

# Long-Term Care COVID-19 Commission Mtg.

Presentation  
on Wednesday, September 30, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 30th day of September, 2020,  
10:00 a.m. to 12:00 p.m.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9

10 Donna Duncan, Chief Executive Officer;

11 Nancy Cooper, Director Quality & Performance;

12 Wiesia Kubicka, Vice President, Policy and

13 Operations;

14 Ruth McFarlane, Vice Chair of the Board of

15 Directors of OLTCA, Chair of OLTCA's Pandemic

16 Advisory Committee and of OLTCA's Human Resources

17 Emergency Task Force, co-Chair of the Association's

18 Red Tape Reduction Advisory Committee;

19 Tommy Wong, Director, Data and Analytics at OLTCA.

20

21 PARTICIPANTS:

22

23 Alison Drummond, Assistant Deputy Minister,

24 Long-Term Care Commission Secretariat;

25 John Callaghan, Counsel, Long-Term Care Commission

1 Secretariat;  
2 Derek Lett, Policy Director, Long-Term Care  
3 Commission Secretariat;  
4 Lynn Mahoney, Counsel to the Ministry of Health and  
5 Long-Term Care.

6  
7 ALSO PRESENT:

8  
9 McKaya McDonald, Stenographer/Transcriptionist.  
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1 -- Upon commencing at 10:00 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 All right. The Commissioners are here, as you can  
5 appreciate.

6 I'm Frank Marrocco with

7 Commissioner Kitts and Commissioner Coke.

8 So we're here. Are you ready to go?

9 DONNA DUNCAN: We're ready to go.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Well, excellent. Well, thank you very much for  
12 coming. You know, we're at the investigative stage  
13 of what we're doing.

14 It's a little bit different, this  
15 situation, because typically a commission is set up  
16 to look back in time at something that happened  
17 because the public want to know what happened, and  
18 this is a little different because it's still  
19 happening.

20 And so typically when you're looking  
21 back at something that happened, you do an  
22 investigation. You have public hearings, and then  
23 you write a report. And that takes two/two and a  
24 half years to do, if you look back at how long some  
25 of these Commissions of Inquiry have taken. Well,

1 that's a little too long in this situation. The  
2 second wave seems to be upon us, and depending on  
3 who you read, there may be a third wave.

4 So we're trying to -- I think what we  
5 will do -- we haven't completely decided yet, but  
6 we're inclined to issue an interim report focussing  
7 on some recommendations, and then we will take a  
8 more conventional approach as far as what happened.  
9 So that's kind of where we're coming from.

10 So it's very helpful to be able to meet  
11 with you because it will hopefully help us and  
12 inform us as to some recommendations that we might  
13 make. So thank you for getting together with us.

14 We have a reporter, Ms. McDonald, so  
15 there will be a transcript, and so we'll have an  
16 accurate record of what's been said.

17 The only thing to start with is if you  
18 have a website, I was wondering if we could put a  
19 link on your website to our website so that  
20 somebody searching your website and wondering what  
21 we were up to would be able to easily find us.

22 And sometimes when people look for us,  
23 they've gotten Justice Gillese as the web offer,  
24 and so we're trying to fight against that. And so  
25 if we could -- if you could give us the opportunity

1 to link, that would be very helpful.

2 U/T DONNA DUNCAN: Absolutely, sir.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. Well, we're in your hands. We're ready to  
5 go when you are.

6 DONNA DUNCAN: Great. Well, thank you.

7 So I am Donna Duncan. I'm the CEO of the Ontario  
8 Long-Term Care Association. I've been with the  
9 association since the end of April 2019.

10 I am joined by Ruth McFarlane who is  
11 the Vice-Chair of our Board of Directors, chairs a  
12 number of our task forces, a very active  
13 association member. And she is also the CEO of  
14 Durham Christian Homes, one of our nonprofit  
15 numbers in the GTA area.

16 We also have Wiesia Kubicka, our VP,  
17 Policy and Operations;

18 Nancy Cooper, our director of Quality  
19 and Performance;

20 And Tommy Wong, our Director of Data  
21 Analytics.

22 By way of background, the OLTCA, as we  
23 are known, is the largest association representing  
24 long-term care homes in Canada, and we are the only  
25 association in Ontario that represents the full

1 continuum of membership.

2 We represent approximately 70 percent  
3 of all homes in the province, so the full continuum  
4 of ownership from small, non-profit, municipal, as  
5 well as for-profit homes. So we have a mix, and we  
6 work very closely with our partner association  
7 AdvantAge Ontario.

8 We are very pleased and certainly  
9 welcome the opportunity to be with you here today.  
10 And, in fact, our association called for an inquiry  
11 in May prior to the government announcement and are  
12 very encouraged by your words around how you're  
13 approaching this.

14 Because we were very concerned that an  
15 inquiry would be so focussed on looking back that  
16 we wouldn't have the opportunity to mobilize in the  
17 face of what we anticipated was going to come so  
18 very encouraged about the fact that you're going to  
19 do an interim report and recommendations.

20 We certainly look forward to sharing  
21 with you today some of our thoughts both on what we  
22 learned from what happened but more importantly  
23 what we need to do today to mobilize, and I think  
24 there's some clear lessons learned.

25 We did share a lot of material just for

1 some pre-reads around some -- just to provide you  
2 with some context around some of the work that the  
3 association has been doing over the last nine  
4 months, nine/ten months, as both before the  
5 pandemic but also during and as we certainly move  
6 into a second wave.

7 Today we have a shorter presentation.  
8 We don't want you to feel bound by it, though. We  
9 actually prefer to have a conversation and a  
10 discussion and hopefully ensure that, through some  
11 of the other presentations, you've seen some  
12 themes. So we're not bound by the deck that we  
13 have today, if that's okay.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 That's just fine, and we have followed the practice  
16 in the past of interrupting and asking questions as  
17 we go along rather than trying to circle back at  
18 the end and pick up points that were made  
19 previously. So, you know, please don't think we're  
20 rude.

21 DONNA DUNCAN: No.

22 COMMISSIONER FRANK MARROCCO (CHAIR):  
23 But this works pretty well for us.

24 DONNA DUNCAN: No, we welcome that. I  
25 think that's far more generative, certainly from

1 our perspective. So with that, I think we'll start  
2 with our slides and just start to frame this  
3 discussion.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Okay. The slides will appear on our screen, and  
6 they have already.

7 DONNA DUNCAN: There we go.

8 COMMISSIONER FRANK MARROCCO (CHAIR):  
9 So we're good to go.

10 DONNA DUNCAN: So one of the most  
11 important things that we really felt that we wanted  
12 to start our discussion with you on is that  
13 certainly, throughout this, there was a -- I would  
14 say people became obsessed with data.

15 And so every day, it's been about the  
16 numbers. It's been about operators. It's been  
17 about beds. It's been about homes. And we really  
18 do not want to lose sight even though we do propose  
19 to discuss data today.

20 But ultimately this is about human  
21 beings. This is about people. And certainly, you  
22 know, we experienced tragic losses in a number of  
23 our homes. We know that even those homes who had  
24 no losses, there's fear, anxiety, worry among  
25 residents, among family members, among our staff

1 members.

2           You know, we certainly also want to  
3 really emphasize that, you know, what we don't want  
4 to lose is our collective duty to the people we  
5 serve. This isn't about the "them" and "us."

6           We've really tried, throughout this  
7 pandemic, to build those bridges, to build the  
8 partnerships. We've had to educate a lot of people  
9 about who our residents are and who our staff  
10 members are and what the conditions for working are  
11 and what some of the longer-term structural and  
12 historic issues were.

13           But at the end of the day, what we're  
14 here to do is talk about how we're going to make  
15 things better for the people we serve and the  
16 people who work with us to serve them.

17           So, you know, when we started this and,  
18 certainly, the work of our association, I would say  
19 over the last year, last summer, summer 2019 into  
20 the fall, our membership and our board and our  
21 various task forces actually did a lot of work in  
22 preparation for the provincial budget consultation  
23 and our proposals to really dig in and look at  
24 solutions around what are the anchoring problems.

25           And rather than telling government "We

1 need more money" or "Government needs to fix this,"  
2 we realized that we needed to find our own agency  
3 and that we needed to really work through to focus  
4 on solutions, recognizing that they're not easy  
5 solutions.

6 So we knew that 80 percent of our homes  
7 were having difficulties with human resources.  
8 This is not unique to Ontario. In fact, in  
9 September 2019, OLTCA hosted a conference in  
10 Toronto with the Global Ageing Network where we had  
11 representatives from around the world trying to  
12 problem-solve for HR issues in care homes and  
13 long-term care around the world.

14 And certainly this has been worn out.  
15 I sit on the board of the Global Ageing Network,  
16 and we've had discussions throughout the pandemic  
17 on this issue. And this is, bar none, the top  
18 issue for us regardless if you're in Australia, the  
19 UK, United States, Italy, Spain, the Netherlands,  
20 Switzerland. This is what we're all up against.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 So do I understand that correctly that, prior to  
23 the pandemic, it would have been clear to operators  
24 or to anybody concerned about the orderly  
25 functioning of this that there's a problem with

1 people -- problem filling shifts?

2 DONNA DUNCAN: Absolutely.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay. So that would come as --

5 DONNA DUNCAN: Absolutely.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 The pandemic wouldn't cause that to -- and you

8 correct me if I'm wrong. But so then the pandemic

9 wouldn't cause that to be some revelation, then?

10 That was always there? That was always the reality?

11 DONNA DUNCAN: Yes, absolutely. And

12 certainly we know that many staff were working

13 across multiple sites.

14 Further, we have homes especially in

15 rural areas where they're almost entirely dependent

16 on agency staff, so there is no local labour pool

17 for them to tap into. So especially for RPNs and

18 RNs, but also PSWs, it's -- we have a massive

19 shortage, just leading into this.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Yeah. We've heard from others earlier, and one of

22 the things we heard is that it's not just a

23 question of personal support workers but it's a

24 question of the distribution of varying skills of

25 people -- registered practical nurse, registered

1 nurse, and so on. And they have to get that  
2 distribution correct as opposed to simply just  
3 increasing the number of personal support workers.

4 Do you have a view on that?

5 DONNA DUNCAN: Ruth may want to jump in  
6 on this, but certainly from my perspective -- and  
7 prior to this, I ran a large children's mental  
8 health agency that was a research teaching and  
9 treatment centre and have worked in the hospital  
10 sector as well.

