Long Term Care Covid-19 Commission Mtg.

Meeting with Ontario Long Term Care Association, OLTCA
on Wednesday, November 25, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 25th day of November, 2020, 11:00 a.m. to 12:25 p.m.

BEFORE:

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

PRESENTERS:

Donna Duncan, Chief Executive Officer, Ontario Long-Term Care Association
Jill Knowlton, Board Director, Ontario Long-Term Care Association
Brent Gingerich, Chair, Ontario Long-Term Care Association
John Scotland, Secretary-Treasurer, Ontario Long-Term Care Association; Chair, OLTCA's Redevelopment Taskforce
Ruth McFarlane, Vice-Chair, Ontario Long-Term Care Association Board; Chair, OLTCA's Pandemic Advisory Council

OBSERVERS:

Wiesia Kubicka, Vice President, Policy and Operations, Ontario Long-Term Care Association
Tommy Wong, Director, Data Analytics, Ontario Long-Term Care Association

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 11:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So I guess everyone's here from the Association.

Let me just say, I'm Frank Marrocco, and there's Commissioner Angela Coke and Commissioner Dr. Jack Kitts. We are the Commission, and I think some of you would have been here before, so I won't go into it any further than that.

We have released one interim report. We are seriously considering issuing a second one. So we're very interested in this issue of the difficulties around development.

I will say this: If it helps in your presentation, we've been doing this for a while now, and we feel that there's some basic facts that we've kind of picked up, and you don't need to dwell on.

You know, there's a shortage. Reducing from four beds to two beds created an additional problem. There's projections which don't appear to have a chance of being met. We have kind of a feel for that, and so you can proceed with that in mind.

If you feel you need to tell us

something, don't worry about whether it's obvious or not -- just say it -- but we do have a basic bit of information now. And so you can perhaps get to the point of what you want us to understand a little quicker than would otherwise be necessary.

So with that -- and we will ask questions as we go along.

Ms. Arnaud is here. She's our court reporter. We have a transcript. We will post the transcript so that people who are interested in what we're doing will know what we're doing.

So with that having been said, we're ready when you are.

DONNA DUNCAN: Great. Thank you very much, Commissioners. We did provide a pre-read to you yesterday afternoon, and we have a shorter deck today. Looking forward to a conversation with you, and we certainly welcomed that approach in our first meeting with you.

We don't intend to speak to every single slide and certainly welcome the opportunity to dwell on slides where you have the greatest interest.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Duncan, my comment was prompted by the fact

that you had 52 slides on the one that I was looking at, so we're pleased to hear that.

DONNA DUNCAN: Yes, we won't do that. Yeah, there has been some repetition, and for us, we really want to make sure that we're answering your questions and helping to explain the best we can and certainly how the Long-Term Care Capital Program actually gets operationalized or not, as the case may be.

So today, we are joined by a number of our members: Brett Gingerich, who is the chair of the OLTCA; Ruth McFarlane, our vice-chair and also chair of our Pandemic Advisory Council; John Scotland, who's the chair of our Redevelopment Taskforce, which has been very active, especially over the last year; as well as supported by our staff team, Wiesia Kubicka and Tommy Wong.

Okay. So as with last time, you know, we do want to start by anchoring our discussion in people. So often and certainly in the media, everyone is talking about beds, when, in fact, these are spaces where people live, people provide care, people visit.

And so certainly, as we go through our presentation today, we'll always strive to bring it

back to the human beings and recognizing the complexity of our residents, the vulnerability of our residents, and the impact of COVID-19 on our very specialized and very frail resident population. Okay.

We certainly did want to highlight for the benefit of you, as Commissioners, the real mix of operating models in the province. Certainly, the majority of homes in the province and spaces are private.

But certainly as the media have unfolded and covered this sector, one of the pieces that's very clear to us that isn't fully appreciated is that we have a lot of very small homes in the Province of Ontario, both non-profit and for-profit homes, very small independent homes, especially in rural communities and smaller communities in the province.

So I think the media and others tend to focus on the very large operators, but we did want to flag and highlight for your benefit the scope of and the numbers of very small homes.

Next slide.

Part of our storytelling is the history of the long-term care infrastructure. Certainly,

there's greater awareness that we have a lot of homes that were constructed pre-1972 still in operation in the Province of Ontario. And certainly, we know that those older homes with three- and four-person rooms did contribute to some of the more catastrophic losses that we saw and tragic losses that we saw in the first wave.

We would highlight that in 1998, there was an eight-year plan to build 20,000 new beds and redevelop what they call the D spaces, the D class of homes. At that time, the B and C homes were not redeveloped. The focus on that program was the D homes, and those were largely municipal and non-profit homes. So B and C homes, you have certainly more private homes, and they were not eligible for the deep redevelopment program in 1998.

In 1999, the government of the day made a commitment to build 20,000 new spaces and to rebuild 13,000 D spaces and 10,000 spaces by 2006.

In 2000, the Long-Term Care Redevelopment Project Office was established by the government of the day wherein the government actually recruited an external consultant who came in and was placed in the Ministry of Health and

Long-Term Care to lead a project team whose sole mandate was to ensure that the 20,000 beds were built.

This person had a mandate to report directly into Cabinet, to work across all ministries, to work with other levels of government, and certainly work with municipalities and homes to ensure that the success of the program was very focused. It worked back from the dates that they wanted to get beds built, and therein was the success of the 20,000 bed program.

In 2007 --

COMMISSIONER FRANK MARROCCO (CHAIR): So, Ms. Duncan, let me interrupt.

DONNA DUNCAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): The eight-year plan with that kind of a navigator or -- that succeeded in realizing the goal?

DONNA DUNCAN: Yes, that supported it. Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. And the goal of 20,000 new beds was achieved?

DONNA DUNCAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

DONNA DUNCAN: In 2007, a new government launched a B and C renewal program, and from that program announced in 2007 2,100 spaces have been redeveloped to date. Between 2002 and 2006, we can say 10,000 spaces were added, and 10,000 spaces were redeveloped.

Next slide.

And certainly, the fact that the program hasn't been able to move forward and we haven't been able to redevelop the B and C homes, really, we are facing the challenges of aging infrastructure, and that has borne out in COVID-19. Certainly, we had cracks before COVID arrived. COVID shattered the cracks with devastating consequences for residents in our hardest-hit homes.

And, Jill, did you want to comment a bit on the aging infrastructures? Jill is a nurse and a clinical lead, and she's actually been doing a lot of work in -- she's worked in every class of home.

JILL KNOWLTON: Thank you, Donna.

Good morning, Commissioners.

