Long Term Care Covid-19 Commission Mtg.

Members of Revera Expert Advisory Panel
on Monday, December 21, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 21st day of December, 2020, 3:00 p.m. to 4:39 p.m.

BEFORE:

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

PRESENTERS:
Dr. Bob Bell, Chair, Revera Expert Advisory Panel, Former Ontario Deputy Minister of Health

Bob Bass, Principal, Bass Associates; Member, Revera Expert Advisory Panel

Dr. Samir K. Sinha, Director of Geriatrics; Director of Health Policy Research, Sinai Health System and the University Health Network; National Institute on Ageing; Member, Revera Expert Advisory Panel

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister Long-Term Care Commission Secretariat

Ida Bianchi, Counsel Long-Term Care Commission Secretariat

Kate McGrann, Counsel Long-Term Care Commission Secretariat

John Callaghan, Counsel Long-Term Care Commission

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Lynn Mahoney, Counsel Long-Term Care Commission Secretariat

Derek Lett, Policy Director Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director, Operations Long-Term Care Commission Secretariat

Jessica Franklin, Policy Lead Long-Term Care Commission Secretariat

Adriana Diaz Choconta, Senior Policy Analyst Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 3:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think -- so everybody knows everybody now or has been introduced, you know the format that we're following.

And Janet is our transcriptionist. We will produce a transcript which we will put on the website at some point so people know what we're up to.

And I think we're ready when you are. If it's okay, we'll ask questions as we go along rather than wait 'til the end and circle back.

BOB BELL: Super. And I thought, Judge, what we'd do, is I'd start off by describing a little bit about the Revera Report, the Perfect Storm, as it's titled, how it came to be -- how it came to be developed and written, and then some specific elements of that I think are probably the most important.

Certainly, we'd start off by recognizing the dedication of that report to families and residents of long-term care who have suffered so much during the last nine months and some of whom have actually passed away, that our work was certainly dedicated to them, and also the

staff that have had such a difficult time, a time of, you know, moral difficulty, looking after people without the kinds of -- without the kinds of support sometimes they deserve to have and certainly with a set of circumstances that were so, so difficult.

The Revera Report that you've heard a bit about was developed to look at the experience of Revera Corporation during Wave 1 and to look at their -- the features that they put in place in response to the pandemic's challenges, to give them advice, to give them recommendations that they could put into play. We didn't know at the time we were doing it that Wave 2 would occur, but we were concerned and certainly thought that it would be wise to give them recommendations that they could follow for Wave 2.

And that panel that was put together, I just want to talk briefly about that because, you know, the issue of whether or not that panel has conflict of interest, how it was constituted, has been commented on in the press and in social media. I don't know whether the Commission looks at social media, but certainly social media, as you know, is alive with discussion of the pandemic and response

to the pandemic.

And Tom Wellner, the CEO of Revera, who I knew from my term as Deputy Minister, called me and said he was thinking about putting together an expert panel: Would I be involved; would I consider chairing? And I thought it was important that this be free of conflict of interest and that no compensation be awarded to myself as the person who would bring together the panel along with Revera.

And the two conditions that I set were first of all, no compensation for any of the work; and secondly, that I would have final editorial control of the -- if we produced a report, that I would have final ability to decide what was in the report. And certainly Revera honoured that condition.

The members of the expert panel represent a variety of different areas of importance to understanding the pandemic's influence. People like Samir, a geriatrician, probably Canada's outstanding geriatrician, international reputation, as someone who understands the background of what seniors living is about and the medical aspects of geriatric care,

experts from Public Health, from infection prevention and control, infectious disease, labour relations represented by Bob Bass on this call, as well as issues related to design and architecture of seniors living facilities.

Some of these people -- Bob is a great example -- have worked in this area forever. So Bob has clearly been compensated during the course of developing his expertise and understanding labour management issues, but no funding was provided specifically to the development of this report.

And members of the panel worked extraordinarily hard without compensation in doing this. I think this became a bit of a payback phenomenon for everybody in terms of the work that was undertaken. We held six meetings over the course of the summer. The panel was put together at the beginning of the summer. Two of our meetings were held. Revera made available to us information, both data in unformatted form, data that had been gathered by Accenture and analysed using artificial intelligence means.

We found -- Jack, you won't be terribly surprised to find that we asked them to actually

reanalyze a lot of data using standard statistics that we were more used to, which seemed to be more intelligible than the AI information, but it showed basically the same information as to various, you know, variables and covariants that actually determined what had occurred in Revera homes.

So we looked at that data over the course of six two-hour meetings. Each one of the panel members was assigned homework, was assigned to present something to the group with each one of our six panel meetings.

Prior to the last meeting which occurred in September, mid-September, we had completed the reports. Each one of the reports had kind of a single lead author as well as collaborating authors. So I was lead author on the testing section, and I had a Public Health doctor and an infectious disease doctor as my panel members who helped me develop that, correct it, edit it, et cetera.

And on the last meeting we held in the middle of September, everyone had committed to read each of the reports and sign off on them as being appropriate as a perspective, as a set of opinions for the entire panel. Each one of the lead authors

developed a set of recommendations. Those recommendations were reviewed by the entire panel and signed off on.

When we reviewed in September what we had, we had a pretty good report, we thought, that was -- you know, had looked at all the information available to us, had drawn reasonable inferences, and, certainly, had some telling recommendations.

But as you might imagine, it had six different voices. It had six different styles and probably would have been read by about 12 people in addition to the six member -- or in addition to the panelists and maybe another dozen people would have read it.

And the audience the report was designed for was for Revera management, obviously, and the Board of Revera with respect to the recommendations. But we also thought it was important, given the commitment that we had to respecting what had happened to residents and family and staff who worked in the long-term care sector in Ontario during this pandemic, we thought that was important that it be accessible to as many people as possible.

So Revera agreed to hire a journalist.

I worked with a journalist. We put together something that we thought was more readable, more accessible but still reflected the integrity of the science and the clinical recommendations, the clinical findings the panel members had. So that took about another month.

During that time, I checked back with the authors to make sure I was interpreting -- we were interpreting their recommendations and opinions in the right way.

After that came through, Revera wanted their lawyers to review it. There were a number of changes that were requested. Most of those we refused to make, and, you know, the commentary was, either accept this or else don't publish it; just take it and this will be the last we all see of it.

To their credit, they accepted, you know, the final editorial strokes that were applied by myself on behalf of the panel, and the result was the Perfect Storm.

Just a brief comment about that, that probably describes the first thing to talk about, and that is our general finding of the long-term care experience in Ontario reflecting a perfect storm, a number of factors that came together to

make the experience particularly problematic, tragic in many instances as you are reviewing and finding.

