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

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

BEFORE:

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

PRESENTERS:

Donna Duncan, Chief Executive Officer;
Nancy Cooper, Director Quality & Performance;
Wiesia Kubicka, Vice President, Policy and Operations;
Ruth McFarlane, Vice Chair of the Board of Directors of OLTCA, Chair of OLTCA's Pandemic Advisory Committee and of OLTCA's Human Resources Emergency Task Force, co-Chair of the Association's Red Tape Reduction Advisory Committee;
Tommy Wong, Director, Data and Analytics at OLTCA.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission

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

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 10:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. The Commissioners are here, as you can appreciate.

I'm Frank Marrocco with Commissioner Kitts and Commissioner Coke.

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

DONNA DUNCAN: We're ready to go.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, excellent. Well, thank you very much for coming. You know, we're at the investigative stage of what we're doing.

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

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

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

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

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

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

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

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

to link, that would be very helpful.

U/T DONNA DUNCAN: Absolutely, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, we're in your hands. We're ready to go when you are.

DONNA DUNCAN: Great. Well, thank you. So I am Donna Duncan. I'm the CEO of the Ontario Long-Term Care Association. I've been with the association since the end of April 2019.

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

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

Nancy Cooper, our director of Quality and Performance;

And Tommy Wong, our Director of Data Analytics.

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

continuum of membership.

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

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

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

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

We did share a lot of material just for

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

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

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

DONNA DUNCAN: No.

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

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

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

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

DONNA DUNCAN: There we go.

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

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

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

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

members.

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

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

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

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

And rather than telling government "We

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

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

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

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

people -- problem filling shifts?

DONNA DUNCAN: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So that would come as --

DONNA DUNCAN: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): The pandemic wouldn't cause that to -- and you correct me if I'm wrong. But so then the pandemic wouldn't cause that to be some revelation, then? That was always there? That was always the realty?

DONNA DUNCAN: Yes, absolutely. And certainly we know that many staff were working across multiple sites.

Further, we have homes especially in rural areas where they're almost entirely dependent on agency staff, so there is no local labour pool for them to tap into. So especially for RPNs and RNs, but also PSWs, it's -- we have a massive shortage, just leading into this.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. We've heard from others earlier, and one of the things we heard is that it's not just a question of personal support workers but it's a question of the distribution of varying skills of people -- registered practical nurse, registered

nurse, and so on. And they have to get that distribution correct as opposed to simply just increasing the number of personal support workers. Do you have a view on that?

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

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

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

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

Ruth, did you want to comment?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: M-hm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: The other --

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

Commissioner Coke?

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

that you would activate when situations like this occur.

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

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

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

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

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

no.

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

Ruth?

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You know, I think -- but where our

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

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

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

Ruth?

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

as the nurses.

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

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

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

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

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

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

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

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

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

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

advocating with government force so we --

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

COMMISSIONER FRANK MARROCCO (CHAIR): So then if I understood you correctly, you communicated with government towards the end of January which means the light must have gone on a little bit before you wrote the -- before you communicated, obviously.

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

DONNA DUNCAN: Yes, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

DONNA DUNCAN: M-hm, yeah.

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

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

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

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

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

So fear became a huge destabilizer as

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

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

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

DONNA DUNCAN: So Ministry of Long-Term Care.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

Okay.

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

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

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

DONNA DUNCAN: I don't recall the exact

date.

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

DONNA DUNCAN: Okay.

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

Commissioner Coke?

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

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

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

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

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

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

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

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

Wiesia?

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

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

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

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

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

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

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

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

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

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

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

times of need?

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

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

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

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

Ruth, did you have anything to add on that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So next slide.

COMMISSIONER FRANK MARROCCO (CHAIR): So if I read that right, then, in February when the alarm is sounded -- I think that's what you said -- the situation is still stable?

DONNA DUNCAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And once the action plan was put into effect, it started to bring the situation under control?

DONNA DUNCAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Who came up with the action plan?

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

sure the government has more detailed...

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

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

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

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

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

So again, it really does speak to those

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

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

DONNA DUNCAN: Yeah. Absolutely.

So, Wiesia, the next slide.

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

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

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

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

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

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

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

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

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

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

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

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

You know, there's a confluence again

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

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

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

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

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

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

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

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

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

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

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

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

RUTH MCFARLANE: Can I just add --

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

DONNA DUNCAN: Sorry about that.

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

DONNA DUNCAN: It's my own mental health.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. We'll take ten minutes.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So I guess we're back.

Ms. Duncan, carry on, please.

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Excellent. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

national and global context.

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

DONNA DUNCAN: M-hm, absolutely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And certainly if you look at what we've

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: M-hm.

COMMISSIONER KITTS: Just wondering who

are the partners that are included in your coalition that develop this plan and is responsibile for implementing it?

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

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

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: M-hm.

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

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

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

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

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

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

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

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

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

have to come together.

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

Ruth, did you have anything else to add?

RUTH MCFARLANE: Yeah, no, no. Definitely I agree with everything that you said. I'd just add that, you know, with the Wave 2 action plan, I think what we did was we really worked on our Wave 1 action plan.

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

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

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

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

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

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

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

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

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

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

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

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

And certainly the government's

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

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

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

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

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

And it's been about three decades of

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

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

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

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

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

improvement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This notion -- and this is my opinion

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

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

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

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

In our school system, we support our

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): So go ahead.

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

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

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

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

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

workforce?

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

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

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

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

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

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

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

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

resident population is moving up.

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

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

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

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

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

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

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

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

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

DONNA DUNCAN: Yes.

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

DONNA DUNCAN: M-hm.

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

very informative of what you were saying.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you. We look forward to the support.

Commissioner Kitts?

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

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

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

DONNA DUNCAN: Thank you, Commissioner.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

COMMISSIONER COKE: Thank you.

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

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

WIESIA KUBICKA: Thank you.

-- Adjourned at 12:00 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 30th day of September, 2020.

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