

Long-Term Care COVID-19 Commission Meeting

Kensington Health
on Thursday, February 18, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 18th day of
February, 2021, 8:58 a.m. to 10:15 a.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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8 PRESENTERS:

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10 MEETING WITH KENSINGTON HEALTH:

11 John Yip, President and CEO, Kensington Health

12 Bill O'Neill, Vice-President of Residential and

13 Community Care, Kensington Health

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16 PARTICIPANTS:

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18 Ida Bianchi, Senior Legal Counsel, Long-Term Care

19 Commission Secretariat

20 Alison Drummond, Assistant Deputy Minister,

21 Long-Term Care Commission Secretariat

22 Rose Bianchini, Senior Policy Analyst, Long-Term

23 Care Commission Secretariat

24 Angela Walwyn, Senior Policy Analyst, Long-Term

25 Care Commission Secretariat

1 Derek Lett, Policy Director, Long-Term Care
2 Commission Secretariat
3 Alain Daoust, Team Lead, Long-Term Care Commission
4 Secretariat

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7 ALSO PRESENT:

8 Judith M. Caputo, Stenographer/Transcriptionist

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1 -- Upon commencing at 8:58 a.m.

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3 LEAD COMMISSIONER FRANK MARROCCO: Good
4 morning, and thank you for coming.

5 Ida, I'll turn it over to you, if you
6 go ahead.

7 IDA BIANCHI: Sure. Today you're
8 meeting with John Yip and Bill O'Neill, both of
9 Kensington Health.

10 John is President and CEO of the
11 organization. By way of background, he has over
12 20 years working in the healthcare industry,
13 leading system and organizational strategy and
14 change.

15 Before joining Kensington Health, John
16 was the Vice-President of Corporate Services at
17 Health Quality Ontario and a Management Consultant
18 with the National Healthcare Practices at CGI,
19 KPMG and PwC before founding his own boutique
20 healthcare consulting firm.

21 Bill is the Vice-President of
22 Residential and Community Services at Kensington
23 Health, which he joined in October of 2000 as the
24 first employee in their brand new long-term care
25 home.

1 He has assumed primary responsibility
2 for planning and opening the two long-term care
3 homes, which amount to 350 beds.

4 He also leads the Kensington Hospice
5 and the Second Mile Club, which I think is -- it
6 says a multisite community support services, but I
7 believe that's primarily directed to seniors; is
8 that right, Bill?

9 BILL O'NEILL: That's right. Seniors
10 living and case management at the site.

11 IDA BIANCHI: So Bill and John have
12 come to talk to you today to give you a brief
13 overview of Kensington's services, to talk about
14 the challenges they face during the pandemic,
15 especially the challenges implementing the
16 directives from the Ministry.

17 They're also going to tell you a bit
18 about their relationships with the hospitals,
19 particularly Women's College Hospital and Princess
20 Margaret, and to talk about their hospice and
21 palliative care programs.

22 I'm going to turn it over to them.
23 They don't have a PowerPoint presentation; they
24 wanted to be more conversational. So I'll let them
25 get started.

1 LEAD COMMISSIONER FRANK MARROCCO: I
2 take it, Mr. O'Neill, you know we have a court
3 reporter and we publish a transcript so people can
4 follow along with what we're doing?

5 BILL O'NEILL: Yes, I've been following
6 a bit of your activities. It's quite interesting.

7 LEAD COMMISSIONER FRANK MARROCCO:
8 Okay, thank you.

9 JOHN YIP: Thanks for having us. Bill
10 and I are thrilled to be here, and thank you for
11 your time and service to this important cause.

12 We've been following, as Bill
13 mentioned, following the transcripts and the
14 activities, and have been quite impressed by your
15 line of questioning, your insights, perspectives
16 and your collective experience within and as part
17 of -- within the healthcare system as part of being
18 members of the public as well.

19 So as I have already mentioned, I'm
20 John Yip. I'm the President and CEO. I have been
21 here for five years.

22 Kensington Health has roots, and
23 Dr. Kitts, you may know, the Doctors Hospital, the
24 former Doctors Hospital, was on this site for many,
25 many years, serving the community, serving

1 immigrants, refugees, newcomers to Canada, I think
2 really truly embodied what a community hospital was
3 back in the '50s.

4 So our roots are from there. And
5 today, as Ida mentioned, we have two divisions.
6 One is a surgical division that I'm not going to
7 talk about, but Dr. Kitts, it's very much like your
8 former Riverside site at the Ottawa hospital, high
9 throughput, high volume of surgeries.

10 We are a not-for-profit charity right
11 across the board on our surgical side and on our
12 residential side, which is our focus today.

13 So within our residential side, we do
14 have 350 long-term care beds in two buildings.
15 And, as Ida mentioned, Bill O'Neill is employee
16 number one. And He has a lot of history, a lot of
17 experience, and I'm so glad he's joining me today.
18 A lot of insights about the sector that he's
19 willing to share with all of you today.

20 In addition, we do have a ten-bed
21 residential hospice. At the time it was one of the
22 first adult residential hospices in downtown
23 Toronto, and Bill helped build and create that
24 program.

25 We are expanding that program from 10

1 to 19 beds, in addition to a number of
2 community-oriented programs which we already have.
3 There's a community day hospice, caregiver support
4 in that palliative end of life realm.

5 Last piece Bill is responsible for,
6 which I just mentioned, there is the Second Mile
7 Club at four sites. It's a seniors active living
8 centre with some case management, and it's been a
9 very key piece to us during the pandemic.

10 Just some quick highlights before we
11 just open it up, how we've been doing. So this has
12 been a very long year for everyone, as you've
13 heard.

14 Bill and I take great pride in our
15 staff. You've heard a lot about the commitment,
16 the passion of our personal support workers, RPNs,
17 RNs and our physicians, as well as social worker,
18 life enhancement, they have really all come
19 together to protect our residents and to create a
20 very healthy environment, despite very, very
21 challenging circumstances.

22 Our situation over the past year, we've
23 had two major outbreaks, one in wave 1, and one in
24 wave 2. We've had a total of 45 positive
25 residents, resulting, unfortunately, in 12 deaths.

1 All of those positives and deaths were
2 on our dementia unit, which is a lockdown unit.
3 The residents tend to wander, so the virus got
4 transmitted quite quickly, like a tinder box, and
5 during wave 1 and wave 2.

6 On top of that we've had 48 positive
7 staff infections throughout the year. A good chunk
8 just a couple of weeks ago, then another chunk
9 during wave 1 a year ago.

10 I'm glad to report that our last major
11 outbreak is -- has been declared over. We have a
12 very small outbreak in one of our buildings, just
13 two positives.

14 And we've been very fortunate to have a
15 partnership with Women's College Hospital, who came
16 in during the, I guess, summer months to help with
17 IPAC, infection prevention and control, PPE,
18 support, personal protective equipment support, as
19 well as staffing during the height of wave 1.

20 About 20 staff came over including
21 nurse practitioners, finance people, willing to
22 lend a hand and support our units.

23 They've also been instrumental in our
24 testing, so they've been coming first biweekly and
25 now weekly to test. Today is testing day, so they

1 come in twice a week, Thursday and Saturdays.

2 And more recently, together with UHN,
3 Women's College and ourselves have completed a very
4 successful vaccination campaign, where we've had
5 96 percent of our residents inoculated, total staff
6 roughly about 70 percent.