And What were those features? Well, the first element of the perfect storm is, of course, the nature of the virus, unrecognized at the time that asymptomatic transmission of the virus was such a fundamental feature.

The second was the transmission of the virus in communities where people lived in relatively high density, where lower income people, where racialized communities, new Canadian communities gathered were, of course, areas where people who worked in long-term care often lived and the risk of folks asymptomatically bringing the disease into long-term care homes unwittingly, unknowingly, the best of intentions, people who were visiting, people who were working in long-term care homes, this being a factor that wasn't recognized in the early days of the pandemic.

The third element we speak to is the focus, understandable focus of the healthcare system. Based on the stories out of Northern Italy, based on the stories out of New York City, Queens, that, you know, the stories of COVID-19

were overwhelmed hospital systems. This is what Ontario Health, the Government had to go on, and base its planning on. And, certainly, they did a terrific job expanding a number of ICU beds in Ontario to 2,000 from under 1,400.

They did the things that were appropriate to prepare for the pandemic that was expected based on stories from outside. But, of course, part of that was focusing personal protective equipment in acute care or hospital settings. Part of it was a desire to decant the hospitals wherever possible, and people were moved to long-term care in the early stages of the pandemic without testing, for example. So the focus on hospitals certainly worked to the detriment of long-term care, we thought.

And then the final feature that built into the perfect storm was the long-standing and chronic issues that have been part of long-term care for many, many years, that I was aware of in my role as Deputy Minister, as Samir, in his wisdom, was aware of when he said that if he had a parent in long-term care, he would probably take them out of long-term care; issues especially related to the design of buildings in Ontario,

multi-resident buildings and so-called C and D homes that you've heard a lot about, I'm sure, were certainly, a concern; the fact, and Bob will speak to this, that because of the 365, 24-hour-a-day nature of long-term care coverage, that up to 50% of long-term care staff were part-time staff; the long-standing problem, the lack of resilience of staffing in long-term care with, you know, not infrequent failures to provide full staffing based on people not showing up at the best of times. And, certainly, this was complicated during the pandemic with unexplained absences; and, of course, also the need for people to stay home in quarantine or in isolation.

Staffing has been a problem in long-term care. The role of the personal support worker in the Ontario Health System is not a resilient role. It's highly variable depending on what part of the system you work in, be it hospitals or what part of the long-term care sector you work in, whether you work in retirement, whether you work in home care, the wages and conditions of work are quite different for different areas of the personal support worker workforce.

These were all concerns that existed in long-term care before the pandemic hit. And, certainly, each one of these elements of weakness in the long-term care system, whether it was the old buildings, whether it was the nature of the workforce, the conditions of the workforce in terms of part-time work, all these, each one of these separate elements contributed to the perfect storm.

When you look at the actual Revera experience, you recognize that the virus was in Revera homes very early on in the pandemic. The data that we saw showed that, you know, the vast majority of people who were infected in Wave 1 were infected in early April, prior to personal protective equipment being available for all staff at a time when the Public Health advice to long-term care was that you didn't need to wear a mask unless somebody was infected; at a time when the only kind of protection against people bringing the virus into the home was screening as to whether or not you had a fever, you had a cough, you travelled outside the country, screening that did not at all speak to the issue of asymptomatic spread of the virus.

Other features that contributed to this

that became evident after the virus was in the home were the weakness of the medical coverage for some of the sickest and most vulnerable people in the Ontario Health System. Most of the medical directors of care -- and Samir will probably speak to this -- were primary care physicians who were being told they should probably close their office, that they should be switching to virtual care. And this advice from, you know, medical associations, from colleges was interpreted to include long-term care facilities.

So at a time when there was probably -- never been a bigger time of need for medical care in long-term care, physicians were trying to provide care to people who couldn't really participate in virtual care with technology that wasn't designed to provide virtual care, another -- yet another feature of the elements that went into the perfect storm that resulted in the kinds of experiences that you've been reviewing.

The one thing that Ontario did right in facing this perfect storm was to decide that surveillance testing of staff and visitors to long-term care was appropriate in managing the concern related to asymptomatic transmission.

It became obvious, probably by May, that the biggest risk to a long-term care facility in terms of disease getting in was the degree of community prevalence of the virus in the areas where staff lived. And by the end of May, the Government had responded to that -- This is the only government in the country that's responded to that to this point -- by instituting mandatory surveillance testing once every two weeks that was upgraded during the course of Wave 2, as you know, to once a week. And Revera and other homes are moving to make that even more frequent now that other forms of testing other than PCR are available.

So certainly the lack of surveillance testing early on was a problem in the development of the perfect storm. But Ontario moved to both put in place surveillance testing and also to limit workers to working in one long-term care home. As Bob will tell you, it was a problem in terms of staffing, but was appropriate in terms of preventing spread.

Once the -- we found that once the disease got into the home, the chief variable that determined whether it would spread and what the

mortality would be was the presence of multi-residential rooms. This was the feature that determined in, you know, a variety of types of analysis, whether the outbreak was one or two residents or whether it became something that infected many, many people in the home.

So that was a general summary, Judge, of our analysis of how the entire long-term care sector was kind of a sitting duck in a way for this virus, an analysis of what happened in Revera homes, and a set of circumstances that brought certain homes and certain residents within homes into greater or lesser risk depending on whether they were in a community that had high prevalence; and secondly, were they in a home that had a large number of -- that had multi-resident rooms within it.

That is kind of a general summary of where to start. And, Judge, I think our plan was to ask Bob Bass to speak specifically to the staffing issues which we went into in great detail and which Bob has provided, I think, some important recommendations for the future.

But before moving on, perhaps I'll stop there and see if the Commissioners have any

questions or comments to start with.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I did want to ask, did your investigation or your study of this problem reveal or confirm a problem with personal property -- personal protective equipment at the outset of this problem?

BOB BELL: So we heard a few things. We heard that there was a supply of personal protective equipment, and I went back to look at that. There was a supply. It was certainly not sufficient to provide droplet protection to all staff working in all homes.

COMMISSIONER FRANK MARROCCO (CHAIR): Why do you think that happened? Because it isn't -- it's across the whole -- it's not just Revera. It's across the whole environment, and I'm just --

BOB BELL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): We've have been told what problems flowed from that.

BOB BELL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm trying to get at why there was this shortage.

BOB BELL: Well, I can speak to that

from my -- not so much from the Revera review, but from my experience as Deputy Minister. You know, our last pandemic brush in Ontario had actually been Ebola, which occurred in, let's see now, 2017, I believe. And at that time, there was a stockpile of personal protective equipment in Ontario. That stockpile had lots of N95 masks, not enough -- not enough, not sufficient to deal with the COVID-19 pandemic as it should have been dealt with. But certainly, it would have provided us with a much better stockpile than we went into COVID-19 experiencing.

