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.

BEFORE:

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

PRESENTERS:

MEETING WITH KENSINGTON HEALTH:
John Yip, President and CEO, Kensington Health
Bill O'Neill, Vice-President of Residential and Community Care, Kensington Health

PARTICIPANTS:

Ida Bianchi, Senior Legal Counsel, Long-Term Care Commission Secretariat
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat

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

Alain Daoust, Team Lead, Long-Term Care Commission Secretariat

ALSO PRESENT:

Judith M. Caputo, Stenographer/Transcriptionist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO: Okay, thank you.

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

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

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

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

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

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

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

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

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

We are expanding that program from 10

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

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

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

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

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

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

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

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

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

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

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

come in twice a week, Thursday and Saturdays.

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

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

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

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

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

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

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

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

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

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

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

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

So that's I think just wrapping it in a

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

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

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

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

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

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

January around the security guards, which has us confused.

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

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

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

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

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

challenge to keep staff.

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

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

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

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

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

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

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

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

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

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

Typically renovating a whole building --

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

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

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

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

So our --

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

BILL O'NEILL: Palliative care isn't

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

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

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

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

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

help?

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

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

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

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

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

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

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

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

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

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

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

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

BILL O'NEILL: Of regulation.

COMMISSIONER JACK KITTS: Regulation?

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

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

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

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

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

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

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

beside the --

BILL O'NEILL: Yes, yes.

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

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

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

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

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

COMMISSIONER JACK KITTS: You obviously

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

BILL O'NEILL: A infection patrol practitioner.

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

BILL O'NEILL: Yes.

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

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

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

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

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

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

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

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

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

the costs of those beds.

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

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

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

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

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

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

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

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

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

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

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

JOHN YIP: I can start. Bill, you can

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

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

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

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

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

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

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

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

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

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

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

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

the unit, and start outbreak management in four texts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

very popular; he just started another one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I did some quick numbers. Just the

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

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

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

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

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

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

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

BILL O'NEILL: Right.

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

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

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

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

BILL O'NEILL: That's right.

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

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

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

already, so pre-pandemic, during the pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BILL O'NEILL: Right.

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

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

very effective.

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

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

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

(Connection difficulties experienced by the transcriptionist).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So having that personal connection,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BILL O'NEILL: Sorry?

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

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

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

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

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

COMMISSIONER JACK KITTS: Do you

compare results on the staff and resident satisfaction?

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

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

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

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

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

We don't have an MAC, a Medical

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

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

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

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

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

COMMISSIONER JACK KITTS: Does each site have on executive director then for the

on-site management; is that...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 beds.

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

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

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

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Coke?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

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

BILL O'NEILL: Absolutely.

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

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

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

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

it would be a better system.

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO: I

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

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

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

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

-- Adjourned at 10:16 a.m.

REPORTER'S CERTIFICATE

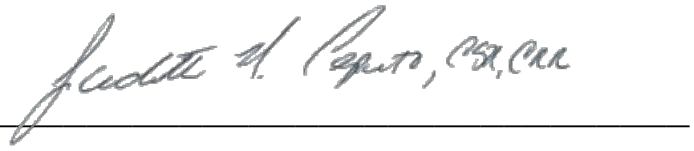
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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

That all 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.



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