11 We have a -- we're not built around the  
12 people we serve, and so, in my mind, we have more  
13 of a very prescribed, heavily regulated staffing  
14 model that prescribes who does what.

15 The legislation has not allowed for the  
16 evolution of the staffing model. And, in fact, it  
17 constrains nurses and RPNs and others as to what  
18 their scope of practice may have been when the  
19 legislation came into effect in 2007 to 2010.

20 So we've kind of hampered our homes,  
21 and then the funding model over top of that doesn't  
22 allow for the evolution of the model around -- that  
23 would actually align with the evolution and the  
24 escalation of the care needs of our residents.

25 Ruth, did you want to comment?

1                   RUTH MCFARLANE: I might add that every  
2 resident population is unique, as you can imagine.  
3 Different residents have different needs.

4                   And so a very prescribed staffing model  
5 actually constrains us in being able to meet their  
6 needs well. And because we're so heavily  
7 regulated, you know, it is something that we worry  
8 about.

9                   Often times you might have regulated  
10 staff doing work that isn't, you know, akin to a  
11 regulated staff. You could have PSWs portering  
12 residents when there could be somebody else who  
13 could be doing that instead. But because we're so  
14 prescribed, it is hard. And because we are so  
15 regulated, we are very limited in what our staffing  
16 model looks like.

17                  DONNA DUNCAN: And you Ruth was a  
18 co-chair of a red-tape task force that had enormous  
19 elements and components around HR and the need for  
20 flexibility.

21                  Certainly, you know, I do think that if  
22 we are going to support our staff and recruit  
23 staff, we need to make sure that we're building  
24 that staffing model around the people who we're  
25 serving.

1           You know, in hospitals you have master  
2 program models and functional program models. You  
3 look -- you build those out. That kind of rigor  
4 and discipline and thoughtfulness in really  
5 defining who is the person, what is their needs,  
6 what's the staffing model to support those needs,  
7 and then what does the physical plan look like,  
8 that's not how our system has evolved.

9           Essentially we have buildings from the  
10 1970s and then, certainly, a funding model that has  
11 become more and more prescriptive and limited.  
12 Certainly the pie is largely fixed. And then we  
13 have an evolving resident population and a fixed  
14 staffing model that's enshrined in the regulation.

15           So that creates challenges because it  
16 doesn't allow for innovation and evolution and  
17 certainly, from my own experience in other sectors,  
18 especially the mental health sector.

19           And again, just tying into that, the  
20 ancient infrastructure, you know, 32,000 of our  
21 beds were built to 1970s standards. Our  
22 association had a say at a capital redevelopment  
23 task force, and we have done a lot of very in-depth  
24 work through the fall and into early winter. And  
25 we're working with government to try to find a way

1 to expedite a capital redevelopment program, again,  
2 one that's not highly prescribed but one that  
3 allows for the innovation that we need and allows  
4 for the flexibility to adapt to a different  
5 resident population but one that could be done  
6 quickly.

7 And certainly yet, you know, we  
8 identified a lot of process issues, a lot of policy  
9 issues. But certainly, as the pandemic bore out,  
10 we realized that infrastructure issue clearly was  
11 one of the root causes.

12 HR crises, ancient infrastructure, root  
13 causes, certainly the red tape, and the staffing --  
14 a couple of those buildings really pushed us, in  
15 the association, very early in the pandemic to rush  
16 to government to get an emergency order so that we  
17 could allow for that flexibility that Ruth was  
18 speaking of. We did not have that flexibility  
19 during the pandemic.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 What -- I guess Commissioner Coke, and then I --  
22 also -- go ahead, Commissioner.

23 COMMISSIONER COKE: No, I'll let you  
24 finish this line. I have a different type of  
25 question.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2 Well, I just wanted to ask you if you had a less  
3 rigid model, you know -- and I understood what you  
4 were saying, the population is changing; the model  
5 isn't changing.

6                   In this new model, who would decide  
7 what was the appropriate level of care or -- I  
8 don't know that that's the correct phrase --

9                   DONNA DUNCAN: M-hm.

10                  COMMISSIONER FRANK MARROCCO (CHAIR):  
11 -- in the situation? How would you -- so that  
12 somebody inspecting -- let's assume there were  
13 adequate inspections.

14                  Somebody inspecting could compare what  
15 the model was supposed to be for the individual,  
16 let's say, versus what, in fact, was being  
17 delivered. How do you see that?

18                  DONNA DUNCAN: No, I think that's a  
19 great question. And again, it speaks to my comment  
20 at the beginning about this being about people and  
21 also the lack of understanding in other parts of  
22 the system about who is in long-term care.

23                  We do think that there's an opportunity  
24 within the context of Ontario Health Teams. And  
25 certainly one of our recommendations as we move

1 forward is that we have better integration and  
2 alignment with hospitals, complex continuing care,  
3 rehab, certainly community care and thinking about  
4 those community models so that --

5 We have a bigger discussion around who  
6 is in long-term care and where they should be.  
7 Certainly home care needs to be part of those  
8 discussions as well.

9 We need to have a concerning discussion  
10 about what long-term care is, and it may not just  
11 be about what we perceive it to be right now which  
12 is a one-size-fits-all institutional home model  
13 that -- where it tries to be all things to all  
14 people.

15 And certainly we do believe there are  
16 opportunities for regional differentiations.  
17 Certainly we see differentiation just in homes in  
18 Toronto and urban centres.

19 But, you know, I'm sure we'll get to  
20 some of the issues around the compliance framework  
21 and what we're actually being inspected for as we  
22 start thinking about those quality outcomes and the  
23 quality measures and best practices.

24 I think we really do need to start to  
25 focus on who is the resident? What is a quality

1 outcome? How do we frame an inspection model that  
2 will actually speak to the outcomes and be more  
3 supportive around that?

4 And certainly I sit on a hospital  
5 board, and I chair their Quality Committee and  
6 Patient Experience Committee. And as I think about  
7 how we go through our quality reviews or our  
8 critical incident reviews, it really is anchored in  
9 the programmatic model and the clinical outcomes  
10 and certainly international best practices and  
11 data.

12 Ruth, you've got more of an  
13 on-the-ground perspective.

14 RUTH MCFARLANE: If I could just add  
15 something: Ultimately, our staffing models are  
16 driven by the residents that we serve. And so when  
17 we bring our residents in, we actually have  
18 multidisciplinary team that meets with the  
19 residents and their families and analyzes and  
20 discussed what their needs and their preferences  
21 are.

22 And then we create what's called a  
23 "care plan." And then that care plan is actually  
24 translated into our staffing models, and that is  
25 ultimately what we want to do is provide that

1 really individualized, custom care that drives  
2 resident and family satisfaction but also, you  
3 know, drives staff satisfaction.

4 So ultimately, that is what we try to  
5 do on our end, but then the rigidity stifles that  
6 type of creativity or innovation where we would be  
7 able to move forward and enhance, you know,  
8 outcomes, enhance resident safety, and also, you  
9 know, enhance staff satisfaction to be able to move  
10 these items forward.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Thank you. That does actually answer -- I don't  
13 always get an answer to my question, but that is an  
14 answer. Thank you.

15 DONNA DUNCAN: The other --

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 Excuse me, Ms. Duncan.

18 Commissioner Coke?

19 COMMISSIONER COKE: You were talking  
20 earlier, obviously, the challenges in terms of, you  
21 know, the staffing situation pre-COVID and  
22 obviously issues in terms of redeployment. But I'm  
23 interested to know would all the operators have had  
24 some sort of outbreak or emergency plan pre-COVID,  
25 probably not for a pandemic, but some sort of plan

1 that you would activate when situations like this  
2 occur.

3 DONNA DUNCAN: Everyone is required to  
4 have a plan. Certainly in some of our discussions,  
5 often times the plans are -- the plans were  
6 developed, actually, after SARS and H1N1.

7 We didn't really contemplate what this  
8 pandemic would mean for long-term care. Certainly  
9 I don't think anybody fully appreciated what this  
10 was going to be.

11 And, you know, certainly we found that  
12 our legislative framework was a barrier to the  
13 implementation of the measures that would have been  
14 undertaken, especially under H1N1.

15 Our team actually did a detailed  
16 analysis around the -- how to realign certain acts  
17 and controlled acts who would need to be able to be  
18 responsive and flexible. And certainly that's when  
19 it became very clear to us that the restrictiveness  
20 of the legislation was going to be a barrier to the  
21 implementation of the acts or of the pandemic  
22 plans.

23 So we had plans. Were they the plans  
24 that we needed in the context of COVID-19? Ruth  
25 can speak more specifically to this. I would say

1 no.

2 And certainly in the broader context of  
3 the government response plan, the initial focus was  
4 on hospitals. And our earlier discussions were  
5 less about containing outbreaks in long-term care  
6 homes and more about accommodating capacity of ALC  
7 transfers from the hospitals.

8 Ruth?

9 RUTH MCFARLANE: Yes. So we do have  
10 outbreak plans. Every home has an outbreak plan.  
11 It's a requirement to have the outbreak plans, and  
12 we are used to having outbreaks. We might have  
13 enteric outbreaks or influenza outbreaks.

14 But typically these outbreaks last a  
15 certain amount of time, two or three weeks, because  
16 they're identified, and then we put in our outbreak  
17 measures.

18 What was distinct about what happened  
19 with COVID was that it wasn't only two or three  
20 weeks. It continued, and there was so much  
21 uncertainty. There was a lot of fear in the  
22 general population, and also, that translates into  
23 fear for our staff.

24 And it was the unknown. There was  
25 confusion with respect to directives and Public

1 Health directives, and I think it was just the  
2 quantum of the pandemic.

3 We are used to dealing with outbreaks  
4 on an annual basis and usually do, but we're able  
5 to manage them because they're on a smaller scale.  
6 It was a different beast when COVID came into our  
7 homes.

8 COMMISSIONER FRANK MARROCCO (CHAIR):  
9 Commissioner Kitts?

10 COMMISSIONER KITTS: Yeah. I've got  
11 two questions. The first is I'm sure you're aware  
12 of the RNAO basic guarantee on staffing in nursing  
13 homes. And if you are, I'd like you to comment on  
14 whether it meets the criteria that you're looking  
15 for in terms of the flexibility with staffing.

16 The second question is what was the  
17 magnitude and impact of the 2019 funding  
18 reductions?

19 DONNA DUNCAN: Those are great  
20 questions. So with regard to -- I'm going to start  
21 with the funding because it's my last quadrant.  
22 It's our last quadrant here.