Some of that, you've probably heard about the N95 masks being out of date and being destroyed. Some of that's true. Certainly, that stockpile was not replenished the way it should have been. And I think that's probably a finger point against the Ministry that I was leading as well as against that government and the subsequent government. It was -- sort of the time that stockpiles should have been replaced was probably around 2017, '18. It should have been replaced and replenished. That wasn't done.

There was certainly a focus on stockpiles being conserved for hospitals, no

question, that the stockpiles were not taken out to replenish supplies in long-term care. And, certainly, the Public Health advice, probably the one aspect of the perfect storm that I failed to mention in Ontario was the lack of coherent Public Health advice across the province; 34 Public Health units, in many cases, giving different advice to the long-term care homes.

But certainly the advice early on was mask wearing is not fundamentally important in protecting ourselves against this disease. If you have an infected patient, you should wear a mask, but the advice was not to wear a mask as part of the social distancing that's -- protection that's required within long term care and within close spaces.

To go back to your specific question, why was there not sufficient personal protective equipment to obey the precautionary principle and mask and, you know, visor everybody right from the start? And the answer to that is there was not sufficient equipment present in the Ontario Health System in total, and part of that was because our stockpiles had not been sufficiently resupplied.

COMMISSIONER FRANK MARROCCO (CHAIR):

Mr. Bass, you wanted to say something, and then I wanted to follow up with --

BOB BASS: So just to reinforce, I think Bob's captured it all, just to his statement. There wasn't sufficient supply, and in the early days, the supply was held for hospitals. So it was a supply issue in early days, which was so critical. Even the surgical masks were in short supply, so...

COMMISSIONER FRANK MARROCCO (CHAIR): When -- sorry, Mr. Bass, I didn't mean to interrupt you.

BOB BASS: No. No. That's quite all right. That's it.

COMMISSIONER FRANK MARROCCO (CHAIR): So when you say there -- was there an actual conscious decision made at some point, a political decision, or a decision on this not to replace, not to replenish?

BOB BELL: So that's a question to me I think, Judge, because I mentioned that.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, it is.

BOB BELL: Yeah, I think -- so there were -- there was only one decision that I'm aware

of that lead to this that was a concrete decision, and that decision was that N95 masks that were beyond their expiry date would be discarded. That decision was made without replenishment. That was, in retrospect, not a smart decision because those masks still had ventilatory capacity. And the only thing that was potentially a problem was the elastic; that still could be used.

I think after that, it's just that it wasn't a conscious decision being made not to replenish. It's just that in the midst of everything else that goes on in government, the decision to replenish stockpiles was not undertaken as an affirmative action kind of thing that should have been done.

COMMISSIONER FRANK MARROCCO (CHAIR): And do I have it right -- sorry, Mr. Bass, go ahead.

BOB BASS: Oh, and just to reinforce that, it's not that it was out there, Sir, to be bought. There was, at the point of major crisis, there was no supply in the world. So it wasn't that it was just there and somebody declined to purchase it.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, that was really the -- this is back 2017 to 2018.

BOB BASS: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): And that's -- I wanted -- was going to ask -- the question I was going to ask was, have I got it right that once there's a pandemic, once, whether it's in January or whenever the world wakes up to the fact that there's a pandemic, it's too late --

BOB BELL: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): -- to go out and start buying.

BOB BASS: Exactly.

BOB BELL: True.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So you either have it, or you're in a spot.

BOB BELL: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

SAMIR SINHA: I just think one thing to add in as well is, I think it's, as you said, either you have it or you don't. And then -- and then how do you quickly commandeer it to where it's needed. And so to my colleagues who said as well,

you know, I think the general sentiment was, you know, that whatever was being preserved was being preserved, you know, to protect our hospitals.

I think, you know, the one example I like to use is what B.C. did, which I thought was quite interesting early on, was that they -- you know, the province basically took control of the entire supply. So it looked at what hospitals had. It looked at what long-term cares homes had. It looked at what primary care providers had because, certainly, when we even talk about, you know, long-term care being the poor cousin of the hospitals here, I think about a lot of my primary care colleagues who just really couldn't find anything. And they were relying on the Ontario Medical Association and others just to try and help them find supply and connect in.

And what I understand and what might be worth looking at is what B.C.'s -- how B.C. quickly created an infrastructure where, by taking control of the entire supply, they didn't allow any unnecessary hoarding. They allowed it to be distributed and using kind of a science-based approach. And so as they had prioritised long-term care and congregated care settings early on, they

were able to actually get PPE very quickly to those settings including to primary care practices much earlier on than we were able to get in Ontario. And I think partly it was because with whatever we had remaining, they weren't allowing unnecessary hoarding, but also working on, kind of, replenishing that supply and that.

So I think there was a third element there, that (a) there was PPE in Ontario. Obviously, it was being conserved I think for certain sectors over others. But in other -- in other jurisdictions in a similar situation, they did find a way to deploy it more efficiently early on to where it was needed. And I think that was a good model that I saw early on that I think was quite helpful in their experience as well.

BOB BELL: Judge, one of the -- one of the reasons why that feature that Samir mentioned of hospital conservation was going on, apart from the initial stories out of Bergamo and New York City related to our past experience with pandemics in Ontario.

So you go back in SARS in 2003 and then to the disease that did not -- hemorrhagic fever or Ebola, these were -- these were hospital-based

challenges. You know, SARS spread in the hospital sector. It didn't occur -- or it didn't spread in the community. Ebola was the kind of disease where you had to have personal protective equipment in the hospital setting.

So not only did Ontario not do an adequate job with replenishing its stocks of PPE, but we also focused the stocks distributed to the hospital sector thinking that, should a pandemic arise, likely, it will -- the response will be led by hospitals. That's what happened in 2003. That's what would have happened with Ebola, and that's where we focused our stocks of PPE.

COMMISSIONER FRANK MARROCCO (CHAIR): And just help me with this: Individual corporations like Revera, can they -- they can go out and buy and warehouse sufficient PPE for their homes.

BOB BELL: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Right. Is there a -- is there a recommended inventory that should be maintained, like a rule of thumb or something, a best practice?

BOB BELL: Well, we've recommended in our report that they constantly maintain a supply

of PPE. I think our report said two weeks' worth of supply at all times, that when that's replenished -- when that's depleted, that it needs to be replenished. I know that Revera has actually gone to more than that already, and I think they have -- I can't remember -- I don't want to say on their behalf, but I know they've certainly put in place a practice that keeps their supplies at a higher level.

And, of course, you know, the other question is what type of PPE, the crucial question of whether this is an airborne or a droplet-spread infection. As time passes, it would appear to be more of an airborne risk. That risk certainly seems to be more prevalent than we initially thought. So the issue that your PPE supplies should include a substantial number of N95 respirators as opposed to just surgical masks is another feature of this -- of this pandemic that wasn't obvious from the start.