7 But 81 percent of our full-time staff
8 have been vaccinated, which are quite high compared
9 to many homes across the sector, which is quite
10 low, due to vaccine hesitancy, which is quite real
11 across the sector.

12 So this has been a key enabler and
13 support for us throughout the pandemic and
14 pre-pandemic, and we can talk about that
15 relationship a little later.

16 I just want to add one more thing. And
17 early on, how we dealt with it because we had the
18 benefit of a surgical side, we did ask our staff
19 there, our RNs to come over and get redeployed.

20 It was voluntary including our
21 corporate staff, finance staff, quality staff,
22 myself, Bill.

23 We've been up on the floors, wiping
24 floors down, serving residents, so it's all hands
25 on deck and we managed to get over 20 of our staff,

1 including members of our Second Mile Club who are
2 normally in the community to work on the floors
3 with residents, to set up iPads to do the virtual
4 connections with their families.

5 And that was a huge help during wave 1.
6 My last point there is Bill and his team came up
7 with a really creative solution during wave 1 which
8 was to hire family members.

9 You may recall during wave 1 it was a
10 complete lockdown, no family members, no visitors.

11 As we know, and all of you know, how
12 critical family members are to be part of that care
13 team. So Bill and his team came up with a
14 fantastic idea: To hire them on a part-time 90-day
15 contract to go up on the floor.

16 Not to just help their loved one but
17 since they're daily visitors pre-pandemic, they
18 knew all the residents on the floor and they went
19 and served with distinction on our COVID units and
20 across the long-term care home.

21 And we had about 8 to 10 family members
22 that were hired. Our union was supportive. Our
23 lawyer scratched her head but basically gave the
24 green light.

25 So that's I think just wrapping it in a

1 nutshell our experience to date. And I'll stop
2 there.

3 BILL O'NEILL: So I'll start in a bit,
4 and I guess just to elaborate on the side of having
5 families around.

6 Families really create a sense of
7 comfort for the other families who couldn't come
8 in. They were a real constant communication to the
9 families, because they would phone them and connect
10 with them on a regular basis.

11 The other thing we did, right from the
12 start, we had a town hall, a virtual town hall with
13 family members, staff, etcetera, etcetera. I think
14 we did staff at one of them, and I think the family
15 members, we had 352 participants in that, so it was
16 extremely well received.

17 And on an ongoing basis we would have
18 weekly communications to our family members, to our
19 staff and to our essential caregivers on what's
20 happening. We've been very open and very upfront
21 in how we're managing the pandemic and we were
22 fairly successful during the pandemic.

23 I guess you want me to talk a little
24 bit about the directives coming down. We were
25 shocked with two directives that came down in

1 January around the security guards, which has us
2 confused.

3 And the rapid testing. The rapid
4 testing is changing as we speak, I think in the
5 directive yesterday, so for changing the rapid
6 testing.

7 We are fortunate, like John said, we're
8 working with Women's College Hospital. They're
9 very helpful in trying to execute this. It's a
10 very complex approach, because we have I think over
11 100 essential caregivers coming in on a daily
12 basis.

13 Any given time we have 100 staff to 200
14 staff coming in during the day for various shifts.
15 Just trying to logistically figuring this out will
16 be a challenge.

17 We're not against testing at all; we
18 think it's a great idea. Three times a week may be
19 excessive. I'm not sure; time will tell. But
20 again, I guess my frustration with the directives
21 it's they issue these directives, but there's no
22 sort of sense of how it is to be executed.

23 We're starving for staff, registered
24 staff and PSWs. We're constantly hiring and
25 orientating new staff coming in. It is a bit of a

1 challenge to keep staff.

2 Give you one example: I have a
3 wonderful PSW at our hospice who is making I think
4 \$23 an hour. She was working part-time in Saint
5 Mike's in the emergency room. They offered her a
6 full-time position at \$35 an hour. It's a bit of a
7 game for that.

8 So in looking at just salaries and I
9 guess vulnerable people working in the sector we
10 need to really address that, and how that's complex
11 work for us trying to recruit people.

12 I won't dwell too much on the security
13 directive. I think that's sort of going away, I
14 hope?

15 I was interested in going to the vendor
16 of record they supplied to us at the start last
17 month. I think they gave us eight vendors; I
18 phoned two vendors, neither of which were security
19 companies. They were HR companies and neither one
20 phoned me back. So I didn't have any success
21 there.

22 I did have three security companies
23 phone, who said they're quite willing to give us
24 security guards at 24 hours a day, 7 days a week.
25 I figured the cost at \$418,000 a year for that.

1 And of course there's no need for that as far as
2 I'm concerned.

3 I guess my big thing we've been very
4 lucky to have the hospice attached to the
5 organization. And that was of a dream, Gary Rodin
6 was a doctor at Princess Margaret, Head of
7 Psychosocial Oncology of Princess Margaret and
8 myself met, probably in 2007, to talk about the
9 dream of having a residential hospice in downtown
10 Toronto.

11 His frustration came out of the fact he
12 had a palliative care unit at Princess Margaret
13 Hospital, 12 beds on the 16th floor, which was a
14 great service but it was time limited. You were
15 there for 12 days and you had to move on.

16 He found it very difficult to say to
17 families, sorry, you have to leave, and send the
18 patient back home or to a long stay, long-term care
19 home.

20 He found it very difficult and said
21 there's a real need for a residential hospice in
22 the city. Our Board bit the bullet; everybody went
23 along with it. We did it on our own. There was no
24 financial support from the government at that time.

25 Typically renovating a whole building --

1 we had a old chapel at the back of the property we
2 rebuilt. The original budget was \$2 million. We
3 ended up spending \$7 million of our own money to
4 build it because it was a very complex build.
5 Anyways, it's a very expensive ten-bed hospice, and
6 it's working well.

7 When I see the difference between
8 end-of-life care in hospice and end-of-life care,
9 in long-term care, I think there's two standards
10 going on right now.

11 We're fairly well staffed in long-term
12 care. We have one nurse for 25 residents. I know
13 in some homes they have one nurse for 62 residents.

14 How you can provide end-of-life care
15 for somebody in long-term care with one nurse
16 providing care for 62 people is beyond my
17 comprehension.

18 So our --

19 IDA BIANCHI: Sorry, Bill. Sorry to
20 interrupt. Can you, maybe you're getting to this.
21 But can you explain a little bit what end-of-life
22 care entails? I know Dr. Kitts is probably well
23 versed in that, but I don't know that the other two
24 Commissioners are.

25 BILL O'NEILL: Palliative care isn't

1 really the end of life; it's transition. I see
2 long-term care as palliative care. Right now,
3 people in palliative care -- people who need
4 long-term care are there for about 18 months.
5 People who need hospice it's much less -- anywhere
6 from 1 to 3 months.

7 But really the end result is they're at
8 end of life. Palliative care in hospice is quite a
9 bit different. They're much more complex at later
10 stages.

11 We're finding right now we're getting
12 lots of people in long-term care who should be in
13 hospice care. They're maybe a month, two months to
14 the end of their life and they really require
15 essential palliative care.

16 There's been a lot written on this. A
17 lot of resources trying to go into long-term care,
18 but there's no real plan to support residents in
19 long-term care at any point, or no really good
20 plans.

21 Again, like I said before, we're
22 fortunate because we have palliative care
23 physicians next door at our hospice. Our doctors
24 can phone a physician and say I'm having issues
25 with a complex person in end of life. Can you

1 help?