23 The funding was -- the promise of the  
24 funding cuts was profoundly destabilizing  
25 especially with regard to pharmacy. And with the

1 capitation model being introduced in pharmacy, our  
2 homes had been supported very actively and where  
3 long-term care pharmacies were actually inside the  
4 homes doing medication reconciliations, training  
5 the staff, teaching the staff, managing the bulk  
6 medications from the province, and certainly  
7 providing a lot of additional staff support.

8           They were partners in the care team.  
9 They freed up the time of the nurses, and certainly  
10 especially with med recs and medication audits,  
11 were vital to the team.

12           At the end of December, that ended.  
13 And the government moved very quickly to a  
14 capitation model where the long-term pharmacies  
15 actually withdrew those on-site services, and, of  
16 course, it certainly led into COVID.

17           They became all virtual services, so  
18 the extra burden on our nurses in the homes in  
19 terms of their responsibilities as we moved into  
20 COVID furthered with that capitation change.

21           The long-term care pharmacies had  
22 actually supported the homes with their eMARS, so  
23 their medical reconciliations, online, their  
24 electronic ones, with technology, with monitors,  
25 with infrastructure for virtual supports. And in

1 many cases, those supports were also taken out of  
2 the homes in January.

3 So we say that we were in a -- facing a  
4 perfect storm as we got into COVID-19, and  
5 certainly, you know, that was a big piece for us.

6 With the wind-down of some of the other  
7 funds, they were problematic because homes,  
8 regardless of your own ownership or size, including  
9 our non-profit homes, were reliant on certain of  
10 those envelopes, such as the structural compliance  
11 envelope, to support their debt -- support them in  
12 servicing their debt covenants.

13 So by winding down those funds, that,  
14 actually, was prejudicing their financial  
15 stability. So that certainly was an impact. They  
16 were already fragile.

17 Certainly they had cuts -- COVID, I  
18 would say, has had even more a destabilizing effect  
19 especially in terms of them being able to refinance  
20 without indemnification or insurance.

21 On the -- with regard to the RNAO  
22 proposal, I think that we need more nurses. And  
23 certainly the proposal provides a foundation for  
24 bringing new nurses in.

25 You know, I think -- but where our

1 membership would be -- and again I'm going to turn  
2 to you, Ruth -- is let's look at -- part of our  
3 challenge and what's destabilizing is everything  
4 gets prescribed.

5           And we describe our sector as being  
6 built like Jenga where you've got one more  
7 requirement piled on top of another requirement out  
8 of context without taking a coherent, organic look  
9 at what it is we're trying to build around the  
10 people we're trying to build it.

11           So certainly in the short term, more  
12 nursing is absolutely needed in our homes. That's  
13 a starting point for us. We certainly believe that  
14 we need to move to more flexible staffing models to  
15 allow for innovation models that are focussed on  
16 clinical outcomes as well as models that recognize  
17 that this is about care in someone's home.

18           Ruth?

19           RUTH MCFARLANE: Yes, I agree. I  
20 definitely agree. I would just add that, you know,  
21 definitely, we would want more nurses in our homes.  
22 But at the same time, at our homes we provide more  
23 than just nursing care. We provide spiritual care.  
24 We provide emotional care. So there is, like, an  
25 increased need for other disciplines also, as well

1 as the nurses.

2 Care is very important, but resident  
3 quality of life is also impacted by other factors  
4 that we try to provide for our residents and  
5 families.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 If I can just take you back to what you were saying  
8 about the funding impacting on the pharmacies and  
9 the pharmacies withdrawing in January.

10 Can you give me some sense of when your  
11 organization concluded that COVID was going to be a  
12 problem for long-term care homes? Like, when would  
13 have been the first moment the light went on, I  
14 guess, is what I'm trying to ask?

15 DONNA DUNCAN: So I would say that,  
16 certainly, in some of my discussions with my global  
17 colleagues in late January on a call, certainly  
18 talking to all of them, it was quite interesting  
19 because, as we saw, Ontario's response actually  
20 mapped against those other jurisdictions. And I  
21 believe the first communication in writing that we  
22 sent to government was likely around January 25th  
23 or 26th.

24 You know, we certainly were hearing,  
25 you know, about ethical frameworks in Italy and

1 Spain. We saw the hospital surges in those  
2 countries. We saw that the surges as it moved  
3 across Europe. We were concerned about our state  
4 of readiness.

5 We were in discussions with government  
6 about preparing for capacity in long-term care. We  
7 were very concerned about the fact that most of our  
8 homes were at capacity.

9 We recall we had about 36,000 people on  
10 the wait list for long-term care at the beginning  
11 of this and realized that we weren't going to be  
12 able to really fully fill the need for those  
13 hospital transfers and to free up hospitals.

14 I would say we were very concerned  
15 about what was going to happen if there were a  
16 hospital surge. I mean, Ontario's very lucky that  
17 we didn't have it, and I'm not quite sure where we  
18 would be today and what our numbers would have  
19 looked like had there been that hospital surge.

20 So certainly early in January, we  
21 started to escalate as we moved through February  
22 around the state of readiness and especially as we  
23 were recognizing how virulent this was for our  
24 population of people over the age of 80 with  
25 multiple comorbidities. And we were certainly

1 advocating with government force so we --

2 I believe it was in March that we  
3 advocated for the emergency order, but we were also  
4 advocating early on to free up the inspectors,  
5 especially the nurses, to support our homes in  
6 doing assessments around protection, prevention,  
7 and control, as well as ensuring that they had  
8 sufficient personal protective equipment,  
9 recognizing where the shortages were.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 So then if I understood you correctly, you  
12 communicated with government towards the end of  
13 January which means the light must have gone on a  
14 little bit before you wrote the -- before you  
15 communicated, obviously.

16 So it sounds like we're into the second  
17 or third week of January where this concern is  
18 starting to -- it's crystallized in your mind; is  
19 that right?

20 DONNA DUNCAN: Yes, yes.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay.

23 COMMISSIONER KITTS: Can I just follow  
24 on that? In terms of the inspectors, so you  
25 realized that long-term care homes were at risk,

1 and you asked government to free up inspectors to  
2 help inspect homes to see what their readiness for  
3 the pandemic is. When was that, and were the  
4 inspectors freed up to come into the homes?

5 DONNA DUNCAN: So we certainly asked  
6 for the freeing up of the inspectors in -- at the  
7 end of January or into February. I believe it was  
8 in late January we asked for the suspension of the  
9 inspections so that we could mobilize the  
10 inspectors for other purposes.

11 We continued that advocacy and into  
12 March were advocating together with the Ontario  
13 Hospital Association as well as the chair and  
14 co-chair of the Ontario Health Toronto Region.

15 COMMISSIONER FRANK MARROCCO (CHAIR):  
16 And it just strikes me as odd. At that period in  
17 time, responding to the crisis, there are lots of  
18 times to do inspections. But at that particular  
19 moment, presumably everybody's focussed on the  
20 immediate crisis that you have to deal with. Maybe  
21 not the best time for an inspection.

22 DONNA DUNCAN: M-hm, yeah.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 Because you're distracted by the inspection then.  
25 I don't even know how you would balance the two,

1 really. I'm just speaking, but it's not a  
2 conclusion. If it's not correct, I'd like to know.

3 DONNA DUNCAN: No, that certainly was  
4 our view. When you consider those four  
5 foundational pieces, if you were doing a risk  
6 assessment, our human resources, our physical  
7 plant, our regulatory framework, and our funding  
8 would all be red for the sector as we were going  
9 into this.

10 So -- you know, and certainly at the  
11 beginning, we didn't know what we didn't know about  
12 the pandemic and about COVID-19. We were aware  
13 there was a global shortage of personal protective  
14 equipment and that hospitals were being  
15 prioritized. We knew that there was a shortage of  
16 tests, and tests were certainly still evolving at  
17 that time. We certainly knew just from the media  
18 about the vulnerability of our residents.

19 And I think to touch on something that  
20 Ruth said, you know, the media was very focussed on  
21 what was happening in homes for the aged and care  
22 homes in Europe as well as what was happening in  
23 hospitals. But certainly we were seeing the  
24 devastation of our population.

25 So fear became a huge destabilizer as

1 well. And certainly, as to early on, as the media  
2 started to engage and asked us questions, we were  
3 asked what our greatest fear was, and our greatest  
4 fear was the impact that fear was going to have on  
5 our homes.

6 RUTH MCFARLANE: And I might add that I  
7 think we wanted to go from the compliance  
8 inspection process to having a partnership with the  
9 Ministry -- working in partnership with the  
10 Ministry to be able to better manage what was  
11 coming because we were worried about what was  
12 coming, and we needed to have their support. And  
13 to have the knowledge about what we were actually  
14 struggling with, we could move back forward.

15 COMMISSIONER FRANK MARROCCO (CHAIR):  
16 Which Ministry? When you say "the Ministry," to  
17 which Ministry are you referring?

18 DONNA DUNCAN: So Ministry of Long-Term  
19 Care.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Okay.

22 DONNA DUNCAN: I do think it's  
23 important to note that the Ministry was new, so  
24 we -- in the summer of 2019, the Ministry was  
25 severed from the Ministry of Health and Long-Term

1 Care, and so we -- you know, it was still ordering  
2 its business through the fall and into early  
3 winter. So they were still building their teams,  
4 still getting organized, and we also had a change  
5 in deputy ministers in March.

6 COMMISSIONER KITTS: Does the Ministry  
7 of Labour count into this anywhere because of the  
8 concerns around staff safety?

9 DONNA DUNCAN: M-hm. So we actually  
10 have a good working relationship with the Ministry  
11 of Labour. And certainly, you know, we have a lot  
12 of inspections in long-term care homes, and labour  
13 was certainly a partner and, you know, certainly  
14 mindful of what some of the risks were, and they  
15 were going into homes and supporting as well.

16 Okay.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 When did the -- sorry, when did the deputy minister  
19 change?

20 DONNA DUNCAN: I don't have the exact  
21 date. I believe it was in March, but you'll have  
22 to confirm that with the Ministry.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 That's fine.

25 DONNA DUNCAN: I don't recall the exact

1 date.

2 COMMISSIONER FRANK MARROCCO (CHAIR):  
3 We can figure that out.

4 DONNA DUNCAN: Okay.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Oh, sorry. There's a --

7 Commissioner Coke?

8 COMMISSIONER COKE: Just back to the --  
9 you were talking about the funding quadrant here as  
10 one of your key challenges. And I'm just  
11 interested in your thoughts about the funding  
12 formula, the Case Mix Index, I believe, of what  
13 challenges you see from that in terms of incenting  
14 what needs to be incenting.