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

BOB BELL: Angela, Jack, any questions before we ask Bob to talk about staffing issues?

COMMISSIONER JACK KITTS: No, I

think -- I think Commissioner Marrocco has covered my questions.

COMMISSIONER ANGELA COKE: Yeah, same here.

BOB BELL: Over to you, Bob.

BOB BASS: Thank you.

Thank you, everyone.

So if you'll see the section that Bob wrote on the staffing, the focus is on the impact of the shortages of PSWs which are the predominant classification by far in long-term care, the predominant classification. And number one, there was a shortage before the pandemic.

Number two, the single site rule, which as Bob has identified, was necessary, because of more than half of the staff being part time, a single site rule had an adverse impact on staffing.

Revera and all the nursing homes tried to mitigate that by offering their existing part-time staff more hours. But in the end, PSWs moved and selected employers based on maximizing hours and maximizing wages if they were working at three or four sites because everyone was doing this.

So they lost a substantial portion of

their workforce to the single site even though they were very proactive on this issue and, sort of, the first to the game of offering extra hours. Even -- they even beat the government on the single site rules. They implemented it themselves in advance of the -- of the regulation or the order.

The third surprising, or I would say unexpected result was a significant portion of the staff didn't attend at work, and repeated phone calls to their -- to their homes elicited no response. So we called them unexplained absences.

Obviously, people -- there was a lot of people who were sick. They have sick-leave plans in these LTCs, so people were not sick and not explaining to their employer it wasn't in their interest, or -- so there were just a number of people, and I think we can all in the end understand it, that they were afraid.

So under the collective agreements, for instance, just to -- the employers were accommodating on this because what could they do? They could -- under their collective agreements, they have absence without leave clauses that sort of trigger automatic termination after three consecutive days of absence without explanation.

No one exercised that right.

These employees are still on the books. The employers are still working, calling, trying to -- and I'll get to that in my recommendations, trying to entice and comfort these employees in a way that will get them back to work. The general sense is these employees will not come back to work until the crisis, the pandemic's over. Maybe the vaccine will help. Maybe that will give an opportunity to give people comfort, but -- so those were those three elements.

And as we can expect, a workplace where they're short of staff already, and two or three major hits to that, nontrivial hits, more than 10% significant hits on each of these items, significant numbers, had a real impact on care because you can't just turn around and fill the workplace if there's an immediate -- an existing shortage; there aren't staff out there to hire.

So there were contract staff. There were other efforts. But you can imagine in the moment of the crisis that hits a home with an outbreak, it's -- the workplace and the care levels by definition diminish; and, therefore, the spread is greater, in my view. The propensity to spread,

the inability to quickly cohort residents and staff, all of these are factors that would be -- are adversely impacted by a lack of staff.

So I'd like to turn if I could, and by the way, I would invite interruptions as I speak. I'm a labour negotiator, so I'm used to that. In fact, it's easier for me, so don't hesitate.

But let's --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, actually, let me take you up on that if you --

BOB BASS: Good. Good.

COMMISSIONER FRANK MARROCCO (CHAIR): -- as a labour negotiator. I mean, is it -- we've heard that, you know, there's too large a percentage of part-time staff and that that's part of the problem.

In your experience, is this a problem that could be solved if -- is this a resource problem that needs to be addressed, or is this chronic? You can't solve it no matter what do? It's a part-time/full-time thing.

BOB BASS: Okay. So that is a great question. That's one I was going to, and I'll just take it first. So -- and you're lucky you have Dr.

Kitts on one of your -- as your committee member because we shouldn't fool ourselves that this same requirement for part-time is not in the hospitals. You have a workforce that has to cover seven days a week with people who work 37-and-a-half hours or five days a week for full-time.

So to get a schedule -- and remember there are three shifts of this -- to schedule that -- I mean, to me, the easiest intuitive explanation is it's got to be, by definition, almost one to one because you have a person working five days. The other two days in the week are covered by a person working two days a week. And often, schedules are created with a full-timer and their shadow, the shadow being the part-timer doing the other two days.

So -- and then you've got -- no, then you've got absences that are natural, simple needs for leave of absence for personal reasons, sickness, vacation, holidays. So the need for part-time staff is not unique to long-term care. It's unique to healthcare.

So there are ways to mitigate it, and I'll get into some of the answers, but it's not a wave the wand and say, we'll just hire more

full-time staff. Here's the point that would explain to you why, if we could, we'd staff it with as many full-time staff as we can and diminish the exercised use of part-time.

The full-time staff at Revera, which is typical of long-term care, have amazing service records in terms of length of service. So the average -- as I recall, the average length of service in Revera was 15 years for full-time employees.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BOB BASS: Well, that's, for any employment place, if your average full-time employee is there with you on average 15 years, you're going to have some turnover. That's a very good retention record, excellent. And that's throughout. We do interest arbitrations throughout this. All the wages and working conditions are determined by third parties in this sector. It's not a right to strike. So we always show that. And typically, it's 14 or 16 years of service. It's very high, always, almost universally, long service employees in the full-time.

So if we could only employee only

full-time employees, we wouldn't have any turnover. It would be fantastic, better than average retention.

The fact of the matter is you can't. You need part-timers to fill in the gaps, to fill in -- somebody's got to replace the full-timer who's sick on Thursday and Friday, and that would be a part-timer.

So there is a need for part-time staff. The argument that they're cheap staff is misplaced. There are different provisions: some have sick leave; some have pro rata benefits; some have in lieu.

But the argument that the in lieu isn't high enough to equate to the full-time benefits, or they don't all choose the benefits when there's pro rata, is not the issue as to why there aren't more full-timers. It's the schedules.

So you could see a number of my recommendations are intended to enhance the opportunity, and I'll get into some of the key ones, I think, when I go. But that is a very key question, Sir, and it's a -- it's a misunderstanding or myth that we have part-timers in healthcare to save money. They're paid on the

same wage schedule. They have the same vacation schedule. They don't often have benefits, although some have prorated benefits.

But the hospital is the same. The hospital, none of the part-timers have benefits. They all have in lieu in hospitals.

In long-term care, there's a greater variation on that. But, Jack --

COMMISSIONER FRANK MARROCCO (CHAIR): I took it that it was the percentage that people were complaining about. I didn't take from what I had heard in the past that there should be no part-time staff. No. I heard very much what consistent -- very much consistent with what you were saying, but that what we did hear is that the percentage of part-time staff is too high.

BOB BASS: Right. Okay. So I'm trying to explain that that's not a logical conclusion because why wouldn't -- why would you have more time staff than --

COMMISSIONER FRANK MARROCCO (CHAIR): That's what I'm asking.

