't think we have any more

4   questions. Dr. Kitts already expressed our

5   appreciation for the presentation. And thanks very

6   much, and it was good to see you again.

7   MICHAEL HILLMER: Yeah, likewise. I

8   enjoy the time spent with you, and I wish you the

9   best of luck and success in the rest of your

10   endeavors. I read your second report with great

11   interest.

12   COMMISSIONER FRANK MARROCCO (CHAIR):

13   Well, I won't impress you any further about the

14   second report. Thank you for referencing it.

15   MICHAEL HILLMER: I appreciate that.

16   Thank you.

17   COMMISSIONER FRANK MARROCCO (CHAIR):

18   Bye.

19   MICHAEL HILLMER: Goodbye.

20   COMMISSIONER ANGELA COKE: Thank you.

21   COMMISSIONER JACK KITTS: Bye-bye.

22   -- PROCEEDINGS CONCLUDED AT 3:23 P.M. --

23

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1   REPORTER'S CERTIFICATE

2

3   I, MCKAYA MCDONALD, Chartered

4   Shorthand Reporter, certify;

5

6   That the foregoing proceedings were

7   taken before me at the time and place therein set

8   forth, at which time the witness was put under oath

9   by me;

10

11   That the testimony of the witness

12   and all objections made at the time of the

13   examination were recorded stenographically by me

14   and were thereafter transcribed;

15

16   That the foregoing is a true and

17   correct transcript of my shorthand notes so taken.

18

19   Dated this 8th day of December, 2020.

20

21   *MMcDonald*

22   _____

23   NEESONS, A VERITEXT COMPANY

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1   C L A R I F I C A T I O N S:

2

3   Page 6, line 11: "radicals" should be "rabbit

4   holes."

5

6   Page 12, line 18: "mandatory" should be "not

7   mandatory."

8

9   Page 22, line 13: "rag" should be "RUG."

10

11   Page 26, line 3: "two orders" should be "two

12   quarters."

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