15 DONNA DUNCAN: I'm going to ask Ruth to  
16 speak to this. She knows it.

17 RUTH MCFARLANE: So the Case Mix Index  
18 is supposed to -- demonstrates the acuity of your  
19 residents. Where the challenge comes in is that  
20 there is a certain amount of funding that is  
21 available, so there's a pie of funding.

22 And the Case Mix Index, well, it  
23 enables people to -- or it enables us to take a  
24 look at how acute our residents are and what type  
25 of, you know, care we have to provide for them.

1                   What it does is it divides that same  
2 pie up amongst our staff. It doesn't actually  
3 increase the funding when the general acuity of all  
4 residents is going up.

5                   And it is also a very interesting, you  
6 know, demonstrator of acuity, but sometimes it  
7 doesn't actually reflect what's happening on the  
8 floor with respect to dementia care and behaviour  
9 care.

10                   So it doesn't actually capture that  
11 amount, and there's a lot of staffing resources  
12 that are expensed on those type of, you know, every  
13 day supports. And so while the CMI is reflective  
14 of that, it only divides up an already-set pot  
15 amongst the sector.

16                   DONNA DUNCAN: And, Wiesia, did you  
17 just want to add anything further on that?

18                   Wiesia?

19                   WIESIA KUBICKA: Sorry, I was trying to  
20 find the mute button. No, I think Ruth covered it.  
21 It's a tool to distribute available funding and not  
22 necessarily the tool that helps us inform the pace  
23 of the increases in acuity and how we need to then  
24 increase the resources to support our homes to meet  
25 those needs.

1                   COMMISSIONER KITTS: Just a curious  
2 question. We've heard the acuity going up with  
3 dementia and multiple chronic diseases and  
4 behaviour, et cetera. Do you ever compare your  
5 sickest or most acute residents with the  
6 hospital -- patients in the hospital who are less  
7 acute than others? Does acuity come in close there  
8 or not?

9                   DONNA DUNCAN: It's a great question,  
10 and certainly, you know, at the outset of this and  
11 certainly in the media when there are talks about,  
12 you know, take your residents out of long-term  
13 care, take your family members out, you know, our  
14 recognition is these are ALC hospital patients  
15 coming into our homes.

16                   So, you know, the data are not aligned,  
17 and I think we've got to find a way to better align  
18 that. And certainly we're hopeful that as we work  
19 more closely with the healthcare system and some of  
20 the new integration opportunities, there will be  
21 opportunities around data.

22                   But, you know, I think we do need to  
23 look at who they were. And certainly as you see  
24 shifts in the healthcare system, even between  
25 complex continuing care -- certainly looking at

1 rehab and some of the new models that we've seen  
2 emerging with hospital partnerships over the last  
3 years, Sunnybrook Hospital with its Pine Villa  
4 model, certainly the Reactivation Centre for Church  
5 Street -- you know, the system is evolving just  
6 based on that hospital pressure.

7 Wiesia, did you want to add anything on  
8 that and then Ruth?

9 WIESIA KUBICKA: No, absolutely. It's  
10 an interesting question. You know, we haven't done  
11 the comparison on a clinical data level. But  
12 certainly, you know, we recognize that the  
13 comorbidities are increasing in our population.

14 And, you know, many of those do, you  
15 know, require sometimes episodic care through  
16 hospitals, and we've seen some of that. But we  
17 don't have an orange-to-orange comparison with the  
18 hospital sector.

19 COMMISSIONER KITTS: Okay. I just want  
20 to follow up on your comment, Ms. Duncan, about  
21 hospitals becoming more partners in the system with  
22 long-term care.

23 Do you have a sense or an opinion on  
24 whether all long-term care homes should have a  
25 partner or a hospital available to work with in

1 times of need?

2 DONNA DUNCAN: You know, there's no  
3 doubt that we should all be working together. And  
4 again, it comes back to that people slide at the  
5 beginning. Who are we here to serve?

6 You know, the citizens and the  
7 residents in our local communities are our  
8 collective responsibility. We have these publicly  
9 funded resources. We really should find a way to  
10 build trust, build understanding, and build a much  
11 more structured continuum of care around the people  
12 we serve.

13 Certainly trust is key. Relationships  
14 are foundational. So, you know, it's just -- can't  
15 just be about contractual relationships. You know,  
16 we do have to allow for this evolution.

17 As I said earlier, we saw some  
18 partnerships with hospitals work really, really  
19 well, and we saw others less successful. And that  
20 was, in part, due to the lack of preexisting  
21 relationships.

22 Ruth, did you have anything to add on  
23 that?

24 RUTH MCFARLANE: Yes. I will add that  
25 I agree that the partnerships are very important,

1 and I think that it also provides an opportunity  
2 for us to educate and maybe update the acute care  
3 sector on what type of care and supports we provide  
4 our residents. Because it is a very different  
5 model from the acute care model and what we do and  
6 how we do it.

7 I believe that by providing that  
8 information we would become part of the system, and  
9 I think that would be wonderful and a plus to all  
10 of the residents in the communities that we serve.

11 DONNA DUNCAN: Yeah. I would just add  
12 to that, certainly, you know, what is the role of  
13 the medical director? You know, it's a link not  
14 just with the hospitals but also with primary care  
15 and the role of our medical director.

16 You know, we do believe that there is  
17 some interesting opportunities around the medical  
18 director role, the infection prevention and control  
19 leadership in the home that we are -- we certainly  
20 are advocating to have embedded more formally and  
21 more specifically.

22 But, you know, those are opportunities  
23 for us. And certainly with IPAC, the infection  
24 prevention and control, assessments and supports  
25 that we saw unfold, those were -- you know, those

1 were really helpful. And so I think those  
2 pieces --

3 But again, what is the relationship  
4 with long-term care versus the hospital? Certainly  
5 what are the accountabilities? We know that  
6 through the first wave, the risk and risk  
7 tolerance --

8 You know, certainly, you know,  
9 hospitals, I would say, have a lower-risk threshold  
10 than our homes did. And so, you know, I think  
11 we've got to have a larger discussion around that  
12 and what are the accountabilities as we work to fix  
13 this on a go-forward basis.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 When you say a "lower-risk threshold," the  
16 hospitals were less accepting of risk? Is that  
17 what "lower" means?

18 DONNA DUNCAN: Yes. I would say that,  
19 you know, as we were looking at getting support in  
20 the homes -- for instance, one of the structural  
21 barriers that our homes faced was that homes were  
22 asked prior to infection prevention and control  
23 assessments to sign a contract, a clause within  
24 which was that they were required to increase their  
25 liability insurance.

1                   And this is at -- so we're in March  
2 now, and at that point, all of our homes are  
3 actually insured by global reinsurance funds, and  
4 insurance for long-term care had been frozen.

5                   So there was no opportunity to meet the  
6 test that they were being asked to provide -- asked  
7 to meet in terms of ensuring that the -- that any  
8 hospital employers were indemnified.

9                   COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Just before you continue, generally speaking, we  
11 will break around 11:15 for ten minutes.

12                  DONNA DUNCAN: Okay.

13                  COMMISSIONER FRANK MARROCCO (CHAIR):  
14 So as we get there, if you let me know where it's  
15 convenient, then that's when we will break.

16                  DONNA DUNCAN: Okay. Great. Thank  
17 you. Okay. So I think, really, this slide really  
18 just speaks to the work that our members did.

19                  So we had about 120 of our members  
20 sitting on different tasks forces and committees  
21 really driving toward solutions, multiple member  
22 meetings.

23                  You know, for us it was about  
24 stabilizing our funding reform; taking measures  
25 around the HR emergency, and we've talked about

1 that already; certainly addressing the capital  
2 program and expediting that and really looking at  
3 some of that regular burden that was contributing  
4 to quality but, in many cases, was creating a  
5 barrier to quality and innovation.

6 And so this was part of our budget  
7 submission that we presented to the Legislative  
8 Assembly Finance Committee in early February. So  
9 again, you know, what strikes us today is that  
10 these recommendations still hold. And so we would  
11 still continue to advocate for these especially in  
12 the face of COVID-19.

13 So the next slide. So here we are,  
14 COVID-19 time lines.

15 Certainly from our perspective, you  
16 know, we started having our discussions at the end  
17 of January. February was when we really --  
18 government started to mobilize and issue things.

19 It was April 15th that the government  
20 announced the provincial action plan for long-term  
21 care, and it was a week later that hospitals and  
22 NCAF started to move into the homes.

23 So those are certainly some of the key  
24 dates, and we really do want to highlight that the  
25 action plan worked.

1                   So we were very clear we were going to  
2 need help, but the Ontario action plan worked. And  
3 this slide shows the impact of COVID-19 and the  
4 rate of cases among those 80 years or older which  
5 are majority of our residents.

6                   It declined quite steadily. And so if  
7 you look at the red line, the darkest red line,  
8 that's the peak.

9                   And so we saw this steep rise as things  
10 were escalating. But once long-term care homes  
11 were prioritized for personal protective equipment,  
12 for testing of residents and staff at the  
13 beginning, certainly the IPAC supports from the  
14 hospitals, the mobilization of workers into the  
15 homes from Ontario Health from hospitals from the  
16 CAF, unfortunately, as well as, you know, certainly  
17 taking some of the steps around really enhancing  
18 our prevention supports but also the containment in  
19 the community as well as -- you know,  
20 unfortunately, the fact that we were closed.

21                   So the order is that that closed for  
22 visitation at the time, especially given the  
23 precariousness of our staffing and some of the  
24 issues that we're dealing with including just  
25 learning about what this beast was, certainly that

1 resulted in the stabilization of, certainly, the  
2 population of Ontario over the age of 80 and our  
3 long-term care homes.

4 So next slide.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 So if I read that right, then, in February when the  
7 alarm is sounded -- I think that's what you said --  
8 the situation is still stable?

9 DONNA DUNCAN: Yes.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 And once the action plan was put into effect, it  
12 started to bring the situation under control?

13 DONNA DUNCAN: Yes.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Who came up with the action plan?

16 DONNA DUNCAN: So I believe it -- and I  
17 believe that that was developed at the command  
18 table with various members of the government and  
19 other structures in government. So certainly there  
20 were pieces we were advocating for around PPE and  
21 testing as well as help.