When we look at the aging

infrastructure, certainly, we definitively know the higher risk and the tragic consequences of residents living in the B and C homes and particularly in the three- and four-person rooms; however, we have to also consider that it's not just around COVID. There are challenges to well-being -- resident comfort and well-being because of the aging infrastructure.

And I think by extension of that, we also have to consider the well-being of our families and our staff. So we look at well-being for our residents, for our families, and our staff, and we know when those three groups do well together, when they're person-centered together, that well-being increases for or improves for our residents.

So the older homes, the lack of privacy in the three- and four-bed rooms, there is -- one of the bill of rights, one of the resident bill of rights is around having the ability to have a private visit with a person of your choice, whether that's a friend or a spouse or whomever.

In the older homes, there just are not those private spaces to be able to achieve that resident right. And you can imagine, if you live

in a four-person room and you want to have a private visit with your spouse that that's likely not going to happen.

Shared washrooms: So three- and four-bed rooms are typically linked by a shared washroom, so you could have up to eight persons sharing a washroom -- again, the safety around that -- but those washrooms have narrower doorways. They don't have 5-foot turning radiuses, so if you get in, you can't get out.

And we typically cannot get the necessary equipment that our residents need to be able to use the toilet, so a lift that would support you to get on the toilet or commode-type of chair. So we have residents living in these older homes that cannot use a washroom. You either have to use a commode beside your bedside in a four-person room with a thin curtain around you, so there's not much privacy there, or you have to be taken down a hallway to a communal washroom.

And you can imagine at midnight, if you just want to get up and go to the washroom, to be taken down the hallway and back is a big exercise. And again, your sleep is going to be disrupted. So there really is a huge issue around privacy in the

older homes.

Lack of comfort, we know about; you know, no centralized heating and air conditioning. Certainly, we heard a lot about the air conditioning this past summer.

But congregate living spaces, congregate dining rooms: None of us were raised or grew up in homes with 60-, 70-, 80-seat dining rooms and served every meal restaurant-style. And yet, typically, you have these very large congregate settings.

Residents do well in terms of weight stabilization, not having to use supplements, being able to focus and not have other behaviours occur when you're in smaller spaces, smaller dining areas, smaller living areas.

Limited elevator capacity: Often these older homes have aging elevators, and there may only be one elevator. And I have an example: I'm living right now in a C home where the elevator's been down for ten weeks, and the residents who live on the second floor have not been able to leave that second floor for over ten weeks because of that aging elevator.

And, of course, electrical and

mechanical systems that would require homes, really, to be deconstructed to be replaced and, again, on old, aging infrastructure, that just is not a reality.

Storage areas: It's important for our staff -- again, I talked about staff well-being being equally important -- to have access to resident supplies and equipment. And for that to be in a convenient way and organized logically for good work flow, that does not exist in the older homes because there just is no storage.

And for residents coming into homes, leaving your own personal homes and moving into their new home typically are not able to bring those items that have meaning to them. We all have things in your lives that have meaning to us and for us and that really communicate a sense about who we are as people, as persons. Those things typically are left behind and cannot be allowed. I'm going to use the term "allowed" but enabled to be used because you have 25 percent of the space in a four-person room. So a lot of who you are is left behind when you come into long-term care.

And then in terms of staffing, space for staffing, very limited space for our staff to

be able to step away, to take a break, to store their -- you know, locker areas to store their personal belongings. And I would want to -- I just want to focus on the access to outdoors as well.

Again, certainly through COVID, we heard a lot about the importance of fresh air and being outside, but we also know, supported by evidence, that access to natural, outdoor space is important to all of us for our well-being. And again, if you live in an older home, you don't necessarily have access to nice, outdoor, natural areas where you can enjoy nature and just being outside.

Smaller rooms and hallways: So residents today have a lot of equipment at times that are associated with their care. You may have a ventilator. You may use oxygen, for example. If the room or the space that's available is in a three- or four-person room, you may not be able to come in to long-term care because we can't support your equipment needs in the space that's required.

If we can, that equipment can be noisy, it can generate a lot of heat, and typically staff have to come in more frequently if you're supported with that type of equipment. And so it can be very

disruptive to your roommates, disrupting their privacy and, you know, really interrupting their sleep and their rest with that equipment.

As well, in hallways: Again, narrow hallways. There is no storage. So the necessary equipment for staff to care for residents safely -- lifts, linen carts, garbage, dirty laundry hampers, for example -- are all lined up in narrow corridors.

There is an evidence-based strategy in a falls reduction program, and that's called decluttering, and yet we cannot declutter because this equipment has to be accessible to our staff, again, to be able to provide safe care, and it lines the hallways.

And if you're a resident who's trying to navigate a narrow hallway with all those carts and lifts and things lined up in the hall down to the large dining room, for example, for meals, this can actually be a hazard and can actually challenge you to be able to safely navigate down the hall.

Again, we also consider staff. It also impacts our staff's ability to be able to function and to be able to do their jobs safely.

So I think COVID-19 has opened --

really, I was going to say the window but I think it's the door, wide open on the challenges of the older homes and particularly the three- and four-person rooms; however, those issues have been very real and very apparent for a long period of time. And we need to be looking at designing these homes for the future and getting these homes built for the future, for this generation, the next generation, and likely the generation after that. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah, just a question about the Ministry of Labour inspectors and even the long-term care inspectors.

JILL KNOWLTON: Mm-hm.

COMMISSIONER JACK KITTS: Clearly, this is, as you said, a hazard to staff and patient safety, and I'm just wondering how they adjust for it because I know that in other places, they would have to have that fixed.

And I don't know whether you have a grandfather clause, or how is this managed at that level?

JILL KNOWLTON: So, Dr. Kitts,

typically what happens is we try and line everything up on one side of the hallway and keep the other side of the hallway clear, but again, these are narrow hallways, so it creates definite challenges around safety.

I think, again, Ministry of Labour, fire inspectors as well, it -- there is nowhere for this equipment to go, and this is equipment that isn't sort of used infrequently or may be. This is necessary equipment to provide resident care on a 24-hour basis, so it has to remain in the hallways.

We try our best to be able to tuck things in. You know, we'll get our baths done, for example, and then once the tub room is -- or the spa room is finished being used for the day, we'll try and tuck everything that we can into those types of rooms.

But again, when you're the staff member and you've got, you know, 10 or 12 residents that you're providing care for, you can't be running down the hall for your laundry hampers, for example, or for the lift.

Sometimes, Dr. Kitts, I would like to say, this equipment gets put into resident rooms. That's the reality --

COMMISSIONER JACK KITTS: Yeah.