BOB BASS: There's no profit motive. There's no profit motive in the nursing envelope. The majority of these staff, PSWs are a hundred

percent in the nursing envelope. So there's zero profit motive. There's -- the funding in the nursing envelope is you pay the PSWs; you pay it out of the nursing envelope. You don't keep any excess because you have to give that back to government.

So if you had -- it is not the profit. So it's not the profit. It's not the service because full-timers stay with you, and one of your costs of part-time work is there's great turnover, there is great turnover. And it's not the -- it's not a differential between the hospitals. The only differential between the hospitals comes into one of my recommendations.

A hospital, for its nursing force, there's a history of having 12-hour shifts. If you had 12-hour shifts, which are very rare in long-term care, if you had 12-hour shifts, it allows -- you can fit within a week more full-time employees. You don't have this five on, two off because, on a 12-hour shift, you don't work five days a week. You work three and four. So it's -- the mathematics of scheduling allow you more FTEs or more full-time.

So I think in a hospital environment, I

checked, and I really don't want to reveal this as a viable source, but just say in my experience, which is fairly extensive in hospitals as well -- I've been retained by Jack and others in the hospitals, central hospitals to do bargaining -- the nurses are about 60%, 40% full-time, part-time. But the service workers aren't because they don't do 12-hour shifts.

In our LTC, the ratio of part-time to full-time is very similar to the CUPE and SEIU and Unifor bargaining units in hospitals because they don't do 12.

So the difference -- and I know that hospitals are proud that they have more full-time shifts -- they're essentially able to do that because they're able to, in those settings, the nurses almost universally work 12s.

In long-term care, it's deemed -- and maybe -- maybe this will change over time, Sir, but it's deemed to be too heavy a workload for a PSW to work a 12-hour shift. I think there's some logic to that. My knowledge is just observational over 40 years, but the 12-hour shift idea is a great idea, but it hasn't been taken up except in very rare circumstances. And it's -- while it

theoretically might be easier for the nurses in long-term care, it hasn't been taken up there either. And keep in mind, the nurses are the predominant classification in hospital. They're not in long-term care. There are very few RNs. So --

BOB BELL: Maybe I could just make one comment, Judge. We wanted to make sure that Bob got a chance to speak to the Commission on this because we thought he might be one of the few people you would see that had experience and expertise in why there are part-timers in long-term care, the fact that it's not a profit issue, the fact that it relates to schedule, and the fact that, you know, it really would take employers and unions and government to focus on this as a problem if some of the recommendations, detailed recommendations that Bob made are to come about, all three parties would have to change here.

We think it's probably an important part of making our long-term care setting more resilient, but it couldn't be done just by employers because, you know, these are negotiated and arbitrated contracts, and the scheduling aspect is part of what is arbitrated in these.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm. Okay.

BOB BASS: And it is -- it is very important, Sir, because if you can imagine, if you had, let's say it's 50% -- head count, 50% full-time, 50% part-time, if you had all of those part-timers working full time, the staffing shortage would be gone.

If we could magically wave a wand and say, okay, everybody works full-time, then the hours would be covered because you then get, let's say, the 50% of the part-timers could get -- work double what they're working now. That gives you a huge 20% hours in the workforce. It's -- unfortunately, it's not possible. But if it were possible, and to the extent that we can move in that direction, we're achieving a -- we're achieving recruitment without hiring new -- not one more employee.

You don't have to hire -- if you're getting -- you know, out of your part-time workforce, if you're getting 10% of them becoming full-time, you're immediately addressing the recruitment problem because you're getting the hours coverage, so it is -- it is a very key point,

and I would hope your report could try to fashion some of the focus on that. So thank you for drawing that out.

I did want to -- let me -- let me just start at a few points I wanted to make to myth bust. So one of the -- one of the myth-busting issues is that the higher wages would address the recruitment problem.

And in my experience, the wage rates in hospitals are about 11% above Revera's. The wage rates in the municipalities, long-term care are about 31% above Revera's obviously telling you that the LTC and municipals are about 20% higher than hospitals.

But then you've got the home care wages which are dramatically below LTC, and you've got the retirement home sector which are dramatically below LTC. So there's about 20% -- 18 to 20% below LTC in the retirement. The retirement home would be the lowest.

Retirement homes, nursing homes, hospitals, and municipal, all four of those groups are subject to interest arbitration to decide the wage rates. So there's no magic. There's no one-side private sector mandating strike, private

sector and retirement grinding a higher profit or something. It's really what's evolved from the sectoral analysis. And obviously, if you're a for-profit nursing home, you want to keep your wage rates in line to the extent that you can so you can maximize your staffing within the nursing envelope.

You don't -- you don't lose money in the nursing envelope, and you don't make profit in the nursing envelope. Your objective is to break even and get the most staff you can.

So in long-term care, a PSW would be $22 an hour, hospitals 24 to 25, municipals as high as 29 to 30 an hour for a PSW. Home care is around 19, and retirement really varies. They have the widest range, but I'd say, you know, starting at just above the minimum wage to $19 an hour. So you've got that range. It's something that not many people are aware of, but they're all important factors.

So why wouldn't LTC attract from home care? Why wouldn't -- why wouldn't all the employees in home care gravitate to LTC? Why, during this COVID crisis, did not the ParaMed home-care employees who weren't employed because home care was drying up during the worst of the

COVID, why did they not go and work for extended care nursing homes? Same company, obviously very attractive. I can assure you Extendicare was looking for them. Or why didn't they go to a Revera place? It's the -- we've got to account for employees and their preferences.

So in home care, it's always been casual, and a lot of the people that work in home care like the flexibility of casual work. A home care employee goes and works. They're paid on a per-visit basis, or they're paid -- they're not paid on a per-visit basis, but the structure of the -- of the work is per visit in various homes. And they are very -- they're allowed great flexibility in their own timing. So that industry attracts a different type of individual looking for home-care work.

Retirement homes, materially lower, why didn't -- why don't they all go to the LTCs? I don't know, but they don't. There is -- there isn't -- we have a very large, vibrant private retirement home sector in Ontario, and they all employ PSWs.

So the simple fact is that a part-timer in an LTC wants full-time employment, and if they

could get full-time employment, that they'd stay -- the facts or the simple facts are they seem to stay. If they become a full-time employee in Revera or Sienna or Chartwell, they stay.

So that's an interesting -- those are interesting facts that I've observed and we've studied over time, not just for this report, and, sort of, coloured our recommendations to improve full-time workload.

So there's one that I would say, separate recommendation that doesn't drive necessarily to the -- directly to the PSWs, and that is, at a point of crisis where there aren't people available, it has struck us, and many of the employers have exercised this management right -- it struck us that there could be support for the PSWs that -- for classifications -- a new classification that doesn't require their skill set. So that would be basically cleaning and making beds and distributing laundry.