2 They may come over, have a look at the
3 person, recommend some different types of
4 medications and make it much more comfortable end
5 of life for those folks that are dying.

6 Having that situation, we're very
7 fortunate, like I said, to have the hospice on our
8 property.

9 I'm really looking forward to the fact
10 that we're expanding --

11 COMMISSIONER JACK KITTS: Can I ask a
12 question about the hospice?

13 Do your residents in long-term care at
14 end of life move into the hospice for end-of-life
15 care?

16 BILL O'NEILL: It's happened a couple
17 of times. We really feel we can provide really
18 good end-of-life care in the Gardens because of our
19 support with the hospice.

20 It's also gone the other way. We have
21 people who have gone to palliative care at the
22 hospice and have rebounded.

23 COMMISSIONER JACK KITTS: You talked
24 about critical partnerships with Women's College,
25 UHN, others. Would you say a critical partnership

1 would be with palliative care support in the
2 community for a long-term care home?

3 BILL O'NEILL: Yeah, yeah. One of the
4 things we have difficulty with, for example, right
5 now, people who may require a CADD pump. For those
6 who don't know, it's a pump that provides automatic
7 pain medicine and management.

8 We can't access them in long-term care.
9 You can access them in the community, you can
10 access them in a hospice, but we can't access them
11 through long-term care. So if we want someone to
12 get a CADD pump, we have to move them to a hospice
13 or a hospital.

14 COMMISSIONER JACK KITTS: You can't
15 access it because of...

16 BILL O'NEILL: Of regulation.

17 COMMISSIONER JACK KITTS: Regulation?

18 BILL O'NEILL: Yeah. It's based on
19 community support. They almost see it as double
20 dipping. Here we have somebody in long-term care,
21 who are already getting the supports for their end
22 of life. That's the way I understand it.

23 Palliative care has been lacking in
24 long-term care for decades, I think it needs to be
25 addressed. I know there's been some attempts to do

1 that. I think our program and our situation here,
2 is a really good example how the two can co-exist
3 and support each other.

4 I think it's imperative having a strong
5 relationships with hospitals. Prior to the
6 pandemic, we had already started a relationship
7 with Women's College Hospital in doing virtual
8 care, hooking up our IT folks to speak to
9 specialists over at Women's College Hospital to
10 help manage, to really prevent people from going to
11 emerge and that was happening a fair amount in the
12 city.

13 So having this virtual care, was, we do
14 find, we continue to find it fairly beneficial,
15 extremely beneficial. You might have a skin wound
16 professional at Women's College, and they can take
17 a quick look at the wound and say, no, this what
18 should be happening, this is how you should be
19 treating it.

20 Our GPs at the Gardens are generalists
21 not specialists, so that support is fantastic for
22 us.

23 COMMISSIONER JACK KITTS: I have
24 another question about the hospice. So you have a
25 hospice, like a community hospice, that's right

1 beside the --

2 BILL O'NEILL: Yes, yes.

3 COMMISSIONER JACK KITTS: Could
4 existing long-term care homes create a hospice
5 within the long-term care facility? You know, the
6 environment that a hospice has, with the support of
7 a palliative care team from the community?

8 BILL O'NEILL: That's an interesting
9 question. I've been talking to a couple of
10 palliative care physicians in Mississauga and Peel.

11 I think one of them has actually
12 presented to you, Amit, and talking about having
13 palliative care teams, ones like Temmy Latner has,
14 going into homes, having palliative care teams in
15 the community going into long-term care and
16 supporting people at end of life in long-term care.

17 We actually started the conversation
18 about a week ago with Naheed Dosani, who is a
19 palliative care physician for the homeless
20 population in the city and his partner, Amit, I
21 forget his last name.

22 Anyways, we're actually starting that
23 conversation about having the team come into
24 long-term care in the City of Toronto.

25 COMMISSIONER JACK KITTS: You obviously

1 know the requirement in the legislation for
2 long-term care for an IPAC, they call it
3 specialist, but probably an IPAC director someone
4 who makes sure --

5 BILL O'NEILL: A infection patrol
6 practitioner.

7 COMMISSIONER JACK KITTS: Now the
8 they're tethered in a hub and spoke model to the
9 hospitals during the pandemic.

10 BILL O'NEILL: Yes.

11 COMMISSIONER JACK KITTS: Would you see
12 that sort of model for a palliative care specialist
13 or palliative care clinician in there supported by
14 the community palliative care teams?

15 BILL O'NEILL: That's the exact model
16 that we're looking at, yeah. And, again, Western
17 has a very good, strong palliative care unit
18 in-patient.

19 Princess Margaret, we work closely with
20 the physicians at Princess Margaret. We're going
21 to continue that conversation, we started it, like
22 I said, a couple of weeks ago.

23 What I read in the newspaper, I've
24 talked to folks who have gone into some long-term
25 care homes who haven't been able to have the

1 resources that we have; and what they see is pretty
2 devastating. So we wanted to see if we can support
3 people and help people in managing those really
4 complex people at the end of life.

5 JOHN YIP: I'll just add, Dr. Kitts,
6 that is one model. The other one is, also
7 Kensington is a co-lead, the co-chair of our local
8 Ontario Health team with UHN. Highly unusual,
9 we're one of the few community led OHTs in the
10 province, and certainly, I think, the only
11 long-term care facility that is taking a leadership
12 role.

13 Despite an extension of what Bill is
14 talking about, to have both hospital supports, a
15 very medical model, as well as a community model
16 which has a psychosocial, and having both of them
17 together, leveraging the resources from the
18 community in one system.

19 You're quite right, and Bill has
20 mentioned this, there are legislative and
21 regulatory barriers for having that.

22 If I am a long-term care operator
23 that's funded by the four envelopes that you're
24 familiar with, I won't necessarily want to give up
25 those beds for a funding model that will not cover

1 the costs of those beds.

2 The funding model of the hospice is
3 \$105,000 per bed. That's it, just for nursing
4 support. It doesn't include all the other expenses
5 that we fund in long-term care.

6 Having said that, I think long-term
7 care as a sector, and the pandemic has certainly
8 shown this with the hospital resource partners
9 going one way.

10 But the other is primary care with
11 palliative specialization coming into the home,
12 which a lot of home physicians are from the
13 community so it's really leveraging both sides.

14 And then concepts like the Ontario
15 Health team, while we're not quite there, certainly
16 lend itself to really create, placing long-term
17 care not at the one end of the spectrum, but
18 possibly in the middle of it, in the very
19 community-focused, very neighbourhood base that
20 works in Toronto but won't necessarily work in,
21 say, Sudbury or Thunder Bay, where it's a very much
22 more logical model built around a hospital.

23 But because of the way the sector, over
24 decades -- and Bill has seen the evolution -- the
25 first build of 20,000 redevelopment beds and we're

1 nowhere close to the number of beds, but the
2 question is how does the sector place itself within
3 the broader healthcare system?

4 I guess one of the silver linings of
5 the pandemic it has allowed long-term care to be
6 part of that.

7 COMMISSIONER JACK KITTS: It has
8 brought the integration. In Ottawa we have
9 community health centres leading our OHT and the
10 Ottawa Hospital is helping, so much like you and
11 the UHN.

12 So I agree the pandemic has really
13 pushed forward the integration of, in our
14 recommendation we said hospitals, long-term care
15 and public health. And now we're adding IPAC and
16 palliative care, so it's coming along. Thanks.