JILL KNOWLTON: -- because there is no space.

COMMISSIONER JACK KITTS: I'm just wondering whether they report that it's unsafe and will be fixed sometime down the road, or they don't report it because they understand that that's just the way it is?

JILL KNOWLTON: I think it's noted. I think it's discussed. I think there's an understanding that this is the current condition, but I wouldn't say that it's necessar- -- I mean, they know that there are no options.

COMMISSIONER JACK KITTS: Okay. Thank you.

DONNA DUNCAN: So certainly, as Jill noted, the pre-existing state of our infrastructure had a tragic impact with COVID-19 in our older homes. The intensity of the outbreaks was more than two times higher in B and C homes versus new to A homes, and three times higher in those three- and four-person wards versus one- and two-person wards.

And as we review the IPAC assessments that had been done by the hospitals, by

Public Health, and also by the Canadian Forces, the risks identified were the limited ability to social distance and isolate with the ward-style accommodation; those shared washrooms and limited dining areas; lack of space for staff to take breaks; to don and doff their personal protective equipment; insufficient in-room wash basins for hand hygiene. The only wash basins are actually in the residents' rooms, those cluttered, congested rooms with minimum storage and space for daily environmental service cleaning, carpeting, and upholstery and common spaces.

We have to remember, going back to our first slide, that these are people's homes. And the tension between the clinical environment that you would find in an acute setting versus a home environment really highlighted the gap around what long-term care is today and who our residents are today, especially within the context of a highly virulent disease.

COMMISSIONER FRANK MARROCCO (CHAIR): Did the Association have a standard in terms of how much personal protective equipment, for example, you should have on-hand? A best practice, perhaps, or something of that nature?

DONNA DUNCAN: Yeah, Jill, did you want to speak to the requirements?

JILL KNOWLTON: Sure. Thank you.

So out of H1N1 in 2009, we created sort of about a three-month supply, stockpile of PPE onsite, and most homes followed that.

But as the supply chains were opened up and -- you know, we really are on a 24-hour ordering system. You know, we place our order today; it'll be on our loading docks by tomorrow morning, and again, we're challenged with storage and space. Often, you know, we would have to store things off-site or in a sea can, that sort of thing.

We went more to -- a three-day supply would sort of be the minimum because -- and where did three days or 72 hours come from? It came from if you ordered today from your supplier -- or sorry, if you ordered on a Friday, it would be on your loading dock by Monday. So you would never -- it's sort of a just-in-time ordering system.

And a lot of us went -- or a lot of homes went to that approach because, again, the supply chain was really wide open, and we are severely challenged by space for storage.

The other thing is is all this product has expiry dates on it. So again, to be able to manage that and to make sure that we're not wasting, you know, supplies was an important consideration.

COMMISSIONER FRANK MARROCCO (CHAIR): So then, do I have it right that once it becomes clear that this is an infectious disease, it's going to spread all over the world --

JILL KNOWLTON: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- it's kind of too late to start purchasing personal protective equipment because the whole world is trying to buy it?

And so the supply chain, that same-day or just-in-time-inventory approach won't work anywhere because the whole world is trying to buy it? So...

JILL KNOWLTON: Yes, absolutely. So we understand that just does not work, and I think as well, we understand the -- I mean, none of us understood the extent of this pandemic and the impact or effects it would have on our homes.

And so when we started in March to be looking at burn rates, for example, if you were

COVID-positive or you were a COVID-negative home, we were starting to be able to put together some of those calculations and those numbers around burn rates.

I just would like to emphasize, though, that that's not the role of the Association. The role of the Association was to provide advice to operators, but we don't actually set standards.

But as operators, certainly, we began to understand the requirements and the burn rates.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I didn't mean to imply that the Association should have set a standard. I was just curious as to what the generally accepted practice was --

JILL KNOWLTON: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- and I think you've described to me what happened, which I can understand.

JILL KNOWLTON: Yes.

DONNA DUNCAN: Okay.

JILL KNOWLTON: Okay.

DONNA DUNCAN: Next slide.

You know, certainly with the existing state of the capital, and now, certainly, the increased awareness on the state of long-term care

homes across the province, especially those older B and C homes where we have over 32,000 residents currently residing with almost 11,000 of them in those three- and four-person rooms, we have been advocating for the last year for an expedited capital program.

We believe our seniors deserve better, and certainly looking back to the program model that was used to move the process forward in 2000, we really believe that we have to work together in partnership with government to advance these projects.

Next slide.

As we are looking, the Government of Ontario made an announcement last week with regard to 29 new projects, and as we look at the number of spaces to be redeveloped still, we need to move those projects forward. The commitment made on Friday for new and redeveloped beds will -- once they move forward and are achieved would serve to meet half the government's commitment of 30,000 new and redeveloped beds in the Province of Ontario.

In Phrase 1, approvals given in 2018, '19, there was an announcement for 6,796 beds. The approvals that went out last week allow for 1,015

beds. We'll still have 23,888 beds or spaces in older B and C homes across the province and would draw your attention to the map where the darkest green areas indicate where the greatest pressures will be in those homes. And you'll note that they're largely in rural communities.

COMMISSIONER FRANK MARROCCO (CHAIR): Do I have that right, though, that those are redeveloped, or are they new?

DONNA DUNCAN: The government has announced redeveloped beds and new beds.

COMMISSIONER FRANK MARROCCO (CHAIR): So when you say the number of B and C spaces to be redeveloped, that's 31,000 beds that already exist but are going to be redeveloped?

DONNA DUNCAN: That will need to be, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): So am I correct, then, in understanding that that will not increase the supply or increase the number of beds? It will improve the quality of it, and so on, but that's no more beds than we had before; they're just better beds?

DONNA DUNCAN: Yes, those are the B and C beds that would need to be replaced in order to

bring them up to standards, and then we will need additional beds. The Provincial Government announced that they were committed to building 15,000 new beds in addition to redeveloping 15,000 beds.

COMMISSIONER FRANK MARROCCO (CHAIR): So that's a commitment to build 15,000 new beds that's given in an environment where, over the period 2011 to 2018, they created 611?

DONNA DUNCAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. All right.

DONNA DUNCAN: We note too that part of the challenge that our members face is that all B and C homes will have their licenses expire in 2025, and so if we don't redevelop the remaining beds, that will result in a potential loss of 24,000 spaces from the system at a time when we have 38,000 people on a wait list.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you think it's likely -- do you think it's likely that they would do that or that they would just extend the licenses? It seems to me it would be a funny thing to do with a 34,000-person waiting list, to just take them off the market. It would

make more sense to extend the licenses. That's not necessarily better for the residents, but that seems to me what they would likely do.