So the PSWs do a lot of work. They are hard workers. They do the personal care. They do the activities of daily living, but they also, you know, clean the room a bit. They make beds in the resident's room. They do companionship. They do

feeding. Some of these things could be done by a lesser-skilled employee, and, you know, it's been our observation that in this -- in this, sort of, economic environment, this opportunity to hire -- they're called -- sometimes they're called personal service assistants or residential support aides. If you go to a -- if there's a job fair, the employers will have a number of people interested.

So they have hired. It's not a violation of the collective agreements. The one barrier that for significant utilization of such staff is that they're not covered by the nursing envelope now. So if I'm to do that, I can't really -- although I'm using them to support the personal care and the personal work, I can't count it as a cost in my personal -- in the nursing envelope.

So that's a bit of a barrier because it's -- it -- that's -- the nursing envelope is to -- is to provide the nursing care to the resident. And this supports or at least takes the workload away from the PSW, takes some of the workload away. You know, could change their ratios from -- particularly at a time of crisis from an impossible workload, which frankly, some of them

have, to a not so impossible workload. So that was -- that's the one focus that really isn't -- change everybody to -- changing to full time.

But a number of our recommendations are intended to try and allow more full-time workers. One that's been very successful in hospitals is the -- I think it's Recommendation 4, under Priority Recommendations, and that is --

And, Jack, you would call them NRTs, but I think of them as float staff.

So if you have a large enough workplace, which hospitals have -- they have huge pools -- the Toronto General and the Ottawa Hospital that Jack ran, have huge workforces. They have enough staff on a given shift that they could predict how many absences they'll have on that day, and they could then create a staff of float nurses -- typically this is in the nursing side -- that they create a full-time job, and they say, you're full-time, and you will be assigned to wherever in the hospital the vacancy occurs.

It's impossible to have that for nurses in the nursing home because there's so few of them. But in theory, in a big 200-bed, 250-bed LTC, you could have a float pool of full-time employees for

PSWs, and that could create more full-time employment. You don't have part-timers just getting one or two shifts here and there. You have full-timers with full benefits, and so that was one idea that we recommended.

COMMISSIONER FRANK MARROCCO (CHAIR): If you have an owner that owns several retirement homes --

BOB BASS: Like nursing homes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- Long-term care homes --

BOB BASS: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- could you organize the staff that way so that they work for one employer, and the employer controls where they're working on a part-time basis and that sort of thing?

BOB BASS: That's certainly worthy of a recommendation, Sir. There are barriers -- the union barriers or collective agreement barriers don't really anticipate that. But we -- the unions are reasonably flexible. We've certainly got a clause in the ONA central 200-home group process where we enable that, and it's a good idea. We've always felt that that's a great idea. You know,

Revera would have, I forget, how many homes with ONA; 18? They're not necessarily proximate, so that's the challenge. I think the -- even if we could get -- grow that idea a little more so that if they could exchange between two disparate employers, but one would be the -- it's complicated, but one would be the lead, and the unions in the two sites would accommodate this, you could do it.

It is a good idea. It's been in the ONA contract for probably a decade. It really hasn't got any traction yet, but I think, you know, a report such as yours might give it some legs. It is implicitly a good idea.

BOB BELL: If I could just interject there, Judge, you know, that, kind of a change or the change that Bob's recommending to create weekend shift workers would require really employers and unions and, importantly, government as well because they have to increase the NPC envelope that we're talking about, the nursing personal care envelope, a bit to accommodate for those unworked but paid hours that a weekend worker would get paid for but not work.

These kinds of changes really require

direction from something like this Commission, I think, to get all three parties to work with the express purpose of increasing full-time work.

BOB BASS: I would say Bob's reference to the weekend worker clause, I negotiated that when I was doing the central bargaining for the hospitals in 2000, and it's -- I always thought it was a great clause. But Jack will tell you, there's not been much uptake on it, even in the hospitals. It exists also in the nursing home.

To me, it was conceptually, a family has got two working spouses with young children. The nurse might work on the weekend, and the --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

BOB BASS: -- husband Monday to Friday, and they'd have care or a student, a student, perhaps, wanting to go to school Monday to Friday and get -- be full time nursing on Saturday, Sunday, a tough challenge, but a lot of people are up to it.

But I think that's a 20-year-old clause, Bob, that I've thought there'd be great uptake on because, of course, the weekends are the hardest shifts to schedule. The weekends are the

hardest shifts to work full-time, part-time with, so there hasn't been the greatest uptake that I hoped for that.

BOB BELL: One of the differences, Judge, between scheduling in the hospital and scheduling in long-term care is the contracts in long-term care generally are five on, two off, with at least every other weekend, Bob, as I understand it?

BOB BASS: Yes, that's right, every other weekend off.

BOB BELL: As opposed to the 12-hour shifts where they're two on, three off, four on, five off that nurses in hospitals enjoy that make it much easier to schedule full-time work within that -- that less segmented kind of scheduling system that long-term care has.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

BOB BASS: You know, another -- just to speak to the PSW shortage from another angle, it has never -- so it's -- it never ceases to amaze us working in this sector that the community colleges are not attracting enough PSW applicants. So many of the community college programs shut down over

the last two or three years even though there was a dramatic need for the -- and it struck me that there were barriers to this. One of the barriers is tuition. Why would we have tuition charged for a -- for a group of employees where we're desperate to have them get the training? It's not -- it's not a lot of training, but there is a tuition, And the tuition for a young person can be a barrier.

So we thought tuition -- we thought engagement with the -- like, a co-operative program, like working in a nursing home and getting your training in a nursing home and free tuition and maybe earning a little money along the way as, you know, an unqualified PSW. But as I say, we're recommending residential support aides. Why can't there be some cooperation with the education, with the government on tuition? And I think long-term care, I think if you read the Revera study, they're doing their best on their own to integrate their own education system and community support.

And so there's -- we've got to try to eliminate the barriers for young people, traditionally women in Ontario to want to go into this job. It's -- now, the barriers are, it's not a great wage rate job, but $22 an hour with a

pension, with full sick-leave benefits and full benefit program is not out of norm for the broader -- they're not lawyers, and they're not engineers, and they're not nurses.

But for the education required, $22 an hour is a -- would be deemed in Ontario to be an okay compensation level. It's not poverty wages, which is often described in the course -- some of them in retirement homes are making 15 or $17 an hour, so -- but in long-term care in the publicly funded --

Yes, Angela.

COMMISSIONER ANGELA COKE: No, please finish your sentence. It's okay.

BOB BASS: So it's a working job. It's a job with reasonable income, and I'm certain that income isn't the barrier to -- so if we could just have some scholarship programs, some support from both government and the community to work together to make the education -- eliminate the barriers to getting educated in this.

