

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.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 Donna Duncan, Chief Executive Officer, Ontario

10 Long-Term Care Association

11 Jill Knowlton, Board Director, Ontario Long-Term

12 Care Association

13 Brent Gingerich, Chair, Ontario Long-Term Care

14 Association

15 John Scotland, Secretary-Treasurer, Ontario

16 Long-Term Care Association; Chair, OLTCA's

17 Redevelopment Taskforce

18 Ruth McFarlane, Vice-Chair, Ontario Long-Term Care

19 Association Board; Chair, OLTCA's Pandemic Advisory

20 Council

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1 OBSERVERS:

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

7

8 PARTICIPANTS:

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10 Alison Drummond, Assistant Deputy Minister,
11 Long-Term Care Commission Secretariat
12 John Callaghan, Counsel, Long-Term Care Commission
13 Secretariat

14 Jessica Franklin, Policy Lead, Long-Term Care
15 Commission

16 Lynn Mahoney, Counsel, Long-Term Care Commission
17 Secretariat

18 Kate McGrann, Counsel, Long-Term Care Commission
19 Secretariat

20

21 ALSO PRESENT:

22

23 Olivia Arnaud, Stenographer/Transcriptionist

24

25

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

2

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So I guess everyone's here from the Association.

5 Let me just say, I'm Frank Marrocco,

6 and there's Commissioner Angela Coke and

7 Commissioner Dr. Jack Kitts. We are the

8 Commission, and I think some of you would have been

9 here before, so I won't go into it any further than

10 that.

11 We have released one interim report.

12 We are seriously considering issuing a second one.

13 So we're very interested in this issue of the

14 difficulties around development.

15 I will say this: If it helps in your

16 presentation, we've been doing this for a while

17 now, and we feel that there's some basic facts that

18 we've kind of picked up, and you don't need to

19 dwell on.

20 You know, there's a shortage. Reducing

21 from four beds to two beds created an additional

22 problem. There's projections which don't appear to

23 have a chance of being met. We have kind of a feel

24 for that, and so you can proceed with that in mind.

25 If you feel you need to tell us

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 Next slide.

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

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

8 We would highlight that in 1998, there
9 was an eight-year plan to build 20,000 new beds and
10 redevelop what they call the D spaces, the D class
11 of homes. At that time, the B and C homes were not
12 redeveloped. The focus on that program was the
13 D homes, and those were largely municipal and
14 non-profit homes. So B and C homes, you have
15 certainly more private homes, and they were not
16 eligible for the deep redevelopment program in
17 1998.

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

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

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

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

12 In 2007 --

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 So, Ms. Duncan, let me interrupt.

15 DONNA DUNCAN: Yes.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 The eight-year plan with that kind of a navigator
18 or -- that succeeded in realizing the goal?

19 DONNA DUNCAN: Yes, that supported it.
20 Absolutely.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay. And the goal of 20,000 new beds was
23 achieved?

24 DONNA DUNCAN: Yes.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

2 DONNA DUNCAN: In 2007, a new
3 government launched a B and C renewal program, and
4 from that program announced in 2007 2,100 spaces
5 have been redeveloped to date. Between 2002 and
6 2006, we can say 10,000 spaces were added, and
7 10,000 spaces were redeveloped.

8 Next slide.

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

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

23 JILL KNOWLTON: Thank you, Donna.

24 Good morning, Commissioners.

25 When we look at the aging

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

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

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

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

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

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

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

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

1 older homes.

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

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

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

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

25 And, of course, electrical and

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So I think COVID-19 has opened --

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

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Commissioner Kitts?

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

16 JILL KNOWLTON: Mm-hm.

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

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

25 JILL KNOWLTON: So, Dr. Kitts,

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

6 I think, again, Ministry of Labour,
7 fire inspectors as well, it -- there is nowhere for
8 this equipment to go, and this is equipment that
9 isn't sort of used infrequently or may be. This is
10 necessary equipment to provide resident care on a
11 24-hour basis, so it has to remain in the hallways.