DONNA DUNCAN: Our sense is that they will have to find some means of mediating the impact. The challenge is the predictability. In addition, the challenge is investments that are going to be required on those spaces.

The majority of those homes are not sprinklered, and there's a requirement that, beginning in 2025, all homes will have to be sprinklered for fire protection purposes.

Brent, did you want to speak to that?

BRENT GINGERICH: Yeah. Certainly, it would be very unfortunate if these homes were not redeveloped by 2025. Jill has clearly illustrated, I think, the limitations to the homes, and as we've seen with COVID, the severe limitation to these older homes. And it's quite unfortunate that it's been left as long as it has.

The C homes under the new Long-Term Care [Homes] Act in 2007 were given that timeline of 2025. And we've really had since 2007 for the government to develop a workable program to rebuild those homes by 2025 that started in, again, 2007.

And, you know, the spaces that have been redeveloped, for instance, between 2012 and 2020 are only 2,124 of them. So certainly, this needs to be a priority and should be a priority.

But to answer your question on -- I don't think it -- you know, there is provision in the Long-Term Care Homes Act to extend the licensed term a slight bit as a potential tool or contingency plan, I suppose, if these homes are not all redeveloped; however, there are, you know, again, limitations in the Building Code, which will definitely not be changed with regard to sprinklers, as Donna mentioned, and a mandatory sprinkler requirement in 2025.

I don't see that changing; however, you know, it's quite disruptive to install sprinkler systems into these older homes to the residents. So, you know, certainly, we should all be focused on rebuilding them by 2025.

DONNA DUNCAN: Thank you.

Next slide.

So as we look at the B and C home renewal, the key timelines, we've had a lot of announcements. 2007, the Long-Term Care Home Capital Renewal Program was announced for 35,000

B and C spaces.

I also note that, in 2007, the government of the day also initiated its aging-at-home strategy, and while significant investments were made in the aging-in-home strategy, both in hospital and home care, there were no investments made to advance the Capital Renewal Program.

Certainly, further announcements in 2009, 2014 with new funding announced.

There was a survey done in 2015; a market sounding in 2018; a call for applications in 2018 to redevelop and award new beds, wherein 7,000 spaces were approved to be developed; and updates on the Construction Funding Subsidy in 2019 and a recommitment or confirmation of the commitment to redevelop 15,000 beds and build 15,000 new spaces.

And then in 2020, we now have the Long-Term Care Modernization Capital Program announced with an increase in the construction funding subsidy, an upfront development grant with approximately 1,000 spaces approved to redevelop and 2,000 new spaces approved.

And so we certainly have a lot of work to do, and you can see that the program really has

failed to progress since 2007.

COMMISSIONER FRANK MARROCCO (CHAIR): There's no shortage of announcements. There's just a shortage of beds.

DONNA DUNCAN: Yes, absolutely.

Next slide.

And certainly, Commissioners, you're aware of the demand that we're facing with our 38,500 on our current wait list. We know that over the next 15 years, the population over 80 in Ontario will double. We're certainly seeing the complexity and the level of acuity of our resident profile increase, and we really are going to have to look at what long-term care more broadly means.

You know, we know that it takes us three to five years to construct a new home. We know that it takes us -- we also know that we have to staff new beds and new spaces, and we have a critical staffing shortage today. We know it takes four years to educate a nurse.

And certainly, looking at the care needs of our residents, we need to make sure that as we're thinking about what the demand is going to be, what the system response is going to be, we also have to look not just at the construction but

the staffing considerations as well and how we're going to meet the needs of our population.

Next slide.

Again, just indicating that if we look at just an existing demand today around our wait lists and looking at the acuity of our residents, we could potentially be looking at 174,000 seniors on wait lists in Ontario. We do need to look at things in a -- we need to look at long-term care within the context of the broader healthcare system, and certainly we're seeing that.

Long-term care was largely ostracized from the healthcare system, and the fact that we were not integrated into the care pathways clearly has created enormous challenges for us, but we would demonstrate that we actually need to move quickly, and we need to move purposely to ensure that we're able to support the needs of our aging seniors.

COMMISSIONER FRANK MARROCCO (CHAIR): Why was it ostracized, in your opinion?

DONNA DUNCAN: Certainly in -- and I'll say my opinion. I'll let my members speak for themselves, but certainly, I think philosophically, the government, the previous administrations were

very committed to aging in place and were very, very focused on that and investing in home care and investing in hospitals to the exclusion of long-term care.

Certainly, there is stigma associated with the long-term care sector. Really, we fail. We fail as family members if we can't continue to care for our loved ones at home. We fail as individuals if we can't look after ourselves. In our long-term care homes, our staff feel any time they have a complaint and call the inspectors and the inspectors come in, they can only fail.

We've really created and fostered a culture where we don't want to talk about it. We don't want to look at it. We know that most people don't have an appreciation for what long-term care is or what the experience is unless they have an interface with it themselves, and we've allowed that to perpetuate. Our decision-makers have allowed that, and society has allowed that to happen.

I believe that we do need to be better, and we need to be more thoughtful. I would suggest too that some of the politics around ownership has been problematic where previous administrations or

governments did not invest in the sector, given the mix of ownership in the sector. So they followed the path around their philosophy of making sure that everybody can have the right to age in home without acknowledging that, unfortunately, there are those who cannot continue to receive care in a home environment.

COMMISSIONER FRANK MARROCCO (CHAIR): Even if you do age in your home, you reach a point, perhaps, where you just need help 24 hours a day, and it's very expensive to have a personal support worker three shifts a day, seven days a week.

DONNA DUNCAN: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): I mean, it's not hard to figure out.

DONNA DUNCAN: Yeah, absolutely.

And, Ruth, did you want to add anything?

RUTH McFARLANE: Hi there, sorry. No, I just -- I think also a lack of general understanding about what we do in long-term care because we do very specialized care, individualized holistic care for our residents. I think that the lack of understanding of what type of care we provide has contributed to that, you know, the very

siloed effect from the acute to the long-term care to the community care.

DONNA DUNCAN: Mm-hm. I --

COMMISSIONER JACK KITTS: Can I just ask, Ms. Duncan: I understand your opinion on ostracize, and I wonder if -- you know, a decade ago, there was a very strong belief that 20 to 30 percent of residents in long-term care homes did not need to be there. And so there was the home first and aging at home in Ontario strategies that have been clearly quite successful in terms of home care but, like you say, perhaps at the expense of long-term care.