22 We were -- our homes were asking for  
23 help. Certainly where we saw the first cases, in  
24 many cases, staff left. We saw homes in dire need  
25 of staff. In the most tragic situations where we

1 saw those untold losses, staff, in some cases, had  
2 been reduced to 20 percent of their compliment.

3 So the help was needed. So, you know,  
4 certainly we're really grateful to government and  
5 those in government who heard the cry.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 You know, from February to April, was the plan --  
8 was it generally known what was needed, or was this  
9 something you tried that wasn't obvious?

10 DONNA DUNCAN: I think early on,  
11 certainly from our perspective, we didn't fully  
12 appreciate exactly what it was that we were dealing  
13 with.

14 And so certainly there was changing in  
15 guidance. There was the PPE shortage. There were  
16 a lot of moving pieces. And, you know, everyone  
17 was working in realtime.

18 It was only when the hospitals were  
19 clearly very stabilized and it was clear that  
20 Ontario wasn't going to have the hospital surge,  
21 that's when we were able to get our support.

22 COMMISSIONER FRANK MARROCCO (CHAIR):  
23 Okay.

24 DONNA DUNCAN: So a lot of contextual  
25 pieces at play underneath this, clearly, and I'm

1 sure the government has more detailed...

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 That's fine. Thanks.

4 DONNA DUNCAN: So one of the things we  
5 did want to highlight here, since we've been  
6 looking and doing a lot of work with our members  
7 around root causes -- and certainly the three and  
8 four bedrooms were, in our mind, a root cause. The  
9 staffing situation was a root cause.

10 One of the other root causes that we've  
11 certainly identified and something that, quite  
12 honestly, we believe is skewing some of the data is  
13 that the majority of the most tragic losses  
14 occurred before the action plan.

15 And so if we look, you know, at those  
16 dots on the left of the red line, really, the  
17 action plan was April 15th. So certainly what  
18 we've identified is, to date, out of all the deaths  
19 in long-term care to date -- and those are people's  
20 lives; these are human beings -- half of them  
21 occurred before April 15th.

22 And about a third of them occurred in  
23 the newer homes, the A-class homes, and about  
24 two-thirds of them were in the older B and C homes.

25 So again, it really does speak to those

1 root causes but also, again, the efficacy of that  
2 action plan and the prioritization of long-term  
3 care.

4 RUTH MCFARLANE: I might add that the  
5 action plan really prioritized the long-term care.  
6 It removed a lot of our regulatory barriers so that  
7 we could better respond to the crisis as we saw it  
8 unfolding. And we were able to gain the  
9 flexibility to be able to provide those increased  
10 controls that we needed to maintain the safety of  
11 our residents as much as we could.

12 DONNA DUNCAN: Yeah. Absolutely.  
13 So, Wiesia, the next slide.

14 So again, this reiterates out of the  
15 625 homes in the sector, about 523 homes or  
16 84 percent of homes had no COVID-19 resident deaths  
17 in their homes. About 344 homes or about  
18 55 percent of all homes have experienced an  
19 outbreak, and 32 homes or 5 percent of all homes  
20 are currently in active outbreak with 69 residents  
21 and 85 staff with confirmed cases.

22 And certainly what we're seeing in  
23 outbreak right now and another root cause,  
24 certainly, that we've identified is geography. If  
25 you were in a hotspot, then you're far more

1 vulnerable. And certainly the Government of  
2 Ontario announced yesterday its Wave 2 action plan.

3 And the strategies for containment  
4 recognize the risk and the vulnerability -- the  
5 risk and vulnerability of long-term care homes and  
6 our residents and staff in those communities with  
7 high social spread such as Ottawa, Toronto, and  
8 Peel.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Can I just ask you about that?

11 On this slide, if 84 percent of the  
12 homes had no COVID-19 resident deaths, that means  
13 that 16 percent of the homes had 100 percent of the  
14 deaths.

15 And I guess what I'm curious about is  
16 would the staff shortages not have been consistent  
17 across both tranches of both the 84 percent and the  
18 16 percent?

19 DONNA DUNCAN: No, I think that's a  
20 great question. So half the deaths actually  
21 occurred in 23 homes. So if we look at the  
22 breakdown of this, certainly the greatest  
23 devastation in staff and where we saw the greatest  
24 losses, where you really saw the dire situations,  
25 those were in the homes with the perfect storm.

1           Those homes were before the action  
2 plan. They were in homes largely with the older  
3 class beds and the three- and four-bed rooms. They  
4 were certainly homes where there were staffing  
5 shortages, and they were in communities that were  
6 hotspots.

7           And you know we do -- certainly in our  
8 analysis, it was a bit of a perfect storm. So  
9 where we saw the worst of this, it really was in  
10 that period before the action plan.

11           And I think to Ruth's earlier point,  
12 that was a time of high fear. So we lost a lot of  
13 employees. So as soon as -- once we saw these  
14 incidents in the minority of these homes escalate,  
15 the staffing situation quickly became very dire in  
16 those 23 homes, as we understand it. You know, and  
17 staff were not coming in in many cases because of  
18 fear.

19           They didn't want to infect themselves.  
20 They wanted to protect their families. Certainly  
21 some of them may have tested positive because,  
22 certainly, in the beginning we weren't entirely  
23 clear about asymptomatic spread. In many cases,  
24 Public Health officials sent people home.

25           You know, there's a confluence again

1 for those homes in what drove staff out. And then  
2 there was no new staff to come in. And then  
3 where -- in the homes where we didn't have  
4 outbreaks, we're still dealing with fear.

5 Certainly early on we would say that  
6 the federal funding for CERB created some barriers.  
7 We know that, even earlier on before orders came  
8 out, there were hospitals and other organizations  
9 moving to single-site directive which taxed all  
10 staff.

11 And then there was the formal order on  
12 single site where employees could only work at a  
13 single site and had to pick their employer.  
14 Clearly, hospitals were the favourite employer  
15 because their compensation was better. And quite  
16 honestly, they were stable.

17 And so again, the fear and anxiety --  
18 and Ruth can speak to the fear of keeping COVID out  
19 and the level of exhaustion and anxiety that that  
20 certainly had the potential to impact the homes  
21 with.

22 RUTH MCFARLANE: Yeah. I think we have  
23 to remember that, you know, once a home went into  
24 outbreak, of course, the fear was huge because  
25 there was still a lot of unknown. But compounded

1 with that was the requirement for us to screen.  
2 And so we needed additional people to screen coming  
3 in and out, to screen our residents. So there was  
4 an increased need on HR, and we were actually  
5 compounding an already-existing HR crisis and  
6 making it more dire.

7           The closing of the economy, the closing  
8 of the schools -- most of our care providers in  
9 long-term care are females. Schools are closed,  
10 they have to take care of their children. So it  
11 was a compounding effect that caused the entire,  
12 you know, HR crisis to escalate in long-term care.

13           DONNA DUNCAN: One thing I would like  
14 to add in -- and since I come from the mental  
15 health sector, I don't think there's a full  
16 appreciation -- so we had a fragile sector to begin  
17 with in January. We had enormous media attention  
18 on COVID-19 and its impact both at the hospital but  
19 also in care homes across Europe and the impact on  
20 seniors.

21           People were very frightened, and it was  
22 this invisible thing where we didn't know it was  
23 coming. And I don't think there's a full  
24 appreciation for the toll that that has taken on  
25 all homes.

1           And certainly those homes who went into  
2 outbreak and among those 23, the media attention  
3 and the media, almost, invasion in some cases in  
4 those homes was stark where, in the quest for data  
5 numbers, media were phoning homes in the middle of  
6 the night to get the night clerk.

7           Media were camped out and encircled  
8 around homes trying to see, you know, the funeral  
9 home vans come. It was -- it was --

10           Sorry, I'm getting emotional now. It  
11 was very stark.

12           RUTH MCFARLANE: Can I just add --

13           COMMISSIONER FRANK MARROCCO (CHAIR):  
14 Well, this might be a good time for the break.  
15 We're getting...

16           DONNA DUNCAN: Sorry about that.

17           COMMISSIONER FRANK MARROCCO (CHAIR):  
18 That's okay.

19           DONNA DUNCAN: It's my own mental  
20 health.

21           COMMISSIONER FRANK MARROCCO (CHAIR):  
22 But seriously though, Ms. Duncan, do you know to  
23 take the break now and then...

24           DONNA DUNCAN: I'd like that. Thank  
25 you.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay. We'll take ten minutes.

3 -- RECESS AT 11:02 A.M. --

4 -- RESUMING AT 11:14 A.M. --

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 All right. So I guess we're back.

7 Ms. Duncan, carry on, please.

8 DONNA DUNCAN: Okay. So I think we've  
9 already covered the COVID analysis around the class  
10 and the residents per room. Certainly, again, I  
11 identified that the co-location of residents and  
12 the three in bedrooms, again, is a root cause with  
13 regard to our old homes.

14 The rate of COVID-19 cases is two times  
15 higher in B and C homes compared to those new A  
16 homes. And certainly as we look at the related  
17 deaths, they're 2.3 times higher in the B and C  
18 homes compared with the A homes and three times  
19 higher in three and four bedrooms compared to one  
20 and two bedrooms.

21 So certainly, again, that physical  
22 plant, our infrastructure really was a contributor  
23 to where we saw quite tragic losses. That being  
24 said, we do know, going back to the other  
25 statistics, that the majority of the homes in the

1 province had experienced no resident losses. And  
2 for that, we're grateful.

3 COMMISSIONER KITTS: Can I just go back  
4 to that slide for a second, the previous slide?

5 Do you know whether the 32 homes that  
6 are in outbreak now are in the hotspot where  
7 there's high community spread?

8 And does Public Health know whether the  
9 spread to the 69 residents and 85 staff -- whether  
10 that spread is in the community or actually in the  
11 home?

12 DONNA DUNCAN: That's a great question.  
13 So we are working with the government so that we  
14 can be part of those discussions so that we can  
15 understand. Certainly during the first wave, our  
16 homes relied on us to support them, but it's  
17 certainly -- we would certainly ask -- we would  
18 like to ask the question that you've just asked.  
19 It's unclear to us right now.

20 COMMISSIONER KITTS: Yeah. Because of  
21 the fear factor is everybody who works in the 626  
22 long-term care homes is afraid, but we're not sure  
23 what the common factor is in the homes that are  
24 really going to be affected. So if we could  
25 somehow get that.