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

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

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

1 COMMISSIONER JACK KITTS: Yeah.

2 JILL KNOWLTON: -- because there is no
3 space.

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

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

14 COMMISSIONER JACK KITTS: Okay. Thank
15 you.

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

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

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

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

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

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

3 JILL KNOWLTON: Sure. Thank you.

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

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

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

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

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

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

10 JILL KNOWLTON: Yeah.

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

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

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

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

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

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

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

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

15 JILL KNOWLTON: Yes.

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

19 JILL KNOWLTON: Yes.

20 DONNA DUNCAN: Okay.

21 JILL KNOWLTON: Okay.

22 DONNA DUNCAN: Next slide.

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

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

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

13 Next slide.

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

23 In Phrase 1, approvals given in 2018,
24 '19, there was an announcement for 6,796 beds. The
25 approvals that went out last week allow for 1,015

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

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

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

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

16 DONNA DUNCAN: That will need to be,
17 yes.

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

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

1 bring them up to standards, and then we will need
2 additional beds. The Provincial Government
3 announced that they were committed to building
4 15,000 new beds in addition to redeveloping 15,000
5 beds.

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

10 DONNA DUNCAN: Yes.

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

13 DONNA DUNCAN: We note too that part of
14 the challenge that our members face is that all
15 B and C homes will have their licenses expire in
16 2025, and so if we don't redevelop the remaining
17 beds, that will result in a potential loss of
18 24,000 spaces from the system at a time when we
19 have 38,000 people on a wait list.

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

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

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

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

13 Brent, did you want to speak to that?

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

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

1 And, you know, the spaces that have
2 been redeveloped, for instance, between 2012 and
3 2020 are only 2,124 of them. So certainly, this
4 needs to be a priority and should be a priority.

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

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

20 DONNA DUNCAN: Thank you.

21 Next slide.

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

1 B and C spaces.

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

9 Certainly, further announcements in
10 2009, 2014 with new funding announced.

11 There was a survey done in 2015; a
12 market sounding in 2018; a call for applications in
13 2018 to redevelop and award new beds, wherein 7,000
14 spaces were approved to be developed; and updates
15 on the Construction Funding Subsidy in 2019 and a
16 recommitment or confirmation of the commitment to
17 redevelop 15,000 beds and build 15,000 new spaces.

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

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

1 failed to progress since 2007.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 There's no shortage of announcements. There's just
4 a shortage of beds.

5 DONNA DUNCAN: Yes, absolutely.

6 Next slide.

7 And certainly, Commissioners, you're
8 aware of the demand that we're facing with our
9 38,500 on our current wait list. We know that over
10 the next 15 years, the population over 80 in
11 Ontario will double. We're certainly seeing the
12 complexity and the level of acuity of our resident
13 profile increase, and we really are going to have
14 to look at what long-term care more broadly means.

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

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

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

3 Next slide.

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Why was it ostracized, in your opinion?

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

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

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

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

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

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

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

13 DONNA DUNCAN: Mm-hm.

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

16 DONNA DUNCAN: Yeah, absolutely.

17 And, Ruth, did you want to add
18 anything?

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

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

3 DONNA DUNCAN: Mm-hm. I --

4 COMMISSIONER JACK KITTS: Can I just
5 ask, Ms. Duncan: I understand your opinion on
6 ostracize, and I wonder if -- you know, a decade
7 ago, there was a very strong belief that 20 to
8 30 percent of residents in long-term care homes did
9 not need to be there. And so there was the home
10 first and aging at home in Ontario strategies that
11 have been clearly quite successful in terms of home
12 care but, like you say, perhaps at the expense of
13 long-term care.

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

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

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

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

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

18 Jill, did you want to weigh in?

19 JILL KNOWLTON: Thank you, Donna.

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

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

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

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

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

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

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

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

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

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

21 COMMISSIONER JACK KITTS: Thank you.

22 JILL KNOWLTON: Thank you.

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

1 which required a higher level of acuity for
2 placement.

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

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

11 DONNA DUNCAN: In long-term care?

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Yes.

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

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

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

22 And the change in admission criteria
23 cut that wait list, I believe, down to about 16- to
24 18,000. But as you can see, even with the change
25 in the admission criteria, which are based on MAPLe

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 But -- yes. No, go ahead.

5 JOHN SCOTLAND: No, go.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Well, it just seems to me that there's a shortage,
8 so then we have a policy of aging at home. There's
9 a shortage, so we changed the definition to make it
10 harder to qualify.