My question to you is what would you or your colleagues say is the percentage of residents in long-term care homes today, a decade later, versus the past, and is there still room at home, or has the investment now got to be more increased in long-term care?

DONNA DUNCAN: I'll opine first, and then I'll pass it over to Jill.

Certainly, I would say that we need both. We need to invest in -- when we look at the demographic projections and recognizing people who're living older, we need to invest in home

care. We need to invest in long-term care. We need to invest in community care, mental health. Unfortunately, it's -- we need to make sure that we're building all the pieces together but building them in a way that connects them.

One thing that certainly challenges us right now as a sector is everyone has an opinion on how to fix long-term care, and each authority is coming with their own specific lens about -- and bringing their view either through a hospital lens or a medical lens when we do need to have a discussion where long-term care is an equal voice and an equal partner in the discussion around what is long-term care. What does long-term care need to look like, and how are we collectively going to work together to embrace our collective responsibility to support our seniors?

Jill, did you want to weigh in?

JILL KNOWLTON: Thank you, Donna.

And I think it's really about what is the definition of long-term care in Ontario. So still largely an institutional definition, and again, we know from when we could travel, when we could get on planes and travel, we would go to other areas of the world -- Denmark, Holland,

certain pockets of Japan -- where there's some real innovation around communities, around healthy aging communities, and support. And their definition of long-term care does not just focus on institution.

But again, if you look at adult day services, adult day services can provide long-term care-level services, and yet you go home. Where most people want to be is they want to go home. So it plays an important role.

I think there's a huge role for primary care in this as well, and again, you know, how do we move from community to primary care to specialized geriatric services? And specialized geriatric services still sit typically within hospitals, within a medical model, and how does that -- again, if you look at redefining long-term care, how do you move those services out into the community and into long-term care settings?

I also think that the siloed approach for long-term care, and again, largely having spent nearly a 38-year career in long-term care, somewhat speaks to our values as a society and where we put our efforts and what we fund and what we don't fund, and again, around the importance of equity at all ages and stages of life and particularly for

the vulnerable adults we care for at the end of life. And so sometimes those investments have not been there to develop.

And so, you know, it's limited and it's kept us siloed, but, you know, largely constrained by resources as well.

COMMISSIONER JACK KITTS: Do you think the Ontario Health Teams will help the integration and take down the silos and provide resources?

JILL KNOWLTON: I was really excited when I saw the OHTs, but I think they're local networks. I think that's the only thing that concerns me is that, you know, do local networks have enough to be able to move that needle, or does it need to be a larger policy, you know, driven more largely by policy?

I hope -- I mean, structurally, I would hope that the OHTs would contribute to that integration, but again, I see maybe a larger policy being required around that as well.

COMMISSIONER JACK KITTS: Thank you.

JILL KNOWLTON: Thank you.

DONNA DUNCAN: One other point that we would make to your question: The criterion for admission into long-term care was changed in 2010,

which required a higher level of acuity for placement.

And so, today, we do see a far-more acute population among our residents, and our length of stay is much shorter. So we are now seeing a length of stay that is under two years, and in many cases, even less than a year.

COMMISSIONER FRANK MARROCCO (CHAIR): So when they started this aging at home, was there a shortage; do you remember?

DONNA DUNCAN: In long-term care?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

DONNA DUNCAN: I'm going to ask John Scotland because he'll know that answer.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, I think you're on mute, Mr. Scotland.

JOHN SCOTLAND: My apologies. Yes, my recollection at the time is the wait list was in the neighbourhood of 24,000 when the aging at home program was implemented.

And the change in admission criteria cut that wait list, I believe, down to about 16- to 18,000. But as you can see, even with the change in the admission criteria, which are based on MAPLe

scores which is an assessment criteria, that list has now grown to, you know, 38,000, so...

COMMISSIONER FRANK MARROCCO (CHAIR): But -- yes. No, go ahead.

JOHN SCOTLAND: No, go.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it just seems to me that there's a shortage, so then we have a policy of aging at home. There's a shortage, so we changed the definition to make it harder to qualify.

And yes, I suppose you could say the waiting list was reduced, but -- you know, that's true --

JOHN SCOTLAND: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- but it's not reduced in the way that one would have preferred to reduce it.

JOHN SCOTLAND: That's right. They were redirected.

So to the earlier question, and I believe it was Dr. Kitts, on the number in long-term care that could have been cared for at home, I believe at a time that was true, that with the change in admission criteria, that has now decreased significantly. You know, I believe that

at a time, it was 20 percent; however, I have seen that number come back up again in a study that was released in 2016, 2017, but it was based on old data, if you actually research it.

And so that is no longer the case, and I believe CIHI reports on that number, and I believe that number is in the 5-percent-or-less range. And that's not based on new admissions; that's based on people who have been in the system for quite some time.

DONNA DUNCAN: Thank you.

And we would note that the current wait time is up to six months.

JOHN SCOTLAND: On average. Although, I admit, we have homes, it'll take you four and five years to get a bed.

DONNA DUNCAN: Thanks, John.

So as we look at the barriers to redevelopment, we've really grouped them in three categories: The inability to secure financing due to insufficient capital funding or unstable operating funding; the ability to secure land -- especially in urban centres, there's a shortage of zoned and affordable land and unworkable process; insufficient, unpredictable, and opaque processes

crossing multiple levels with government and ministries.

And the government controls the processes of approvals. Homes just can't go and build a new home or redevelop a new home. They must have government approval in order to proceed to redevelop.

COMMISSIONER ANGELA COKE: Can I just ask a question about the -- you mention here unstable operating funding.

DONNA DUNCAN: Mm-hm.

COMMISSIONER ANGELA COKE: Can you just elaborate a bit? When you say "unstable," just explain that part to me.

DONNA DUNCAN: So perhaps if we go ahead to the funding model slide? There. Go back. There.

So the funding model for long-term care, I'm going to ask Brent just to speak to this, and he can walk through it. It's a very, very complex funding model, and over the years, the funding envelopes are highly reconciled, and as well, the funding envelopes have been reduced.

So we did face a number of cuts last year as well, but I'm going to let the accountant

speak to the numbers.

Brent?

BRENT GINGERICH: Thank you. To try to answer your question about the stability of the funding, you know, sort of the budgets -- I guess the short answer is the Provincial Government controls all aspects of our funding envelope through quite a structured system. And the budgets can increase or decrease on a yearly basis, and that's kind of what we mean about instability. And if we looked, you know, over the years to the changes to the system and such, it's been somewhat unstable.