1                   Do you know if it's iPHIS or anyone  
2 else you're working with for the data to see that?

3                   DONNA DUNCAN: So we've asked the  
4 Ministry of Long-Term Care, and we've asked the  
5 Incident Management Structure if they would share  
6 that information with us so that we can have an  
7 understanding so that we can support our homes and  
8 understand in each community what supports need to  
9 be in place and what's in place, what's not; what  
10 are the gaps; let's do the assessment and make sure  
11 that we're having those discussions together.

12                  COMMISSIONER KITTS: Excellent. Thank  
13 you.

14                  DONNA DUNCAN: So again, just a summary  
15 of the root causes:

16                         High rates of COVID-19 within the  
17 community; outdated infrastructure including three-  
18 and four-bed wards; high levels of congestion  
19 increasing the intensity of outbreaks in many  
20 cases.

21                         Homes only have one meeting room so  
22 even for staff or family -- even early on when  
23 families were going in and now families who are  
24 going in now for visits, there's not a lot of extra  
25 space in these homes where you can isolate

1 effectively or even ensure that you're social  
2 distancing so certainly creating some ongoing  
3 structural challenges.

4 And certainly we've identified on a  
5 go-forward basis that we need to look at capacity  
6 as we think about the future and where we are  
7 today. That preexisting staffing shortage  
8 exacerbated by absences for a variety of reasons.

9 Certainly, as I said, we see the  
10 vulnerability of the staffing population now based  
11 on some fear again and clearly some mental health  
12 and well-being challenges given what all staff have  
13 gone through and recognizing that they, too, are  
14 supporting the mental health and well-being not  
15 only of their residents but also the families and  
16 other visitors.

17 Certainly the evolving public guidance  
18 and regional, local inconsistency and the  
19 interpretation and application of that.

20 What we found was that the COH guidance  
21 was interpreted -- it was taken as a minimum  
22 standard interpreted very differently across the  
23 province depending on the Public Health unit,  
24 depending on the Ontario Health region, depending  
25 on who your hospital partner was. And also, when

1 we had the CAF in, there were also other  
2 interpretations. So, you know, that certainly fed  
3 to some of the confusion on the front line.

4           Again, just reemphasizing that the --  
5 what we would consider to be a profound lack of  
6 understanding at the long-term care sector by  
7 health system partners and poor integration with  
8 the rest of the system, delays and deployment of  
9 support to long-term care and lack of preparedness  
10 early in the pandemic with a shortage of personal  
11 protective equipment and challenges accessing  
12 testing but also an evolving virus on a global  
13 scale.

14           And I think I do want to emphasize  
15 something that gets lost for us in this is is this  
16 is a global pandemic. This is a national pandemic.  
17 This is not unique to Ontario. And certainly --

18           You know, I had a call with my  
19 international partners yesterday talking to my  
20 colleague in the UK where they're looking at what  
21 they're doing about visitation and lockdown. And,  
22 you know, we're all living this again today, and --  
23 except in the US where they still consider  
24 themselves in the first wave. But, you know, I do  
25 think it's important that we not lose that broader

1 national and global context.

2 RUTH MCFARLANE: If I can just add if  
3 that's all right, Donna.

4 DONNA DUNCAN: M-hm, absolutely.

5 RUTH MCFARLANE: The whole supply chain  
6 was strained globally. And even with the  
7 prioritization from long-term care, the response  
8 was slow. And there was a lot of questioning about  
9 accountability and a very low risk tolerance.

10 So at some point, you know, it came to  
11 the point where either you have masks and gowns, or  
12 you -- or you don't have masks or gowns, or you  
13 would have expired masks and gowns. It was the  
14 slow response that also caused the pandemic to take  
15 hold.

16 DONNA DUNCAN: M-hm. And well, to feed  
17 on that, we actually had members who created a  
18 group -- a bunch of our large members and operators  
19 partnered with some others across Canada to create  
20 a bit of a consortium to actually source personal  
21 protective equipment for long-term care and seniors  
22 housing across Canada.

23 And they were originally purchasing it  
24 for themselves but actually, in the end, purchasing  
25 significantly more and partnered with the Federal

1 Government to get cargo space on planes and ended  
2 up purchasing stock for our -- for anyone who  
3 needed it across Canada.

4 So, you know, we're certainly lucky to  
5 have had the benefit of our larger medium and  
6 larger members that they were able to take that  
7 initiative because, certainly, smaller homes were  
8 clearly disadvantaged.

9 RUTH MCFARLANE: And definitely with  
10 respect to the PPE, when we were prioritized and  
11 there was a system, although it was, you know, a  
12 slow system, it came to the point where when you  
13 were reaching out to these emergency response  
14 numbers and people and trying to get PPE, and you  
15 would be -- the response would be that they would  
16 offer you expired PPE and a waiver to sign, you  
17 know, admonishing any risk from the Ministry  
18 providing this equipment.

19 And so it became, you know -- it became  
20 a trust exercise. I mean, what are we going to do?  
21 How are we going to move it forward?

22 DONNA DUNCAN: M-hm. And I would utter  
23 you, too. Just in terms of the PPE, we did have  
24 homes who had hospital partners who were mandating  
25 it well before the guidance said "universal

1   masking." They were mandating universal masking,  
2   and our homes had run short. They were maybe  
3   running on a day of -- a day or one to two days of  
4   supply.

5                   And so as you heard the guidance coming  
6   out saying "you must have this," and you know,  
7   again, that contributed to the fear factor and,  
8   again, was quite destabilizing.

9                   COMMISSIONER KITTS: Given where we are  
10  today, with high rates in the community and  
11  et cetera, what is your level of confidence that  
12  we've addressed these root causes sufficiently to  
13  mitigate Wave 2?

14                   DONNA DUNCAN: Maybe that's a nice  
15  segue into our Wave 2 action plan. So we developed  
16  this Wave 2 action plan at the end of May, and,  
17  again, it was through the work of our Pandemic  
18  Advisory Group that Ruth, actually, now chairs and  
19  working closely with our Quality Committee, our  
20  Finance Committee, and others.

21                   You know, certainly, I guess, two weeks  
22  ago, our coalition of long-term care and senior  
23  partners did communicate to the Government of  
24  Ontario that we are very concerned about readiness.

25                   And certainly if you look at what we've

1 proposed in terms of the immediate solutions, many  
2 of them are simply a continuation of the Wave 1  
3 action plan. So the prioritization around the PPE  
4 and testing, certainly a quick return around  
5 testing results and prioritizing long-term care  
6 testing results for our employees, continuing with  
7 the hand hygiene and other measures, certainly  
8 enhanced IPAC specialists.

9           Medical presence in our homes, we  
10 believe, is paramount. Our most critical problem  
11 is staff. And, you know, we may have staffing  
12 numbers right now especially with reduced  
13 occupancy, but we know how quickly that can  
14 implode.

15           And we have heard through the work that  
16 we've done as an association and building out a  
17 recruitment platform and working with  
18 internationally trained professionals and colleges  
19 and students to find out what it's going to take to  
20 bring people in that safety is Number 1.

21           We're certainly -- we've been concerned  
22 as -- we felt very early on in the pandemic and we  
23 felt very strongly, certainly, as we saw the  
24 reports from the hospitals and saw the reports from  
25 the CAF in the spring that we needed to embed

1 infection prevention and control expertise in all  
2 of our homes, especially from compliance and  
3 monitoring supporting family visits.

4 It's important psychologically, quite  
5 honestly, we believe, as well, for everybody  
6 certainly having a mechanism to incent the  
7 physicians. We understand that in the first wave,  
8 hospital physicians were afforded stipends to go  
9 into long-term care. Our long-term care physicians  
10 were not.

11 So, you know, I think there are some  
12 pieces we can actually move quickly on to  
13 stabilize. What I would say with yesterday's  
14 action plan, certainly all of the elements of what  
15 we've proposed in our action plan and including  
16 looking at performance monitoring and  
17 accountability are there.

18 Certainly better integration with the  
19 healthcare system is there. The PPE is there. The  
20 testing, we still want to make sure we get the  
21 results turnaround for our staff.

22 We're going to have to do whatever we  
23 can do today. It's not going to be perfect. I  
24 think this is the point we are today. And while we  
25 certainly would have preferred for action in the

1 spring and through the summer months, this is where  
2 we are.

3 So we've got the plan. We've got the  
4 foundation. Now we have to mobilize. But it is  
5 very clear to us the tone and approach of this  
6 phase has to be different.

7 This really has to be a -- if we're  
8 going to get more -- if we're going to retain our  
9 staff, if we're going to recruit more staff, if  
10 we're going to the support mental health and  
11 well-being of our residents, our families, and our  
12 staff and our leaders, quite honestly, it really  
13 does need to be about a very aggressive  
14 partnership.

15 Government demonstrated with the  
16 emergency orders that they can pivot and move  
17 quickly, and that's just what we're going to have  
18 to do. And it's not going to be perfect, but I do  
19 think that in working with our colleges, working  
20 with organizations like the Michener, we can be  
21 really innovative in how we can bring in new people  
22 and train them up quickly.

23 Certainly Ontario Health helped in  
24 Wave 1, what's the model go-forward. But I do  
25 think it needs to be more of warmer mentality where

1 we're all mobilizing around coming together and  
2 that we're more concerned with the people. And  
3 it's not a "them" and "us" hospital versus  
4 long-term care.

5 It really has to be how do we support  
6 each other together in this? So we -- are we  
7 ready? We're concerned that we're not. But we  
8 have to get on a better path to readiness, and  
9 certainly regional responses and more of an  
10 iterative approach will be really important.

11 The thing I would say about the IPAC,  
12 you know, certainly we need to build out the  
13 spokes, and we've heard the government talk about a  
14 hub-and-spoke model with hospitals. We need to,  
15 very quickly, mobilize to create the spokes in that  
16 system.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 And, Commissioner Kitts, you wanted to ask a  
19 question?

20 COMMISSIONER KITTS: Yeah. You spoke  
21 to the importance of partnerships and trust between  
22 the various players in the system as a key to  
23 success.

24 DONNA DUNCAN: M-hm.

25 COMMISSIONER KITTS: Just wondering who

1 are the partners that are included in your  
2 coalition that develop this plan and is  
3 responsible for implementing it?

4 DONNA DUNCAN: So this plan was  
5 developed by OLTCA and our membership and shared  
6 with our Resident and Family Councils, AdvantAge  
7 Ontario, and our other colleagues.

8 This has been -- we've pushed it out  
9 with media. Quite honestly, we've been  
10 communicating on this publicly since early June.