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

14 JOHN SCOTLAND: Yes.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 -- but it's not reduced in the way that one would
17 have preferred to reduce it.

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

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

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

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

11 DONNA DUNCAN: Thank you.

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

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

17 DONNA DUNCAN: Thanks, John.

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

1 crossing multiple levels with government and
2 ministries.

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

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

11 DONNA DUNCAN: Mm-hm.

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

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

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

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

1 speak to the numbers.

2 Brent?

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

14 So when we're talking about creating a
15 large, you know, infrastructure program to build
16 45,000 new spaces by 2025, it requires a stable,
17 predictable funding system in order to do that.

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

1 matched against the expenses in those areas.

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

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

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

25 In addition, there's some other

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

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

8 "Funded through resident
9 co-payment."

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

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

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

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

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

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

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

10 JOHN SCOTLAND: Goes back to the
11 government.

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

16 So there may or may not be
17 subsidization intermingled into that revenue for
18 raw food. So the government would provide some
19 money, and the residents would provide some money,
20 but essentially, the government is fixing a number
21 where they essentially -- you know, if you have
22 97 percent occupancy, then you get 100 percent of
23 your funding for raw food.

24 COMMISSIONER JACK KITTS: Do all --

25 BRENT GINGERICH: Does that explain it?

1 COMMISSIONER JACK KITTS: Do all
2 residents pay something?

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

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

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

16 BRENT GINGERICH: That's correct.

17 COMMISSIONER JACK KITTS: Okay. Thank
18 you.

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

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

24 BRENT GINGERICH: Correct. So --

25 COMMISSIONER ANGELA COKE: And so what

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

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

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

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

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

1 JOHN SCOTLAND: Sure. Go ahead, Ruth.

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

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

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

16 John?

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

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

25 So yes, the resident funds a portion of

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

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

15 And just around the instability,
16 unpredictability, if I could just offer an
17 illustration: In 2002, the nursing envelope was
18 funded at \$52.38. Today, it's at \$100.26. That's
19 18 years later. It has not quite doubled.

20 The OA envelope was funded at \$40.21.
21 It's currently at \$56.16. It has gone up \$16 in
22 18 years.

23 Raw foods, a similar challenge: It was
24 \$4.49 back in 2002, and in 18 years, it has only
25 increased to \$9.54, and I know that, you know, we

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

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

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

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

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

18 What we need is stable funding that's
19 clearly consistent and smoothed across all
20 12 months and not just sort of these big pots that
21 come retroactive very, very late in the year
22 because our residents need stable funding for care
23 year-round, and this happens year over year over
24 year.

25 So again, we don't have an ability to

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

5 DONNA DUNCAN: Thanks, everyone.

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

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

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

1 about pennies. We were talking about cents.

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

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

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

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

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

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

5 John?

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

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

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

1 actually make that happen.

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

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

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

22 Could we flip ahead to...?

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

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

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

17 Brent, did you want to touch on the
18 process?

19 BRENT GINGERICH: Sure.

20 DONNA DUNCAN: Equity?

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

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

4 So there's really minimal grant money
5 here. If it was more like a hospital model where,
6 you know, the majority of the money was financed by
7 the government in a grant as opposed to a loan in
8 equity, we would need about \$13 billion in capital
9 to build these 45,000 new beds that we need by
10 2025, right?

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

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

1 DONNA DUNCAN: Thanks, Brent.

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

7 Ruth, would you like to speak to this
8 now?

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

14 Ruth?

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

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

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

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

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

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

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

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

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

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

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

25 DONNA DUNCAN: Brent, did you have

1 something to add? Your --

2 BRENT GINGERICH: I think it's --

3 DONNA DUNCAN: -- frustration?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 DONNA DUNCAN: Thank you,
24 Commissioners.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Thank you.

2 COMMISSIONER JACK KITTS: Thank you.

3 COMMISSIONER ANGELA COKE: Thank you.

4 DONNA DUNCAN: Bye.

5 -- Adjourned at 12:25 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, CSR, Certified
4 Shorthand Reporter, certify:

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;

9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 25th day of November, 2020.

19
20 

21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: OLIVIA ARNAUD, CSR

25 CHARTERED SHORTHAND REPORTER

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