So when we're talking about creating a large, you know, infrastructure program to build 45,000 new spaces by 2025, it requires a stable, predictable funding system in order to do that.

So this is our funding model, illustrated. Essentially, there's a few envelopes, what we call envelopes, and those envelopes are categories of revenue and expenses that need to be matched together. So, for instance, nursing and personal care would include direct staff salaries and benefits and essentially nursing and medical equipment and personnel, and those revenues are

matched against the expenses in those areas.

So those revenues cannot be spent on any other item except those areas, and if there is a surplus at the end of the year, it gets clawed back by the government.

So these three areas, nursing and personal care, programs and support services -- which is your therapy and recreation staff -- and then your raw food, all those three areas are essentially a fixed envelope. And any surpluses are clawed back at the end of the year, and surpluses are not allowed to be retained into any type of restricted fund or any such contingency fund. They're simply just taken away at year-end.

And then there's what we call the other accommodation envelope, which is largely funded by the resident co-payment. So the residents co-pay a portion of the revenue that we receive, and those services are what you might encounter in a hotel, let's say: So dietary, housekeeping, administration, capital expenditures, spending on financing costs, mortgage payments, and those types of things. You know, you're allowed to run a surplus in those areas.

In addition, there's some other

supplementary funding streams that are, you know, intermingled in each of these envelopes, but that's the Coles Notes version.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm just a bit confused by the chart because there's a box around "Raw Food and Other Accommodation," and it says at the top:

"Funded through resident co-payment."

So is raw food funded by the co-payment or by the Ministry, or how is it funded?

BRENT GINGERICH: Yeah. So, essentially, it's the Ministry setting the policy around raw food funding. So there's a number of revenue that we receive that's dedicated toward raw food expenditures. I guess the costs are offset by the resident co-payment, but we essentially, you know, receive that money from the government, and then it's partially funded by the resident co-payment. So [inaudible] --

COMMISSIONER FRANK MARROCCO (CHAIR): So the resident co-payment funds a part of the raw food cost, and the government funds a part of it.

But is that raw food cost dedicated? So if you don't spend it, it goes back to the

government or goes back -- does it go back to the co-payment, to the resident co-payment as well?

BRENT GINGERICH: So the raw food, if there's a surplus, that gets clawed back at the end of the year.

COMMISSIONER FRANK MARROCCO (CHAIR): But if part of it's paid for by the resident co-payment, is it clawed back to the co-payment or clawed back to the government? How...?

JOHN SCOTLAND: Goes back to the government.

BRENT GINGERICH: Yeah, it's clawed back by the government, so essentially -- you know, the resident co-payment can vary as well depending on a resident's ability to pay.

So there may or may not be subsidization intermingled into that revenue for raw food. So the government would provide some money, and the residents would provide some money, but essentially, the government is fixing a number where they essentially -- you know, if you have 97 percent occupancy, then you get 100 percent of your funding for raw food.

COMMISSIONER JACK KITTS: Do all --

BRENT GINGERICH: Does that explain it?

COMMISSIONER JACK KITTS: Do all residents pay something?

BRENT GINGERICH: So depending on a resident's ability to pay, they may not. So they -- you know, for instance, if someone is on a fixed income, getting, you know, Guaranteed Income Supplement and Old Age Security pension, their rates are essentially geared toward their income.

If someone has zero income, maybe they don't qualify for those welfare streams that -- you know, then the government would subsidize their accommodation portion.

COMMISSIONER JACK KITTS: So there is a minimum co-payment, and if the resident can't do it, the government meets it?

BRENT GINGERICH: That's correct.

COMMISSIONER JACK KITTS: Okay. Thank you.

COMMISSIONER ANGELA COKE: So, sorry, I had one last question. On the instability issue, so there's a formula that's predictable.

The unstable part of it or the unpredictable is that there may be cuts?

BRENT GINGERICH: Correct. So --

COMMISSIONER ANGELA COKE: And so what

have been recent cuts that you've had to experience that you wouldn't have been able to predict were coming?

BRENT GINGERICH: So, for instance, the -- you know, Pharmacy Medication Management Program has been restructured to essentially -- it's essentially resulted in a cut to our service levels in the medication management area. That happened just recently, about a year ago, just before COVID-19, coincidentally.

In addition, our nursing and personal care funding is -- the needs go up every year. So, you know, with wage increases and inflation, certainly there's cost pressures; as well, our level of acuity, so we can track our level of acuity year over year, and it tends to go up a percent or two every year.

So if we're not getting increased funding, we're essentially getting decreased service, right? So as acuity levels go up every year and inflation goes up every year, if our funding doesn't go up every year, we essentially lose ground on the care side.

DONNA DUNCAN: I think John and Ruth also wanted to comment.

JOHN SCOTLAND: Sure. Go ahead, Ruth.

RUTH McFARLANE: That's okay. I was just going to add: The conversation that we have had prior, just as a reminder, the acuity of our resident population is measured annually. And then if you can recall, it is re-indexed.

So there's a pie of funding that's provided by the Ministry of Health, and even if the acuity of our residents goes up, the pie is still the pie, and so there's a re-indexing factor that gets applied to our funding model. And we're not aware of what that is until it's announced.

And even though our acuity continues to go up, the unpredictability of that funding following the acuity provides the instability.

John?

JOHN SCOTLAND: So as you've gathered, it's a very complicated funding model, but if I can offer just a couple of clarifications for you.

So basic accommodation rate, the co-pay that a resident pays is $62.18; that's for a basic bed. The raw food and OA envelope funding amounts are approximately $66, so you see there's a $4 differential to it.

So yes, the resident funds a portion of

those two envelopes, but that's not actually how it works. The government funds us the per diems, we collect the money from the resident -- which may or may not be rate-reduced -- and it offsets the cash flow. So I probably just made it more complicated.

With regards to the regular increases, yes, there are regulated increases for the co-payment -- they do go up by inflation each year -- but that doesn't necessarily remain with the operator; in fact, historically, only a fraction of that increase has remained with the home. To fund those costs, the government has taken that back and put it back, essentially, into Ministry funding. So that's not...

And just around the instability, unpredictability, if I could just offer an illustration: In 2002, the nursing envelope was funded at $52.38. Today, it's at $100.26. That's 18 years later. It has not quite doubled.

The OA envelope was funded at $40.21. It's currently at $56.16. It has gone up $16 in 18 years.

Raw foods, a similar challenge: It was $4.49 back in 2002, and in 18 years, it has only increased to $9.54, and I know that, you know, we

all go shopping in the supermarket and we know where the prices of food have gone.

It is not only unstable and unpredictable, but it remains a real challenge to operate within these constraints.