17 BILL O'NEILL: Okay. Is it question
18 time?

19 COMMISSIONER JACK KITTS: I just
20 noticed in your introductory remarks you said you
21 had two major outbreaks, one in wave 1 and one in
22 wave 2. I'm curious to know what the major
23 causative factors in 1 and 2 were, and were they
24 the same or different?

25 JOHN YIP: I can start. Bill, you can

1 jump in. I think wave 1, Bill and I were talking
2 about the pandemic right from the fall. We were
3 following it. As soon as it landed in B.C. in the
4 long-term care home, I think both of us kind of
5 looked at each other and going, "ugh-oh".

6 Like many homes at the time, we're
7 talking, Bill, I think it was late February, we
8 kind of went "ugh-oh", like panic. And, you know,
9 Bill called a meeting and, basically, it was all
10 hands on deck.

11 And so like many homes we were short on
12 PPE. In fact, we had two weeks' worth. And we
13 made a very tough decision mid-March.

14 So just before the lockdown, and prior
15 to the government issuing universal masking, we
16 made a decision with two weeks' supply to go to
17 universal masking. And just rolling the dice. If
18 we ran out, we ran out.

19 But fortunately, two days before we
20 were about to run out, a shipment came in. It said
21 it was from the Ministry of Health. The source of
22 it is unconfirmed; 10,000 pieces landed on our
23 doorstep and I think that saved us.

24 Then the Province went into lockdown
25 and we started seeing our first case, I believe it

1 was late March and that was through community
2 spread. And, you know, at the time our IPAC
3 practices were okay, I wouldn't say they were
4 pandemic-proof.

5 Our pandemic plan, we had one, it was a
6 very good one, but it wasn't thorough or
7 comprehensive to manage COVID. But it was
8 up-to-date, we'd passed accreditations, so we had
9 one.

10 So that was dusted off and we quickly
11 moved into -- not even planning, it was response
12 during wave 1.

13 So the summer, like across the
14 Province, it was a time to kind of reassess,
15 regroup, restock our PPE. Supply chains came back
16 online and wave 2 very similar. Community spread
17 was the source.

18 Bill mentioned this early on. One of
19 the things that we got a lot better on was
20 communication, not just with families but I think
21 internally.

22 Now, and Bill knows this, we
23 implemented Microsoft Teams like two weeks before
24 the pandemic broke, so it's like text messaging.
25 We were able to get notification of a pandemic from

1 the unit, and start outbreak management in four
2 texts.

3 We have a group, so it's our directors
4 of care, Bill and I, HR, occupational health and
5 safety, our physician, our medical director, as
6 well as communications.

7 And within four texts, there's almost
8 real-time a notice drafted to families and POAs.
9 Another note is drafted in 28 point font to
10 residents, and then to staff.

11 So there's one point where we're
12 sending a dozen pieces of communication, going out
13 on multiple channels. So wave 2 we had that in
14 place. Wave 1 we're kind of fumbling a little bit,
15 to be honest. We just weren't sure what was going
16 on and how to communicate it.

17 And Bill did mention early on, this is
18 now the norm, but this is in, I think, April or May
19 or late April we didn't know what Zoom was. And we
20 hosted that town hall, which really, I think calmed
21 our families.

22 We had our medical director, we had a
23 family member speak, who we had employed,
24 Mr. Cochrane, and he really gave a bird's eye view,
25 actually not a bird's eye view, on the ground view

1 of what was going on. I think other families
2 hearing another family member talk about their
3 experience really leveled us out.

4 The short answer is, community spread,
5 different levels of preparation between wave 1 and
6 wave 2, we cringed every Saturday morning because
7 test results come in Friday night.

8 To get that little ding first thing
9 Saturday morning, ding, we have a positive or ding,
10 we're all clear, it's almost a trigger to go ugh-oh
11 every time I hear that ding. I think that's the
12 long and short of it.

13 COMMISSIONER JACK KITTS: Better
14 prepared for wave 2. Is that staffing, IPAC,
15 ability to isolate capacity, all of the above?

16 BILL O'NEILL: There's more PPE
17 preparation. Staffing were a lot more relaxed. In
18 Phase 1 it was so unknown and people were really
19 anxious about everything. People were on edge.

20 The ones that were able to do with
21 Phase 1, I deployed a couple of nurses from our hospice
22 to come over and work with the residents who were
23 at end of life.

24 And they were able to really support
25 our staff and make them feel a little more at ease

1 to help support these people in transition. It was
2 a really good learning experience for them.

3 At Phase 2, we actually got volunteers
4 of staff to work on an outbreak floor, because they
5 had some experience. So they put their hand up and
6 said, yeah, we'll go on, not a problem. A totally
7 different transition from Phase 1 to Phase 2.

8 We did a little internal upgrade in
9 pay. We said if anybody wants to volunteer, we'll
10 give them an extra \$2 an hour. We had 20
11 volunteers that said sign us up, we're on standby.

12 The last outbreak we had on the first
13 floor of the south building, we had people lined up
14 to support.

15 Again, the professionalism of staff
16 just exploded. They know what to do, know how to
17 do it, had no qualms or fears about confronting a
18 co-worker who has their face mask down a little bit
19 below their nose, or wearing their face shield
20 upside down.

21 It felt really good -- a peer pressure
22 type approach to good IPAC practices. So night and
23 day from March to now.

24 So we've learned a lot. Our boardroom
25 has disappeared. Our boardroom is now a stockroom

1 for PPE. Everything is just packed with PPE. I
2 think we have enough N95's to help us for -- if
3 every personal home care goes into outbreak, we're
4 good for 14 weeks.

5 COMMISSIONER JACK KITTS: Wow, you
6 responded. Just one last question and I don't want
7 to monopolize, but the \$2 an hour was that pandemic
8 pay from the government or in addition to the --

9 BILL O'NEILL: That was in addition.
10 That came out of our pocket.

11 COMMISSIONER JACK KITTS: That is how
12 you felt you needed to get the staff --

13 BILL O'NEILL: Yeah, yeah. It was
14 worth every penny.

15 JOHN YIP: Dr. Kitts, we did take
16 advantage of the government pandemic pay. Those
17 who qualified, we gave them the same. And then
18 Bill is talking about a top up on top of that.

19 The other thing we did, too,
20 recognizing staff wellness was critical. We saw
21 firsthand the burnout, the stress.

22 Our unionized staff did not have
23 employee assistance programs as part of their
24 collective agreement. We decided -- Bill's
25 leadership made a decision -- we have to do

1 something. The HR director and our CFO said we
2 don't have the money but we're going to do it
3 anyways.

4 We did offer EAP assistance to all
5 staff at a cost, I believe like a quarter million
6 dollars. Again, it's not that we have money
7 falling out of the sky, but we decided to do it
8 unilaterally to really recognize our staff and the
9 need for supports.

10 COMMISSIONER JACK KITTS: Can I just
11 ask -- the employee assistance program? Will that
12 continue for those who need it as long as they need
13 it for?

14 BILL O'NEILL: Yes, we've embedded it
15 into our collected agreements.

16 COMMISSIONER JACK KITTS: What about
17 residents and families? I know they're not
18 employees, but is there assistance for them as
19 well?

20 BILL O'NEILL: So that's interesting,
21 good question. What we've started to do about two
22 months ago is support groups for families.

23 We have a social worker who is really
24 skilled at bereavement and case management, and he
25 started a support group for families. It's been

1 very popular; he just started another one.