The other related --

Okay, Angela. Sorry. I'm finished that thought, so --

COMMISSIONER ANGELA COKE: Yeah, I just

wanted to pick up on your issue about, you know, the wages. And obviously, we know that's not the only thing that attracts and retains people to any job. And we have heard from a lot of people about the work environment.

And so I was curious about what came out through your review in terms of the quality of management and leadership in these homes, how that impacts the work environment and the desirability of that work environment, and also the quality of folks to manage in a crisis like the COVID situation that we're dealing with now, so a little bit about leadership, management-level folks, and culture and things like that.

BOB BASS: Yeah, so that's hard for me to comment on except to the extent that I deal with the managers all the time, and they seem very motivated. This is a sector of people, the PSWs, the managers. To attract people to this sector, you have to be a caring-type individual. So it's a good question.

The corporations are lean. So this is not like a hospital with a hierarchy of managers. This is a -- this is -- a long-term care facility has a very lean management structure, an

administrator, a director of care, maybe occasionally an assistant director of care, then into the bargaining unit nurses. And for the housekeeping, laundry, dietary, they have a manager. But the director of care is in charge of all the nurses and all the PSWs.

So the funding envelope which pays the director of care and the assistant director of care is generally optimised to maximize the number of PSWs you can employ because of the workload. So it's a good question. It may be worth a mention in the report. I myself can't comment directly. Maybe --

BOB BELL: So if I may, Bob.

You know, as I read your second interim report with interest in that you really focused on leadership, And I think you're absolutely right there. If you look simply at the issue of education, of teaching in long-term care, and you compare it to the hospital, it's typical in the hospital that you will have an educator for virtually every unit, someone who will do skills-based training, hands-on training with the nursing staff that's there.

And certainly, you know, the educators

in long-term care, it's unlikely that there'd be even one for every long-term care home. They might be shared across long-term care homes. And that's a significant --

BOB BASS: The chains would have them, Bob, but only not one per.

BOB BELL: Yes.

BOB BASS: So a simple one-owner home, it just -- the funding is not structured for that, Angela. It's not --

BOB BELL: But that's a key issue, you know, because instruction on hands-on care is a critical --

BOB BASS: Yeah.

BOB BELL: -- component in health care, and I would say it's something that's absent either entirely or absent to the extent that you would want it to be Especially since the majority of care is provided by nonprofessional staff. So you're not relying on the profession of training nurse standards. You're relying on the three-month college program extended in the home by some -- I don't know. Samir hasn't had a chance.

What do you think, Samir? I don't think that leadership in long-term care is probably

sufficient for the kind of responsibilities we see.

SAMIR SINHA: No. And I think certainly, I think one of the things we did hear from, you know, when Revera was, you know, analyzing the data for example, and something we heard broadly was that, again, you know, again, back to that idea of the conditions of work, you know, equal the conditions of care, that obviously, if you have a home, for example, with a junior or inexperienced manager, for example, versus a home with a well-experienced manager, you know, (a) you know, the care environment may be different, for example. You know, experience will inform, you know, potentially -- you know, the more experience, you know, the better a home may be managed, but also within an outbreak as well.

And I think -- and I think, certainly, it's something that we heard about, and I think it's, certainly, something that -- as well, I think back to what was just being said, if you think about -- I think a huge amount of a lot of this relates to the fact that I think we're rearranging deck chairs around the Titanic when you have a nursing and personal care envelope of $102.34, which is currently what it is.

And so to the point that, you know, kind of -- you know, Bob Bass was making, for example, I think -- I think to the point, you know, again, you've got to maximize that budget, for example. And I don't think there's an opposition to -- I don't think anybody's saying that we're against more full-time work. You know, I think we need to have more time full-time work, but even this Government's commitment to now say that we're going to -- we're going to put up, you know, $1.9 billion a year, you know, to hire 27,000 more frontline workers, you know, to come in, you know, to work up to four hours, you know, to provide four hours of care a day.

Right now, you've got a nursing and personal care envelope based on this provision of 2.45 hours a day. And I think really -- I think all of that together means that you've got pressure in that envelope to say, how do you maximize that? We heard originally --

BOB BASS: That's right.

SAMIR SINHA: -- that, and if there's pressure in that, frankly, I mean, you know, again, you know, not to say that there's, you know, again, I don't think that there's any deliberate, you

know, attempt to say, let's hire more part-timers versus full-timers. You know, there's -- I don't think there's a conclusion there.

But you know, if you know, if you have -- when there are more people working full-time, they're more likely to stay a longer time and do that. But one thing that I found that was absolutely fascinating here is that, again, if you have a person who works, you know, for example, like SEIU or CUPE or whatever, it's interesting when you hear that a full-time contract -- you know, a full-time worker gets 10 to 14 days of paid sick leave a year, kind of somewhere in that range, whereas a part-timer might only get 1 to 3 days of paid sick leave.

And I think -- I think this is where you start realizing that within these -- within this -- you know, within this very tight, you know, nursing personal care envelope, (a) you don't necessarily -- and that broader funding that a home gets, there's not the home for the educators, right? There's not the home -- the paying for the -- and that's education for infection prevention and control. That's for, again, depending on what training you got as a personal

support worker or an RN or an NP, making sure that we can have that critical skills development.

There may be, in a big chain, more of an opportunity where you have that, you know, some back-office supports that can actually provide, you know, a reason why you might want to be at Revera versus a single site, single-ownership home because you may not be able to get access to that.

So all of that, I think, makes it a lot tougher because then you've got workers at the frontline who may not get that opportunity to develop their skills.

You know, Bob says, you know, $22 an hour, it's pretty -- you know, a pretty reasonable wage if you don't have that much, you know, education, for example. But, you know, I think the issue this -- where this really feeds in very quickly is for the part-timers that come in -- let's not forget the full-timers for a second, but for the part-timers, there's a huge amount of churn because now you're making 22 bucks an hour. You're working in an environment where there should be four hours of care a day according to the Government's own staffing study, but it's only resourced to do 2.45 hours a day. And I think we

just churn through a lot of staff. It's almost a bit of a meat grinder, frankly. And I think -- I think we have to really focus on what is the care envelope that we're doing; how are we enabling more full-time work that can be provided? But not only more full-time work, but if we're actually supporting staff with the education, the resources, you know, the motivations, for example, to be able stay long longer and feel fulfilled in these environments, I think that lifts, kind of, everything.

I think the problem is that we've been wrestling, you know, and arbitrating within a minuscule budget, for example, that even our own staffing experts say isn't going to provide you enough staff whether it be full-time or part-time to do the work well. I'll stop there.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts.

BOB BASS: Go ahead.

COMMISSIONER JACK KITTS: Actually, Bob, if you're answering -- if you're responding to Samir, I have a different question.