JILL KNOWLTON: Could I add one point as well around the instability, please?

So the funding notices can be delayed several months into a calendar year, and we can receive our funding notice, let's say, in August retroactive to April 1st funding increases.

So we get that retroactivity where we're left with -- you know, we receive a large amount of retroactive funds, but between August to the end of the year, we don't have an ability to be able to spend all of that money. So we end up paying it back, which doesn't make any sense.

What we need is stable funding that's clearly consistent and smoothed across all 12 months and not just sort of these big pots that come retroactive very, very late in the year because our residents need stable funding for care year-round, and this happens year over year over year.

So again, we don't have an ability to

be able to spend all that retroactive money, or, you know, you go out and spend it on things that you don't really need. That money needs to be spent on care.

DONNA DUNCAN: Thanks, everyone.

I think that if we could amplify a number of things, our residents and their families believe that the full co-pay goes to the home and that's it's at the discretion of the home to spend those funds on their behalf. There isn't a full appreciation that the government actually controls those dollars, and homes don't have the discretion, in large part, to allocate them as they would want.

Similarly, in addition, [inaudible] amplify that in the other accommodation envelope, those funds where there are surpluses, those funds are used to service their mortgages and their debts as well as all of those other regulated elements that the government mandates be funded through that envelope.

Again, so much of it is regulated. It's controlled. It's reconciled. There's not a lot of discretion. One thing I've learned, certainly new to this sector, we talk a lot -- and you heard it through John when we were talking

about pennies. We were talking about cents.

You know, this is how -- unfortunately, the funding is not mapped to the needs of our residents. It doesn't contemplate the high level of acuity of our resident needs. It really is built -- we have this static funding model that has been locked in, and if anything, it's become more complicated over time.

We've got these old buildings that have been locked in time as well, and if there had been changes in our sector, the changes are to who we serve, our residents, and our changes that we are losing staff to support them. And we're not funded to actually have the level of care staff that we actually need in our homes. But again, our care model is prescribed by the government as well.

With that, we will move on -- I'm mindful of the time -- to the economics of the Capital Program because we are here today to talk about capital as well and recognizing that we do need more spaces for our residents.

I'm going to ask: John, would you like to speak to the economics of this?

I think, overall, our members are in long-term care because they care. They care about

people. They have a social mission. But we do need to make sure that if we're going to have a viable sector, we need to make sure that all of these pieces actually work together.

John?

JOHN SCOTLAND: They do, indeed. If I could just touch on that as well: I work for a family company; I'm not a family member. I've been here for 20 years; the company's been in business for 57 years. Opened their first long-term care home in 1970. It turned 50 years just two months ago. It is a C home. It is known for great care, but it is small and it is old.

And we have been -- we've had it on our redevelopment agenda since 2007 when that first program was announced. We just haven't been able to find a way to make the economics work. We would love redevelopment. We have a large presence in the community. The people who work in that home, the people who live in that home are like family.

But at the end of the day, it takes financing. We need to find a lender who'll lend to us and we need to put equity into that home and we need to be able to run it and maintain it for the next 30 years. And so we need a program that will

actually make that happen.

When we built our four homes in the early 2000s, part of the 20,000-bed build-out, it cost us an average of $120,000 a bed. Today, it costs us $285,000 a bed to build those, and yet the funding has gone from 10.35 to $18. It's just not reflective of the cost, and the challenge right now is that cost is going up at a significant rate every single year because of the pressure on the construction industry and the cost of materials that go into it.

At the end of the day, we need a program. We need it now. We need it robust enough to make the process work for, as you've seen, you know, 24,000 B and C beds and a government commitment to rebuild 15,000 new beds at that same time.

And right now, there are a number of challenges that need to be addressed in order to make that happen, and it's the government who has the levers to implement them.

Could we flip ahead to...?

DONNA DUNCAN: Yeah, I think one of the key pieces is that in long-term care, the homes actually bear the risk. So it is either

individuals or the companies who actually have to finance 100 percent of the project upfront, and they bear 100 percent of the loan guarantee for the full redevelopment as well.

So unlike in hospitals where the hospital may be responsible for having 10 percent of their share and the government would finance the rest, in long-term care, the financing is secured by the home who is developing or redeveloping. They have to secure the lender. They have to either secure a mortgage or secure the equity, regardless of ownership, other than municipal homes, who have the benefit of the tax base. For our non-profit and our private homes, the onus is on them to make sure that they have the pieces in place to secure a lender.

Brent, did you want to touch on the process?

BRENT GINGERICH: Sure.

DONNA DUNCAN: Equity?

BRENT GINGERICH: Yeah. So as Donna mentioned, in order to build a home, we need to go out and get a loan. So a loan is essentially -- you know, it could be a bank loan or a loan-type of mortgage, as well as there's equity that's required

to invest. So that's the -- and in return for making that investment, the operator received an annual revenue payment.

So there's really minimal grant money here. If it was more like a hospital model where, you know, the majority of the money was financed by the government in a grant as opposed to a loan in equity, we would need about $13 billion in capital to build these 45,000 new beds that we need by 2025, right?

So it's really a -- it's a way to manage, I think, the financing of that. You know, the tax base just is not large enough to grant that amount of money. So the structure that was put in place is to provide an annual funding stream by the government and then have the operator go out and get a loan and provide equity to build that.

So when the operator builds a home, all that money goes in, and the revenue does not start until the home is complete. So the operator bears the risk of the construction project entirely, and it's not essentially -- it doesn't essentially receive any funds from the government until the home is actually built and then inspected and ready for occupancy.

DONNA DUNCAN: Thanks, Brent.

So with that, we will move over to just our process map so you can have an appreciation of what's actually involved in building this. And this schematic was developed by our Redevelopment Taskforce over a period of days.

Ruth, would you like to speak to this now?

Now, Ruth is the head of Durham Christian Homes, which is one of our non-profit members, but she is uniquely one of the few people in the province who is in the process of opening a new home.

Ruth?

RUTH McFARLANE: Sure. So as you can see on this mapping, that is a very long and inefficient process, and it's very frustrating. It has multiple levels of the Ministry attempting to work through the process, and unfortunately, those different offices don't always speak to each other.

And then, you know, combined with that is also, you know, the municipal processes that are required in order to move forward.

In order for our lenders to provide us with financing, we need to have a clear commitment

from the Ministry, which includes a licensing commitment in order to get the financing, and there is a very long process for this to go through.