2 So, he does a lot of work with
3 Wellspring, for bereaved families across Canada.
4 He does a lot of work virtually with folks right
5 across Canada who are going through the bereavement
6 process.

7 But the in-house one is a big hit for
8 our family members. It's very well-received.

9 Can I just get back just briefly about
10 the directives? I was on a call this morning with
11 the Ontario Long-Term Care Association and the new
12 director around the pandemic, rapid testing, the
13 rapid testing.

14 Ministry is also suggesting that PSWs
15 have a -- can do the tests, can administer the
16 tests. And we did a quick survey this morning,
17 what homes are doing, what homes are doing what, as
18 far as RNs, RPNs or PSWs doing the tests.

19 The majority of homes are having RNs
20 doing the test, but 20 percent are asking PSWs to
21 do the test. I was on a call with our insurance,
22 and he said, don't even go there. The liability
23 that you're creating in that situation would be
24 enormous.

25 So, again, it's just a whole concept of

1 how poorly the execution of this directive is.
2 It's like the wild west out there. So I thought I
3 would throw that in there this morning. That was a
4 quick survey, I think we did 500 homes survey, so
5 --

6 LEAD COMMISSIONER FRANK MARROCCO: Can
7 I just follow up on that?

8 Was the concern that a PSW would
9 administer the test, or was the concern about the
10 test itself?

11 BILL O'NEILL: Sorry, it was about the
12 PSW administering the test.

13 LEAD COMMISSIONER FRANK MARROCCO: Do
14 you think that there's a role for the rapid
15 testing?

16 BILL O'NEILL: Absolutely, I think
17 there's a role. I think the way it's been executed
18 isn't appropriate. We just don't have the
19 resources right now.

20 I think it's been amended as of
21 March 16th for us to be fully implemented for us to
22 do testing for staff three times a week, essential
23 caregivers three times a week and contractors
24 coming into the building at every time they enter
25 the building.

1 Again, I like the idea that the rapid
2 testing, but it's --

3 JOHN YIP: Just to give some context
4 for the Commission --

5 IDA BIANCHI: Can you provide -- I was
6 going to ask the same thing, John. Sorry, go
7 ahead.

8 I have a bit of delay with my Internet,
9 so I'm sorry about that. But I was going to ask
10 Bill to elaborate on what he meant about the
11 challenges in implementing the rapid testing,
12 because you had spoken with me about that on our
13 previous conversation.

14 BILL O'NEILL: Yes, I think I was
15 saying for morning shift, we'd probably have a
16 hundred people coming in to work: PSWs, RNs, RPNs,
17 kitchen, laundry, etcetera, etcetera. They have to
18 go through the testing first.

19 Now the Ministry has given us some
20 leeway, and said you can go start your shift and
21 then come down and get your testing.

22 We figure it's going to be probably
23 three staff to do the testing on any given shift.
24 It's going to have to be 24 hours a day.

25 I did some quick numbers. Just the

1 cost of the test itself is about \$25. For us it
2 would be about \$819,000 to administer the test
3 annually.

4 I assume we're going to get support
5 from the Ministry around that, but I don't know if
6 that's a really good use of money and a really good
7 use of time.

8 We also, I think earlier mentioned the
9 fact we're resource-starved for RNs, RPNs and PSWs
10 and to take them off the floor to do that testing
11 is going to be a challenge for us and probably a
12 challenge right across the sector. I have sort of
13 lassoed Women's College to help us out with that.

14 They are going to be on site three
15 times a week to help us at a particular point in
16 time, I think a four-hour window for those three
17 days we're going to be doing it.

18 But other homes like in northern part
19 of the province, and underserved areas, it's going
20 to be really complicated and difficult to do that.

21 LEAD COMMISSIONER FRANK MARROCCO: But
22 how does it -- give me a feel for how it works.

23 You have, what did you say 100 people
24 coming in? The rapid test --

25 BILL O'NEILL: Right.

1 LEAD COMMISSIONER FRANK MARROCCO: The
2 rapid testing appeals to me. I'm just wondering
3 what it's like with 100 people, how you actually do
4 that?

5 BILL O'NEILL: I think we've figured it
6 out. Initially, it was they had to have the test
7 before they went upstairs to work on the floor.
8 The Ministry has given us some flexibility around
9 that.

10 We are actually going to set up mobile
11 teams with carts and staff with RNs and RPNs. And
12 they go from floor to floor and do all the staff.

13 LEAD COMMISSIONER FRANK MARROCCO: I
14 see. As people are starting work, then these teams
15 are going out and testing everybody?

16 BILL O'NEILL: That's right.

17 LEAD COMMISSIONER FRANK MARROCCO: How
18 long does it take to get the result, approximately?

19 BILL O'NEILL: We heard about
20 15 minutes. I'm going to go on a webinar today at
21 11 o'clock which will be more specific. We heard
22 anywhere from 5 to 15 minutes.

23 JOHN YIP: Just to add more context.
24 For the sector, for the Province has, as Bill has
25 already mentioned, there's a staffing shortage

1 already, so pre-pandemic, during the pandemic.

2 Two, vaccinations. So we've just come
3 out, as I mentioned earlier, with a very successful
4 campaign but hugely resource-intensive.

5 All of us, we had volunteers from our
6 finance, corporate offices, ushering people,
7 directing people, ensuring proper distancing.

8 So all homes are doing that across the
9 province. Fortunately we're in the first wave; the
10 rest of the province is catching up. So the amount
11 of effort required to do vaccination, the
12 continuation of PPE and managing PPE supply chains
13 and education, again, resource-intensive.

14 And let's not forget day-to-day care.
15 That's probably the first thing, that day-to-day
16 care in pre-pandemic was tough enough; during the
17 pandemic, very hard. And you layer in the three
18 other points I've just mentioned, it's a very, very
19 challenging situation.

20 So to lever on PEM bio testing and this
21 third-party security item that Bill talked about.
22 And today is testing day. Every Thursday Bill and
23 I line up with staff, and they'll tell us: We're
24 tired of doing this once a week. I have sinus
25 issues, my nose keeps bleeding.

1 If any of you have gotten tested, it's
2 uncomfortable. It feels like your eyeball is going
3 to be poked out. Imagine doing that three times a
4 week.

5 I don't even want to do it once a week,
6 but I know it's good modelling. Bill and I are
7 both on site every single day; we want to model
8 good behaviour.

9 We get screened, I forgot about
10 screeners, too. I forgot it's almost like normal
11 now to have someone check your temperature, ask you
12 the five questions, checking in and checking out.

13 And I got nailed for going out the side
14 door and/or not getting the right temperature. Our
15 screeners chased me down to make sure that everyone
16 was compliant, including the CEO.

17 So it's, there's also a question about
18 the efficacy of the test, so 80 percent for rapid
19 test? We're okay with that. We would rather
20 prefer some sort of saliva test, because it's much
21 less invasive, but that's still to come online.

22 So it is -- while the policy is
23 well-intended, particularly with the emergence of
24 the variants, there's an implementation challenge.
25 We are not Loblaws, we are not Walmart that can

1 deploy resources and spend money on staffing to do
2 this, or airlines.

3 We are a not-for-profit charity,
4 under-resourced, managing multiple priorities and
5 to take on another item in a very short timeframe
6 is just not tenable.

7 COMMISSIONER JACK KITTS: Are you doing
8 the residents as well as the staff once a week?

9 BILL O'NEILL: No. We do the residents
10 -- if there's a potential risk for outbreak on a
11 particular floor we'll test all the residents.