11 And again, it was really anchored in  
12 what our members experienced during the first wave.  
13 It was anchored in what was identified as being  
14 issues that needed to be addressed in the CAF  
15 reports as well as infection prevention and control  
16 and other hospital assessments in the first wave.

17 So again, let's look at what happened  
18 and then consider the solutions. And we would  
19 argue we know what we need to do. We know what  
20 worked in Wave 1.

21 Certainly we know that help coming in  
22 and boots on the ground, the wraparound around  
23 long-term care and the prioritization was  
24 effective. Where we're concerned in this wave is  
25 that we may have hospital surges in communities.

1                   One thing that we have done in  
2 certainly working with the Ministry of Health and  
3 the Ministry of Long-Term Care -- our association  
4 actually did a total mapping of the province to  
5 look at the three- and four-bed rooms in the  
6 province so that, with reduced occupancy, we would  
7 know, one, where there may be ongoing risk; two,  
8 where there may be reduced capacity; how does it  
9 map against the ALC of the hospitals; what is the  
10 local solution going to be; how do we work around  
11 that?

12                   And be mindful as well, where those  
13 homes are relative to communities, where there may  
14 be spreads -- that we'll all know that when that  
15 happens, we'll have a sense of where the  
16 vulnerability is in the system.

17                   So, you know, I think those discussions  
18 have been very fruitful over the summer, and  
19 certainly we've had far more increased engagement  
20 over the last months with our Ministry of Long-Term  
21 Care around building out solutions and certainly  
22 also with the Ministry of Health and Long-Term  
23 Care.

24                   So I would say even our relationships  
25 across government and within government but also

1 with some of our partners including the Residents  
2 Council and the Family Councils and the Ontario  
3 Hospital Association are far better, and we've  
4 shared these with them as well. And I do think  
5 there's clear alignment.

6 COMMISSIONER KITTS: Thank you. You  
7 mentioned, I think, early on in your introduction  
8 about the need for integration and partnerships and  
9 everybody working together. I think you mentioned  
10 Ontario Health Teams?

11 DONNA DUNCAN: M-hm.

12 COMMISSIONER KITTS: Am I correct?  
13 Where do you think their role is in this?

14 I know that the state of maturity is  
15 not where you'd want it to be, but do you think  
16 Ontario Health Teams have any role where they  
17 actually exist?

18 DONNA DUNCAN: You know, certainly I  
19 know from some of my board experience where there's  
20 some very healthy discussions and dynamics and,  
21 certainly, appetite and work being done to engage  
22 with long-term care.

23 Ours certainly -- our understanding  
24 from our membership -- and, Ruth, you can speak to  
25 this, I'm sure -- is that in large part, for

1 Ontario Health Teams, long-term care was outside of  
2 the discussion. And they have been approached --  
3 they might have signed a letter but certainly were  
4 not involved in any of the governance structure  
5 discussions, weren't involved in really building up  
6 the core elements of them.

7 And, again, it was that silo from the  
8 rest of the system and a lack of understanding  
9 about what long-term care is and who we serve. So,  
10 you know, again, it speaks to the need to build  
11 that trust.

12 Our understanding is that we have a  
13 number of -- in a number of communities where the  
14 government is now expediting the next tranche of  
15 health team applications, long-term care has been  
16 invited to those tables.

17 I certainly think we've been  
18 disadvantaged not to have been part of the earlier  
19 discussions. And so, again, you're kind of forcing  
20 some marriages here, and they're -- it won't be  
21 perfect.

22 But certainly, I think there's a  
23 recognition -- and certainly when we were  
24 developing this Wave 2 action plan with our board  
25 and our membership, there is a recognition that we

1 have to come together.

2 Again, it's about people, and where we  
3 were disadvantaged was when we were clearly,  
4 clearly disconnected from the health system.

5 Ruth, did you have anything else to  
6 add?

7 RUTH MCFARLANE: Yeah, no, no.

8 Definitely I agree with everything that you said.  
9 I'd just add that, you know, with the Wave 2 action  
10 plan, I think what we did was we really worked on  
11 our Wave 1 action plan.

12 And as you've heard, human resources  
13 was a big challenge for us. And being able to  
14 recruit and the flexibility to be able to staff  
15 accordingly actually helped us out a lot and helped  
16 us improve the safety of our staff. And we were  
17 able to redeploy staff. We were able to  
18 cross-train staff which better served our  
19 organizations.

20 And really, it is the need for the  
21 staff to have the resources behind them to continue  
22 to be effective in our sector. And the resources  
23 behind them are the PPE and are the regular testing  
24 and the timely results for the swabbing, for the  
25 IPAC supports and the physicians being present.

1           Like, we need that type of backup to be  
2 able to decrease the fear and to be able to empower  
3 our staff to do what they need to do.

4           DONNA DUNCAN: I think one of the  
5 pieces -- again, so we've chatted about the  
6 psychosocial framing of all the people in our  
7 sector -- our residents, our families, and our  
8 staff.

9           Going back to our financial foundation  
10 in wave -- at the beginning of January, which was  
11 precarious, you know, it is even more precarious  
12 right now. And so our homes, in many cases, have  
13 lost insurance, or they no longer have coverage for  
14 infectious diseases.

15           They're subject to class action  
16 lawsuits in many cases. We still have an acute  
17 staffing shortage. They are subject, in many  
18 cases -- and it's more on the small homes and small  
19 non-profit homes, in particular, where we're  
20 certainly hearing that agencies who are supplying  
21 staff are asking for cash on delivery -- so upfront  
22 payments.

23           PPE continues to be a cost, and the  
24 agency costs are significantly inflated. They're  
25 approximately twice what a normal compensation

1 level in a home would be for a nurse, an RPN, or a  
2 PSW.

3 Certainly PPE costs are inflated, and  
4 again, it's where they're doing their own  
5 procurement. You know, we're hearing from our  
6 regular suppliers for this system that the system  
7 is largely stable right now, and homes are able to  
8 go through their regular resources, but there are  
9 still some weaknesses in that system.

10 The government has committed to ensure  
11 a supply for homes, so that's certainly  
12 encouraging. But the costs that were accumulated  
13 in Wave 1, the government did make containment  
14 funding available.

15 But if you think about some of the cuts  
16 in the last fiscal year that were destabilizing,  
17 homes spent whatever they could. So we certainly  
18 know from -- regardless of ownership, homes were  
19 spending approximately triple or double.

20 And we know that, right now, the run  
21 rate, now that we got through to the other side, is  
22 about \$57 million above their traditional operating  
23 funding envelope for the entire sector. And we  
24 think that is the go-forward.

25 And certainly the government's

1 commitment for funding yesterday -- well,  
2 stabilizing, in some respects, may well not be  
3 enough to ensure that homes are able to continue to  
4 be sustainable from a financial perspective.

5           They run with financing. They have  
6 debt service requirements. Many of our homes are  
7 in breach of those debt service requirements. They  
8 can't get additional financing. They can't get  
9 additional insurance.

10           And so even as we think about that  
11 capital investment and the future of the sector, we  
12 have been told by homes that their lenders, with  
13 whom they were in discussions about redevelopment  
14 and financing, have -- those discussions have been  
15 put on hold.

16           So, you know, we are back in another  
17 different kind of perfect storm, I would argue. So  
18 again, all the more reason why -- as we think about  
19 how we all rally around, you know, this creates  
20 significant vulnerabilities.

21           The vulnerability of our sector creates  
22 significant vulnerabilities for the rest of the  
23 healthcare system and certainly vulnerabilities for  
24 the people we are here to serve.

25           And it's been about three decades of

1 lack of support and investment, and we do believe,  
2 though, that this is an opportunity. And certainly  
3 the messaging from the government yesterday and the  
4 from the Premier was very encouraging around the  
5 tone and approach.

6 Premier made a plea for people to rally  
7 around. I do think this is a moment in time that  
8 even in, you know, the end of December or January,  
9 we're wondering how are we going to move the  
10 changes to the system.

11 For us, this is that moment. And, you  
12 know, I think we can do these pieces. We can  
13 certainly make incremental progress on them. I do  
14 think we're going to have to -- Commissioner Kitts,  
15 to your point about the hot homes -- really keep an  
16 eye and partner together on how we support those  
17 homes.

18 You know, government does talk about,  
19 you know, their inspection plan. And one thing I  
20 would add on that, the inspection should be about  
21 how do we come in and help you improve.

22 And I've been through lots of  
23 inspections in the children's services sector, and  
24 I've certainly been involved in inspections --  
25 accreditation in hospitals and ensuring quality

1 improvement.

2           How do we go in and help the homes to  
3 bring them up, not go in and say "You had a menu  
4 violation and put in a critical incident report two  
5 months ago. And on that day, this is how you  
6 failed"?

7           I do think it's, as we know, what  
8 happens and happened in Wave 1 with these homes  
9 that are at risk. It really needs to be about a  
10 building up and a supporting and figuring out what  
11 do you need and how do we help you get there.

12           And I think that tone and approach is  
13 going to be profoundly important. I think we can  
14 make progress on this. The government has a plan.  
15 Let's start. There are gaps in it, yes, but I  
16 don't think we have a choice but to mobilize as  
17 quickly as possible.

18           COMMISSIONER FRANK MARROCCO (CHAIR):  
19 In these investigations, are they rooted in  
20 interviewing people about what happened, or are  
21 they more concerned about the physical location of  
22 what happened?

23           And the reason I ask that is, as you  
24 can appreciate from this format, it's possible to  
25 interview people quite extensively without setting

1 foot in the home. And you know, if I asked you to,  
2 you could move your camera around. I could see the  
3 space, if I'm concerned about it. Is anything like  
4 that happening?

5 DONNA DUNCAN: It is -- you know, and I  
6 think, Ruth, you can speak to this just given that  
7 you lived this.

8 RUTH MCFARLANE: Yes. So not --  
9 compliance inspections are highly prescriptive, and  
10 so it isn't kind of a remote inspection process.  
11 The compliance inspectors will come on site, and  
12 there could be three or up to five of them.

13 They would remain on site for a time  
14 period of a minimum of two weeks up to, say, a  
15 month or a month and a half. It is very  
16 paper-based, and it is also interview-based.

17 It is very prescriptive, and there are  
18 examples of where it is counterintuitive, what  
19 actually gets cited but has to be -- but results  
20 and being cited because of the legislation and the  
21 regulations.

22 For instance, I know of a situation  
23 where we had -- where there was a home that had a  
24 medication plan that included that the resident was  
25 supposed to have insulin twice daily. What

1 happened was that the nurse used her professional  
2 judgment, looked at the blood sugar level, and  
3 decided that there was insulin that was not  
4 required and withheld that insulin for the  
5 resident's good.