You can see the number of steps. Now, we have 15 steps. I believe that we went through this process in approximately two and a half years; it did take. And in order to move forward, to build and ensure that we can continue to serve the most vulnerable in our communities, I think what we need to know, we need to know that this is a fair, transparent, and timely process because it is still unclear how these items actually move forward.

Beyond the frustration of the really long ministry process is, again, the municipal process, and the extended timelines that are created through the insecurity -- create, sorry, insecurity with lenders and instability with trade pricing. So we need to be able to provide that clear ministry commitment to the project to assure our lenders to move forward, but we also need to lock in the trades before pricing changes and, of course, workforce issues arise, especially right now with the COVID situation.

I think we talked a little bit about having that lead in the past to move the process

forward, and I think having a lead to help the Ministry expedite the process and work with the municipalities could be of benefit to the timelines, and we could better begin to serve those on our wait lists.

For example, we were very fortunate to be able to receive a donation of land and receive a minister's sovereign order to be able to move forward with one of our projects, but the multiple red tape around that actually stalled the process for an additional eight months prior to us being able to move forward with redevelopment.

So I think there has to be a coordination and a streamlining of how these processes move forward. It does take two and a half to three years to build, so you can imagine these processes, in addition, took time.

And if we're already at 2020, at the end of 2020, and we need to rebuild by 2025, we're going to have to change that situation. It's extremely frustrating. I know that there are many operators who really do want to rebuild, have put in applications, and are still waiting to hear from the Ministry.

DONNA DUNCAN: Brent, did you have

something to add? Your --

BRENT GINGERICH: I think it's --

DONNA DUNCAN: -- frustration?

BRENT GINGERICH: Yeah. I mean, as an operator of homes, you know, we want to provide spaces for our residents and spaces where they can live in comfort and safety for the remainder of their days. That is our mission when we get up in the morning.

We cannot begin to tell you how frustrating and infuriating the process is for every operator across Ontario, whether you're private, municipal, or non-profit. You know, we've sat for months with spaces ready to be built and waited for approvals. Each day, each of us waited. So did a senior who needed that place to go for care, together with their families.

We need more spaces. We know people are staying in their own homes longer, and they should, but most of our elderly will, at some point, need a higher level of care than can be delivered in their own home, and they'll need the level of care that we provide.

The impact of, you know, lengthy wait lists on our seniors and families should not be

underestimated, and those lists are only going to get longer if this process remains cumbersome and unresponsive to our community needs.

DONNA DUNCAN: This really is one where we need a facilitator. We need somebody to work back from when we need to build, and we need some real leadership on this and political will, quite honestly.

We have asked for a documented process. We documented this ourselves. There is no written process. So unlike for hospitals, you can't go online and find out what the program is for redevelopment for long-term care because it doesn't exist. There are no service standards. There is no clarity as to who's actually making decisions and when a decision is actually going to be made.

So if we are going to move this program forward, we need that transparency and that clarity and predictability for our homes, for those who would finance the homes. We know that, in light of COVID, we are seeing equity partners leaving the sector and not supporting long-term care and saying we are no longer going to invest in long-term care. We have seen banks indicate that they are not going to participate in the financing of long-term care.

We are in a very, very precarious situation right now, and the system is highly vulnerable at a time that we can least afford it.

So certainly, as we think about our solutions, we still have a lot of challenges that we need to bridge, and there's a lot of room for improvements. We know that the government has made some progress and offered up some improvements, including broadening the scope of our construction funding subsidy, increasing the construction funding subsidy in recognition of inflation. They've introduced an "upfront payment" at substantial completion, though, really, it's largely on occupancy. But we still have outstanding issues, including this process piece.

We know that we need a large urban and rural program. Our rural homes, and especially when you look at the B and C homes in rural communities, need special consideration as well as the urban centres, especially around the GTA, around the affordability and zoning of land.

We need to make sure that CMHC Program is reintroduced into Ontario. So in Ontario, long-term care homes are not eligible for CMHC financing. We're the only province who isn't, and

we believe that that financing through CMHC will also give other lenders incentive to support our sector, and certainly that stable operating funding continues to be a concern on a go-forward basis.

Certainly, we know that you have heard from others, and we did speak to the issue of liability insurance in long-term care. We note that this is a global issue; it's not unique to Ontario. It's a global reinsurance market, and we've been advised that there is no private sector solution for liability issues.

By the end of December, we estimate that 60 percent of Ontario's long-term care homes will have no liability coverage for infectious diseases, not just COVID -- coronavirus, influenza, other infectious diseases -- and this is an existential issue for us. This needs to be urgent.

We have been appealing to both the Federal and Provincial Government to support us with this. The liability protection recently passed by the House is specific to COVID-19 and this pandemic.

We can't secure financing. We can't get a mortgage if we don't have insurance. We can't operate if we don't have insurance. And so

we are really quite anxious about this particular issue, not only in terms of being able to redevelop for tomorrow but to be able to operate today.

We do have members among our non-profit homes where, currently, their boards of directors have no directors and officers insurance. So their leadership teams and their board directors have no liability coverage.

And especially in these charitable homes in small communities, these are people who are caring for people they grew up with in these small communities, and yet they're going to have to make a decision about whether or not they're willing to expose their own family savings and put those at risk in light of this insurance problem.

So in terms of our next steps: Streamline the capital process and policies to expedite recommendations; provide additional funding supports in large and urban, northern and rural communities who face extraordinary costs and other considerations, especially access to trades and supplies; revise the policy for the new upfront grant to eliminate any unintended risks to securing financing; secure that CMHC support for our long-term care homes; introduce a federal insurance

backstop, and where the Federal Government is unwilling, then a provincial backstop to mitigate the risks of insurance; and again, provide that stable and predictable operating funding that's really built around the needs of our residents and the people we are there to care for.

I think that's it. We made it to the end.

COMMISSIONER FRANK MARROCCO (CHAIR): You did? Well, I don't think we have any further -- well, thank you. Thank you very much. We asked the questions as we went along.

This is an area that we felt we needed to understand better. We really did not have a sense of the financial environment that you were facing. We probably still don't understand it fully, and we may very well come back to you for further assistance, but this has been very helpful.

It leaves us with some questions, but we had far more questions before you started than we do now, and so thank you very much. Thank you very much for that, and you may hear from us again.

DONNA DUNCAN: Thank you, Commissioners.

COMMISSIONER FRANK MARROCCO (CHAIR):

Thank you.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

DONNA DUNCAN: Bye.

-- Adjourned at 12:25 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 25th day of November, 2020.

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NEESONS, A VERITEXT COMPANY
PER: OLIVIA ARNAUD, CSR
CHARTERED SHORTHAND REPORTER

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