12 COMMISSIONER JACK KITTS: So rapid
13 testing won't be used for residents? It's just for
14 staff?

15 BILL O'NEILL: Right.

16 JOHN YIP: Our nurse practitioner, when
17 there was sort of symptoms emerging quick, rapid
18 tests just as a screen and then backed up with the
19 PCR tests to confirm.

20 If the PEM bio showed -- just assume
21 it's a positive, we would enact the protocol while
22 we get the PCR confirmation. From that standpoint
23 for resident testing -- we've only done it a
24 handful of times -- when a resident has a runny
25 nose, did they have COVID or not, that PEM bio is

1 very effective.

2 LEAD COMMISSIONER FRANK MARROCCO: The
3 relationship with Women's College, when was that
4 established?

5 BILL O'NEILL: We started working with
6 them probably almost two years ago, way before
7 anybody heard of pandemic. Again, we talked about
8 the virtual screening or virtual consultations with
9 physicians at Women's College.

10 They can't actually accept anybody via
11 ambulance to the hospital because it's not a --

12 (Connection difficulties experienced by
13 the transcriptionist).

14 BILL O'NEILL: We have five physicians
15 working in the hospice, she supervises them --

16 IDA BIANCHI: Can you hold on a second.
17 The transcriptionist needs to --

18 -- TRANSCRIPTIONIST'S NOTE: (The
19 transcriptionist reconnected and advised where in the
20 meeting the internet connection dropped.)

21 BILL O'NEILL: So I was briefly talking
22 about Women's College and our relationship started,
23 Dr. Kitts, probably more than two years ago and
24 they were providing support to us through virtual
25 care, primarily.

1 And it was a brand new, I think,
2 resource for them and for us. Maybe they got some
3 new equipment, I'm not sure. But they wanted to
4 try it out and it worked out beautifully.

5 So we have people who should have gone,
6 may have gone to emergency care, because of a
7 complex situation.

8 And instead of doing that Women's
9 College, we would connect with one of their
10 physicians, specialists and using virtual medicine,
11 TeleHealth type of information and do things over
12 video.

13 Like they show, for example, a bad
14 wound, came up with some recommendations on how to
15 treat that. And any number of things, hydration
16 issues, etcetera, etcetera.

17 IDA BIANCHI: Just in case it wasn't
18 captured earlier in the transcript, you did say
19 Women's College Hospital had extended the
20 invitation to you as well as other long-term care
21 homes?

22 BILL O'NEILL: They extended up to a
23 number of long-term care homes in the city to join.
24 And when we went there, we had a meeting in the
25 boardroom, and we were the only ones there.

1 It was a probably a good thing for us,
2 because we benefited immensely from Women's
3 College's support. Just fast forward to now, when
4 the Ministry assigned hospital partnerships with
5 all long-term care members, when this first
6 started, we were very fortunate to already have
7 that relationship, so they hooked us up with
8 Princess Margaret -- with Women's College.

9 We were the only long-term care that
10 Women's College had. UHN, I think, had 19 homes
11 they were dealing with, and Mount Sinai had a
12 number of homes. So we were one-to-one, which is
13 really helpful for us and helpful for them. It
14 didn't really stress their resources. It was a
15 win-win situation for us.

16 I think that was because of the
17 relationship we had built two or three years ago.
18 Strong relationship.

19 JOHN YIP: I will just add it's also
20 built because Bill and I being in healthcare for
21 20-plus years, knowing all the players on a
22 personal and professional level, we were
23 comfortable picking up the phone and just calling a
24 member of the executive team.

25 So having that personal connection,

1 professional connection really helped establish the
2 initial partnership, pre-pandemic and then
3 definitely solidified it during the pandemic.

4 LEAD COMMISSIONER FRANK MARROCCO: Can
5 I just change the subject for a minute?

6 This vaccine hesitancy, how does it --
7 why is it concerning to you if all of the residents
8 have been vaccinated? Vaccine hesitancy on the
9 part of staff or PSWs?

10 BILL O'NEILL: I think in our
11 situation, we're fairly pleased with the uptake for
12 the full-time staff at about 81 or 82 percent.

13 There is a hesitancy amongst certain
14 cultural groups we've noticed. And I'm sure
15 there's some longstanding history there, or some
16 certain cultural groups.

17 My concern, if staff don't fully
18 uptake, all the residents may be vaccinated but
19 staff to staff, I don't want to see a whole sort of
20 rampage of staff recuperating at home for 14 days.
21 It would have a huge impact.

22 When we did the vaccines, some people
23 have reaction to the vaccine, so we had to stagger
24 out how we're going to administer the vaccines.
25 Because we didn't want to do all the staff in one

1 shot because they may have a reaction to the
2 vaccine, which a number of staff did. Primarily
3 the second shot, I think it was.

4 LEAD COMMISSIONER FRANK MARROCCO: We
5 heard a lot about staffing issues, as you could
6 imagine. What's the percentage of full-time and
7 part-time?

8 BILL O'NEILL: Our retention rate for
9 full-time is probably 80 percent. We're really
10 quite high. Once they get here, they like it here.

11 For part-time it's more complex because
12 they might have two or three different jobs. One
13 might be a full-time job, or two or three part-time
14 jobs. As you know, it's a complex staffing or
15 monetary issue, too.

16 Certainly in the city of Toronto and
17 probably in other municipalities, too, there's the
18 for-profit, the not-for-profit, there's the
19 municipals.

20 Municipal is a bit of a challenge for
21 us because they're paid on a different rate,
22 because they get support from the taxpayer, a
23 considerable amount from taxpayer.

24 So, like I say, we're paying our PSWs
25 \$22 to \$23 an hour; city might be \$32, \$34 an hour,

1 something like that. It's a huge variance in pay.
2 But as far as our full-time staff, we have a union,
3 just a fact of life.

4 We work well with the union. In some
5 ways it's easier for us because they give us a rule
6 book and just follow the rules, the collective
7 agreement. We're always in negotiations around
8 salaries.

9 If they want more we want to stick with
10 what the Ministry's mandate, so that's a bit of a
11 challenge. We're not the highest pay or the lowest
12 pay; we're somewhere in the middle.

13 Some people say that's a disincentive
14 for retaining staff. I think it's primarily the
15 casuals and the part-time.

16 What we're doing here is trying to take
17 a couple of part-time and make them full-time if
18 they're interested.

19 IDA BIANCHI: If you had to explain why
20 there is not so much turnover in your full-time
21 staff, and it really doesn't sound like you pay
22 better, what are the other factors do you think
23 that makes them stay with you?

24 BILL O'NEILL: I think it's a good
25 working environment. I think there's consistency

1 in the leadership. They got lots of support, lots
2 of education; we provide tons of education for our
3 staff.

4 We do recognize staff on a regular
5 basis throughout the year for different programs.
6 Like John said, we just introduced the past support
7 situation, PAP, which is a good thing. It's
8 relatively new, but we got a lot of kudos from
9 staff about that, a lot of thank you's.

10 IDA BIANCHI: Bill, your education, is
11 that ongoing annual training that you're talking
12 about?

13 BILL O'NEILL: Ongoing annual training
14 but over and above. We do over and above training.
15 I was on a call this morning about students whether
16 or not students are going to be covered under our
17 insurance any longer. I'm told there's a big issue
18 in the sector.