6           What happened then was that the  
7 Ministry cited that home because they did not  
8 follow the medication management plan. So there --  
9 it is counterintuitive to what is best for the  
10 resident, not always, but oftentimes.

11           And that's why I think we have to take  
12 a look at risk and safety, and definitely, we  
13 welcome the compliance inspection process that  
14 addresses the risk and safety of the residents.

15           But when it becomes so prescriptive in  
16 that we are so -- the most regulated sector in the  
17 province with -- I can't even remember how many  
18 regulations there are.

19           It becomes overly cumbersome and  
20 burdensome, and it takes up away time from our  
21 nurses and our personal support workers to provide  
22 the bedside care for our residents, and that's  
23 really what they want to do. They don't want to  
24 fill out paperwork. They want to be able to  
25 provide that care. And so I think there's a

1 balance that we haven't arrived at yet with respect  
2 to compliance.

3 DONNA DUNCAN: Yeah, and I would add --  
4 so, you know, I have my experience again, as I  
5 said, from being in a hospital and being part of  
6 accreditation and following -- you know, being part  
7 of a Quality Committee and quality improvement  
8 initiatives in the hospital but also in my  
9 children's mental health agency.

10 And the children's mental health agency  
11 were captured under the Child and Youth Family  
12 Services Act. We had inspections. We had advance  
13 notice of the inspections. We worked to those  
14 inspections. We worked really hard to comply.

15 We certainly found that there -- I  
16 found that there are similarities in the long-term  
17 care sector where there is more of a reporting and  
18 a tracking of the volume of incidents and not the  
19 culture that we have in hospitals where you look at  
20 a critical incident -- look at the materiality of  
21 the critical incident, gauge it, and then also have  
22 those very purposeful discussions about how do we  
23 make sure that -- what happened? What were the  
24 root causes? How do we avoid this?

25 This notion -- and this is my opinion

1 based on my personal experience working in those  
2 other sectors -- is this notion that we should have  
3 to surprise a home rather than give them the  
4 advance notice.

5 And let's -- you know, and certainly we  
6 know that when homes submit critical incident  
7 reports, they know that they will have an  
8 inspection. There will be an investigation because  
9 they've invited it with the fact of the report.

10 But this notion that it has to be a  
11 shock and awe surprise, again, speaking to tone and  
12 culture, is -- you know, why would you not want to  
13 work with them to help them prepare and address an  
14 issue in the moment rather than to come in and try  
15 to catch them out.

16 I do think that speaks to the culture  
17 and the challenges that we have around human  
18 resources because, you know, the investigation is  
19 about what had happened at that moment of the  
20 complaint, and it takes into consideration nothing  
21 that you might have done to remedy the situation at  
22 all. And the report that you're going to get is  
23 going to be a report on failure. "You failed; you  
24 failed; you failed."

25 In our school system, we support our

1 students to do the very best we can. We recognize  
2 and support them to do better. And yet in our  
3 long-term care homes, the people who work in them  
4 can only fail. So why would you want to work in a  
5 sector where you know that as soon as the  
6 inspectors are coming in, you have already failed,  
7 just the fact that they came into your home.

8 So, you know, again, as we move into  
9 this new wave and potential subsequent waves, you  
10 know, I do think there's an opportunity to learn  
11 from the hospital models around quality improvement  
12 and that just culture that Justice Gillese talked  
13 about.

14 Because it -- that compliance framework  
15 for the sake of compliance with thousands of  
16 sections of both the legislation and the  
17 regulation -- it -- we -- again, we lose -- going  
18 back to my first photo, we lose sight of the people  
19 in this, and it becomes about compliance with a  
20 clause in a statute that was written in 2007 and  
21 ignores the reality of what's happening in the  
22 homes and ignores the humanity of this, quite  
23 honestly.

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 So go ahead.

1 DONNA DUNCAN: Okay. So I think,  
2 really, just, again, that really does feed into our  
3 stabilization. As we go forward, that --  
4 maintaining that regulatory flexibility that we  
5 received in the order is paramount for us.  
6 Certainly maintaining the order to allow for the  
7 deployment of individuals from other parts of the  
8 system, paramount.

9 Our concern -- and this goes back to  
10 your comment, Commissioner Kitts -- is right now it  
11 may well be, as we saw in Ottawa, ultimately, the  
12 solution was for the hospital to do a management  
13 order.

14 And you know we've got -- it's going to  
15 take us time to build up some of these other  
16 pieces, so I think being able to provide for that  
17 redeployment where hospitals will come in or where  
18 we need to redeploy into field hospitals or other  
19 settings because of capacity pressures in hotspots  
20 around the process is going to be very important.

21 Certainly we're a big proponent of  
22 on-the-job training and are in discussions with  
23 Colleges Ontario.

24 And certainly had a call the other day  
25 with regard to the Michener. Can we tap into a new

1 workforce?

2           You know, people from the accommodation  
3 and hospitality industries have, unfortunately,  
4 lost their jobs. How do we take that new role that  
5 we have through that flexibility, that resident  
6 support worker, bring people in, and, in realtime,  
7 allow them to take their theory for a PSW online  
8 and then, in realtime, mapped against that module,  
9 work with a preceptor of a home to do their  
10 practical training.

11           We could -- we could train -- we could  
12 train a workforce pretty quickly. So we've been  
13 talking about this, again, for a number of months,  
14 but let's start. You know, we think the  
15 possibilities are endless here for this.

16           But that tone and approach and that  
17 culture and not blaming operators or finding faults  
18 and really trying to focus on the people in this, I  
19 think, is going to be really important for us if we  
20 are going to stabilize the workforce we have,  
21 protect our residents and our seniors, and attract  
22 a new workforce because we do know that the  
23 hospital workforce is not there.

24           So even as we think about do we have  
25 enough people now, well, maybe. But it's

1 precarious. And we know that we're going to need  
2 to build more especially around infection  
3 prevention and control and PSWs. But of course, we  
4 still need more nurses and more RPNs.

5 But this is the beginning for us. As I  
6 said, let's not lose our moment. Let's make sure  
7 that we do what we have to and just celebrate those  
8 incremental steps, and ultimately, we will get to  
9 better. And we certainly believe that we owe our  
10 seniors, our residents, our families, and staff  
11 better.

12 RUTH MCFARLANE: And, Donna, if I could  
13 just add, for the stabilization of the HHR, we need  
14 a strong foundation. Historically, our funding has  
15 been going up at 1 percent per year. And our  
16 actual arbitration decisions -- we're a very highly  
17 unionized workforce, and our labour increases are  
18 trending between 1 and a half and 2 percent per  
19 year.

20 On top of that, we're looking at even  
21 larger increases on the benefit plans that we  
22 provide for our employees. And, of course, we've  
23 discussed, you know, CMI and how well that does  
24 demonstrate acuity within a home. It doesn't  
25 actually address the acuity as a whole, and our

1 resident population is moving up.

2 80 to 90 percent of our envelope  
3 funding, which is very complex, is spent on  
4 staffing. And if it is not spent, then it is  
5 returned to the government. Those rare occasions,  
6 it goes back to the government.

7 So I think it is fundamental that we  
8 have a really strong foundation to be able to  
9 stabilize our health human resources too.

10 DONNA DUNCAN: Yeah, absolutely. One  
11 thing I will comment, Commissioners, some work that  
12 we've undertaken right now is we are, right now,  
13 currently in the field trying to do an assessment  
14 as to what is the actual state of our HR in the  
15 field.

16 We know that homes feel vulnerable.  
17 There are lots of actions out there, so we're  
18 certainly working in partnership with counsel to  
19 get a clear read so that we actually all know what  
20 the facts are.

21 And we look forward to being able to  
22 share aggregate data with you once we are in  
23 possession of that so that we'll have a clear line  
24 of site of what it actually looks like as we go  
25 forward.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2 We'd be pleased to receive that information, the  
3 aggregate data. So please don't think we're  
4 reluctant or hesitant. We would like to get it.

5                   DONNA DUNCAN: Okay. Thank you. And  
6 we welcome the opportunity to follow up with you.  
7 We're on the field with -- in the field now on some  
8 other initiatives for research.

9                   We have a very robust membership  
10 population, and we've been quick to pivot and be  
11 able to get a sizable sample that can inform some  
12 of the policy and other decisions that we're  
13 working with government on. So we really thank you  
14 for this opportunity.

15                   COMMISSIONER FRANK MARROCCO (CHAIR):  
16 Well, thank you. I take it page 18 is the last  
17 page in --

18                   DONNA DUNCAN: Yes.

19                   COMMISSIONER FRANK MARROCCO (CHAIR):  
20 -- the presentation.

21                   DONNA DUNCAN: M-hm.

22                   COMMISSIONER FRANK MARROCCO (CHAIR):  
23 It's been very informative for us, and I hope you  
24 can appreciate there's been a good interchange as  
25 we went along. We found it very interesting and

1 very informative of what you were saying.

2 We might be back and probably will be,  
3 and so I hope that -- you may hear from us again as  
4 we get into this in different ways. But thank you  
5 so much.

6 DONNA DUNCAN: No, we welcome that.  
7 And certainly, as we said at the outset, we called  
8 for an inquiry, and this is the nature of the type  
9 of inquiry we wanted, one that wasn't going to be  
10 diverted on the past but was looking at solutions,  
11 especially on solutions to help us stabilize on a  
12 go-forward basis. And we also said that we wanted  
13 to have a conversation, so we've really welcomed  
14 this and, again, look forward to continuing to  
15 support your work.

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 Well, thank you. We look forward to the support.  
18 Commissioner Kitts?

19 COMMISSIONER KITTS: Yeah, I just want  
20 to commend you on -- your slide deck that you sent  
21 in advance is amazing. It's got all kinds of  
22 incredible information.

23 What I'm impressed is how you have  
24 taken that slide deck and condensed it to 17 or 18  
25 slides. So I appreciate your doing that, and I

1 really appreciate the information you shared today.  
2 It's been an excellent session. Thank you.

3 DONNA DUNCAN: Thank you, Commissioner.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Thank you.

6 COMMISSIONER COKE: Thank you.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 All right. Well, goodbye, and we'll see you again.

9 DONNA DUNCAN: Great. Thank you very  
10 much. We will.

11 WIESIA KUBICKA: Thank you.

12 -- Adjourned at 12:00 p.m.

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