19 I was surprised to see there was 2,000
20 students hired or working, PSW students placement
21 in Ontario in the year. We have about 1,500
22 students a year that go through here. Not just
23 PSW, our entire social work, Allied health
24 professionals. We have a really robust group of
25 students going through.

1 That again is a game changer for us
2 because we actually go to the nurses on the floor
3 to be preceptors, the PSWs to be preceptors, in
4 support of the student. And that's a bit of a kudo
5 for them, they really like that. Gives them a bit
6 of a change in the day, leadership experience.

7 We do try to hire from within,
8 promotion from within, I mean, from the get-go. I
9 don't have a magic wand. It's just those little
10 things to recognize staff and how important they
11 are to the organization.

12 COMMISSIONER JACK KITTS: Does your
13 fund-raising go to both operations and capital or
14 what? I mean, are you dependent on the extra
15 money?

16 BILL O'NEILL: We don't depend on the
17 fund-raising for operations, per se, no. We have a
18 enough need for things like building maintenance
19 and, you know -- we do things like, we've gone to
20 the foundation for things like specialists, like a
21 music therapist for a period of time, or
22 specialized programs.

23 And we work closely with Princess
24 Margaret Foundation. We might share our music
25 therapist, an art therapist, that type of things.

1 LEAD COMMISSIONER FRANK MARROCCO: Is
2 there a vehicle for all of the long-term care homes
3 to communication with each other?

4 BILL O'NEILL: Sorry?

5 LEAD COMMISSIONER FRANK MARROCCO: Is
6 there a vehicle that permits the long-term care
7 homes to communicate with each other?

8 BILL O'NEILL: We have a couple of ways
9 to do that. We started, a number of years ago,
10 we'll call it an "alliance group". We have about
11 30 homes, non-for-profit homes in the GTA.

12 We have a CEO group that meet or a
13 quarterly basis, and we have an HR group that meet
14 through that group. And that's sort of a
15 voluntary, join if you want.

16 We do some things like staff
17 satisfaction surveys, resident satisfaction
18 surveys, some quality indicator stuff all on our
19 own dime. We just do it because we think it's an
20 important thing to do and stay connected with the
21 not-for-profit sector in the GTA.

22 And then we have the two associations,
23 the Advantage and the OLTCA, which we're a member
24 of the OLTCA, but we do do a couple of things.

25 COMMISSIONER JACK KITTS: Do you

1 compare results on the staff and resident
2 satisfaction?

3 BILL O'NEILL: All the time, very
4 competitive. We don't know how some homes do it.

5 COMMISSIONER JACK KITTS: I just want
6 to change subject for a moment. Just briefly, can
7 you give us an idea of your governance and
8 management structure just at a very high level?

9 JOHN YIP: So a couple of years ago we
10 reorganized. I used to report in to five boards,
11 and we've changed that.

12 So we now have a single board, duty
13 govern board. We do have a skills matrix, a
14 competency-based matrix, and we have done this, and
15 made big changes, where we have an almost - not
16 quite gender parity -- but there were no women on
17 our previous board.

18 We changed that. We brought a person
19 of colour, two people of colour, and we have a
20 committee structure, audit and finance, quality,
21 gov nom. And we just created a Community Advisory
22 Committee, which will be approved by the Board in
23 March, which is a collection of volunteers, members
24 of the community, physicians.

25 We don't have an MAC, a Medical

1 Advisory Committee, so a different type of advisory
2 with a line into the Board.

3 We are composed of three corporations,
4 so we have a research one; so I'll park that. Our
5 ambulatory is one corporation, and the health
6 centre, which Bill is responsible for, has like the
7 long-term care home, the hospice and our community
8 programming, Second Mile Club, which has its own
9 sub board within the structure in order to fulfill
10 City of Toronto funding for that entity.

11 The management structure is I'm
12 responsible for the entirety, more the strategy
13 side and the direction; the CFO and Bill manages
14 that complete residential division.

15 We had an equivalent of Bill on the
16 ambulatory side. She retired, so I decentralized
17 that, so we have five very strong directors who are
18 managing the ambulatory side.

19 And Bill has his leadership team as
20 well. But we're very lean. We had an executive
21 meeting that was me, Bill and our CFO. And Bill
22 and I, or the two Bills, we talk I don't know 4, 5
23 times a day. Very lean.

24 COMMISSIONER JACK KITTS: Does each
25 site have an executive director then for the

1 on-site management; is that...

2 BILL O'NEILL: I'm associate director
3 for my group. I have two directors for nursing and
4 I have a director of client services, who manage
5 the intake and the social work department. And the
6 hospice. And I am manager of HR and director of HR
7 that does globally all the entities.

8 COMMISSIONER JACK KITTS: Just remind
9 me, how many sites are you?

10 BILL O'NEILL: We have two long-term
11 care homes, the hospice, about five sites in the
12 community program, and the ambulatory is one
13 building. But how many services over there, John,
14 is it four?

15 JOHN YIP: We have four services.
16 We're basically three-and-a-half acres in the heart
17 of Kensington Market, we're a campus. The
18 long-term care, hospice and our ambulatory are all
19 one site, and the community sites are spread across
20 the city.

21 LEAD COMMISSIONER FRANK MARROCCO: If I
22 can change the subject again, we have been told
23 that there's an insurance problem, and that it's
24 important. Can you help us appreciate that, if
25 there is one?

1 BILL O'NEILL: There is one. We were
2 on the call this morning talking about the
3 insurance issue. There are some companies that try
4 to pull back from the pandemic, infectious diseases
5 piece of their coverage. Officers and directors
6 they try to pull back from.

7 They were fortunate we didn't have that
8 situation. We have an insurance company that is
9 very progressive. They did drop our coverage from
10 20 million down to 10 during the pandemic, but I
11 think we're still okay; so we have that coverage.

12 But in the sector there's a real
13 concern about coverage and overall coverage in the
14 sector.

15 LEAD COMMISSIONER FRANK MARROCCO:
16 Change the subject again. We have a shortage, as
17 you know, in the province, according to what we've
18 been told, a waiting list of 38,000, or whatever
19 the number is.

20 Do you have a sense of why that
21 happened? How it is that we find ourselves in this
22 situation? Because that seems like a rather
23 daunting challenge to me.

24 JOHN YIP: There's the short answer and
25 the complicated answer. The short answer is simple

1 supply and demand, much more demand not a lot of
2 supply of beds. Hence the government's direction
3 to build more beds.

4 The more complicated answer is around
5 the whole system, the healthcare system and how it
6 operates. How we have not invested in community,
7 in primary care. There's been multiple tests, Dr.
8 Kitts knows, around primary care reform. We
9 haven't gotten it right.

10 They are not keeping people at home,
11 there's about appropriateness of care, in the
12 appropriate care setting. And I think over decades
13 there's been a mismatch around that.

14 So people who could be at home, aren't
15 at home. And those that need to be in a long-term
16 care home are not, and they are waiting and they
17 are deteriorating.

18 Bill mentioned earlier our average
19 length of stay is about 18 months on average.
20 Today the acuity levels are way higher. Many of
21 our residents should be at complex continuing care.

22 As Bill knows, 20 years ago the average
23 length of stay was ten years. People would walk
24 in, throw the keys, just park their car, walk up to
25 their rooms with their baggage, go back outside for

1 a smoke. They're not doing that today. They're
2 coming in by ambulance from hospital.

3 So there's a shift in demographics and
4 we are not operating as a system. Our waitlist,
5 Bill, I think is what now? 1,500?

6 BILL O'NEILL: About 1,500, yeah.

7 JOHN YIP: So that's what, about 4 or
8 5 years?

9 LEAD COMMISSIONER FRANK MARROCCO: Four
10 or five years, but if the median stays 18 months.

11 BILL O'NEILL: That's right. It's a
12 lot longer.

13 LEAD COMMISSIONER FRANK MARROCCO: It's
14 a bit of an issue.

15 BILL O'NEILL: And the other issue is
16 that during the pandemic there's a lot of press
17 around long-term care obviously and people are
18 staying away from long-term care.

19 Right now we're usually at 99.5 percent
20 occupancy and now we're seeing about 93 percent.
21 So we have empty beds.

22 So, again, we're trying to problem
23 solve around that, making a call this morning to
24 UHN to see if we can take some pressure relief off
25 the beds at UHN. I can give them a whole unit of

1 25 beds.

2 It's just trying to think out of the
3 box, in how to support the sector and how to
4 support the hospital because they are bursting at
5 the seams.

6 LEAD COMMISSIONER FRANK MARROCCO: It's
7 a matter of returning the favour too, I guess.

8 BILL O'NEILL: That's it, yeah.

9 LEAD COMMISSIONER FRANK MARROCCO:
10 Commissioner Coke?

11 COMMISSIONER ANGELA COKE: I just have
12 a question on a different topic completely. I'm
13 just curious about your experiences with the
14 Ministry's inspection process and any thoughts you
15 have about how that could be improved.

16 BILL O'NEILL: Have you got a couple of
17 days?

18 COMMISSIONER ANGELA COKE: I've caused
19 laughter. I don't know what to make of that.

20 BILL O'NEILL: Again, I'm not against
21 inspections. I think they're wonderful. I think
22 they have to shift their focus onto quality as
23 opposed to the negative.

24 It would be much easier if they came in
25 and said your home is 99 percent compliant with the

1 regulations, as opposed to, "You've done it again.
2 And we're going to have to post this finding.
3 You're noncompliant."

4 So the folks coming in doing the
5 reviews, the drop-ins, I have no issue with them.
6 They're doing their job. Most of them are very
7 well educated, very skilled in what they do.

8 But the act doesn't allow them to do
9 their job to the fullest. I'm sure they'd much
10 rather focus on the positive and work
11 collaboratively.

12 We used to have advisors, Ministry of
13 Health Advisors; now they're inspectors. That's
14 changed the whole flavour of the inspection.

15 JOHN YIP: It's very much a tone, a
16 punitive tone. I think if we took a strength-based
17 quality improvement lens, so it's, yeah, there's
18 areas of improvement and we're happy to improve.
19 And happy to make those adjustments.

20 And, Dr. Kitts, imagine having hospital
21 inspectors come in every so often dropping in and
22 criticizing what you're doing.

23 So there is a bit of a different lens
24 between sectors, hospitals, primary care. We're
25 inspected by the CPSO on our surgical side; it's

1 not the same tone. It's very much running through
2 your processes and there's these couple of areas
3 you might want to tighten up and we'll write you
4 up, and that's great.

5 But with long-term care it seems very
6 punitive and almost secretive. They go in their
7 room and close the door, they invite you in. This
8 is our home. I don't want to be invited into my
9 boardroom. The tone needs to shift.

10 Like Bill, I'm not opposed to
11 inspection; I'm not opposed to compliance. There
12 are very good actors in our sector and there are
13 not so good actors. The purpose of inspection to
14 focus on those bad actors. But we feel we're very
15 much a good actor.

16 We're not perfect; we do have
17 occasional complaints that are justifiable. And
18 when that complaint and/or inspection noncompliance
19 comes in, Bill is there and they meet, the director
20 of care put together that particular action plan.
21 And before I even get the official notice I go to
22 Bill, I go, "what's this?"

23 "Oh, we've taken care of it. Here is
24 the results." It's a very quick action that we
25 want to fix and comply with the legislation.

1 COMMISSIONER ANGELA COKE: Thank you.

2 LEAD COMMISSIONER FRANK MARROCCO: So
3 if I understand you, though, there's a role for a
4 more sharply focused inspection that you need to
5 know who you're inspecting in a sense, right? You
6 need to know -- you need to know who the problems
7 are --

8 BILL O'NEILL: Absolutely.

9 LEAD COMMISSIONER FRANK MARROCCO: -- have
10 one attitude there and perhaps a different attitude
11 elsewhere.

12 BILL O'NEILL: Every home, it's an
13 optional thing to go through accreditation on a
14 three-year basis and we chose to do accreditation
15 from day one. We've always done it. And that's a
16 really good process to look at quality, and look at
17 programs.

18 We use a CARF, which is a Commission on
19 Accreditation Rehabilitation Facilities. It's a
20 great organization. We feel that's a really
21 helpful thing. We also do quality satisfaction
22 surveys with our alliance group. That's some good
23 information. We also report to HQO on our stats.

24 I'm just saying if they switched around
25 to focus more on quality as opposed to punishment,

1 it would be a better system.

2 JOHN YIP: I just want to add too,
3 context matters. The inspectors take a very narrow
4 view.

5 So in some cases, we might have been
6 short-staffed, staff may have been distracted and
7 helping another resident in crisis and there was an
8 infraction, the resident fell.

9 They don't focus on the entirety of
10 that situation. They just focus on the resident
11 fell, and you're bad because that resident fell.

12 Well, we know that shouldn't have
13 happened, right? But they don't take into account
14 a full context of what's actually happening on the
15 floor.

16 Not to sound defensive, we fully
17 recognize in that particular situation there should
18 have been coverage or some sort of recognition or
19 safety mechanism put in place.

20 But it's a very, very narrow view of
21 the broader picture and certainly that quality
22 improvement it is about that plan/do/study/act
23 cycle. There isn't that cycle in inspection, it's
24 very much -- it's like: You're wrong, act.

25 LEAD COMMISSIONER FRANK MARROCCO: I

1 think we finally did run out of questions, I guess.
2 Let me -- I'd like to thank both of you for the
3 presentation. It's been very helpful to get some
4 what at least to me were candid responses to some
5 issues that we have been, if you've been looking at
6 the transcript we have been wrestling with for some
7 time and your responses are helpful.

8 They confirm perhaps certain thoughts
9 that we have, and have perhaps given a little
10 clearer perspective on others. Thank you both for
11 taking the time to help us with this.

12 BILL O'NEILL: Thank you for taking the
13 time to listen to us and I hope it's helpful on
14 your end. It's a pleasure meeting you three and
15 the others.

16 LEAD COMMISSIONER FRANK MARROCCO: It's
17 certainly been helpful. Thank you. Bye.

18
19 -- Adjourned at 10:16 a.m.

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REPORTER'S CERTIFICATE

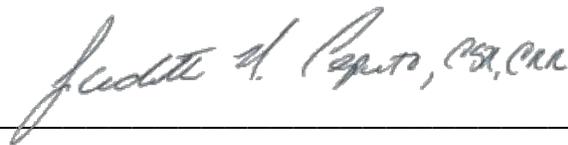
I, JUDITH M. CAPUTO, RPR, CSR, CRR,
Certified Shorthand Reporter, certify;

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

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

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

Dated this 18th day of February, 2021.



NEESONS, A VERITEXT COMPANY

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

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