BOB BASS: Okay. So I'm responding to Samir and a bit to Angela. The question is

education. So if right now, with $102 in the nursing envelope that Samir identifies, the question would be to a nursing home, should I spend that money -- and I'm a single operator and I can't spread it over 37 homes or 42 homes. Should I hire an educator to do ongoing training, full-time educator, because you wouldn't -- you'd really have to hire a full-time educator, or should I have that two PSWs? Because probably, your educator, you'd want to be an RN, And you can have two PSWs.

And, of course, inevitably, Angela, the answer is, well, I guess we better have two people on the floor rather than two less people with education.

That, I think, has been the degree of choices that have been made. Whether they're the right ones or not, I think if we have four hours, and there's the -- then the flexibility within that four hours to have a full-time educator Monday to Friday, let's say, that's a different story.

But if you're -- if you're put to the test of two more PSWs or one educator, inevitably, they have chosen the PSWs. So I think it's just -- it's the tough choice that they're given, really, an impossible choice.

I did have -- Jack, I did have one more point on the staffing, but --

COMMISSIONER JACK KITTS: Yeah, this is about staffing, so --

BOB BASS: Okay. Good.

COMMISSIONER JACK KITTS: So I think I read that Revera runs 170 long-term care homes in Canada?

BOB BASS: In Canada, yeah.

COMMISSIONER JACK KITTS: And I'm just trying to get my head around the scope or the scale of this problem. You've got 170 homes, and I don't believe that all of them have the same exact problem with the staffing, or if they do, then that's a different story.

But are there any of the homes where you can point to and say, somehow, despite all of these barriers and hurdles, some of them are getting it right?

BOB BASS: Jack, it was my observation when I looked at the single-site data, the unexplained-absences data, and the sick-leave absences, that it was pretty universal. Remember, you have -- they pay virtually the same -- or Revera pays virtually the same for its PSWs,

across Ontario. So, you know, I can't speak to the rest of Canada for them, but I -- there's really no shining example that we can point to where they, sort of, as you say, got it right.

Samir, do you have a comment on that?

SAMIR SINHA: But I wanted to point to, you know, kind of B.C.'s, you know, approach for example because B.C. did their analysis in late March. And Isobel Mackenzie, the Seniors Advocate, can speak to this and others because they calculated, if we actually took everybody working in a long-term care home, because we are going to implement a single-site order, and B.C. successfully implemented their order, I think, by March 27th, for example. Ontario announced its single-site order like Alberta and other Revera areas, and that only got implemented, you know, by mid to late April in other jurisdictions.

But B.C. definitively said single sites, and it basically said, you know, back to the point that Bob was making earlier, you know, (a) you know, if I'm working part-time at a municipal home and part-time at a Revera home, and I'm going to see who's going to give me better hours, better benefits, whatever, what B.C. did definitively is

they calculated the costs of saying, let's make everybody -- we're going to take everybody who's working in the sector, we're going to pay you full time. We need you to choose one site where you're going to work, in fact, actually, because we're taking control of your employment now. We're going to say, Bob, you've got to work at this home. Bob, you've got to work at that home. And by doing that, you know, (a) we stabilize the workforce; everybody gets the highest unionized rate. So if it was 27.50 or 29.50, everybody gets it. They get their benefits, 14 days of paid sick leave.

Because the problem is now -- you know, I did a lot of thinking on this over the weekend -- because we didn't actually create a unified platform, and then, you know, you have all those other factors that start fitting in, if I can't necessarily get -- you know, I might get -- I might choose this home versus that home because I might get more part-time hours here because, you know, as you heard, Revera was offering more hours but not necessarily full-time work necessarily. But, you know, all of a sudden, you started having people making those choices, those preferences in an environment with fear. And if you're on a

part-time contract, even though I'm getting more hours, I only might get 1 to 3 days of paid sick leave, for example, if that's what my part-time contract pays.

By B.C. stabilizing a lot of those factors, we have to remember that 50% of Ontario retirement and nursing homes have gone into outbreak, for example. Alberta has now just peaked at over 60% of their homes. B.C. is still sitting at about 30% of their homes in outbreak, far, far, you know, less worse situation from their staffing piece, and I think partly because they gave that security to staff.

Because I think when we start getting back to, you know, the point about how do we keep outbreaks happening in homes, because universally, we've got staff bringing it into homes, and not -- and I think as Bob Bell made the point earlier, not because people want to bring it into homes, but because these staff tend to not be paid well, like, you know, relatively to other folks in the healthcare system. They tend to live more in crowded housing, marginalized settings and communities.

And the idea is if you're now working

in a situation in a jurisdiction where you only have one to three sick days, we know that when you actually look at the data where we've actually reintegrated family caregivers, family caregivers are not bringing this into the home. Why not? Because the last thing a family member wants to do, is if they have a sniffle, they're going to stay home. They don't want to kill mom.

However, if a staff has a bit of a sniffle, you now have a Sophie's choice. The idea is you don't want to cause harm to any of the residents you care for, but if you're going to -- if you only have limited sick days because you're on a part-time basis, you know, do you stay home, not get paid, or do you take one of your few sick days and get a reduced pay and then not put food on the table? Or do you go into work and you wear a mask and you hope for the best because you don't want that have difficult choice?

And I think if you ask any of the -- any of the employee unions, for example, how many of your employees during this pandemic, you know, have been working sick, whether their full-time or part-time, I bet you they'll say a hundred percent of their staff, you know, have actually come in and

worked on a day when they're sick. And I think that's why we then look at this dichotomous choice. Test the staff every single day because how do you actually try and make sure, you know, that they're not bringing it in. But why in a hospital that I work at, Sinai UHN, I have only been tested once during this pandemic because we know that our staff have, you know, good benefits. They're not going to come in sick. They're going to actually take advantage of --

BOB BASS: Samir, I think you've taken it to an unsustainable model. I can't -- you couldn't, in the hospitals, run -- if you can run it nursing homes that way and have everybody full time, you can run it in the hospitals that way. And we could never sustain that in Ontario. I --

SAMIR SINHA: Yeah.

BOB BASS: -- looked to see the B.C. model. It's not a sustainable model.

SAMIR SINHA: But it only cost them $10 million extra a month to --

BOB BASS: Well, it would cost Ontario much more than that, I assure you, Samir.

BOB BELL: Jack --

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I just -- can I just stop for a second? The onsite, the rapid test, is that -- which I think Alberta is intending -- I thought I read Alberta was intending to use, does it allow for the kind of daily testing that you want, or is it not a reasonable alternative?

BOB BASS: I think it's to be seen. It's not yet -- not yet --

BOB BELL: That's two tests a week using the 10 Biotest, so it's an antigen test --

SAMIR SINHA: Yeah.

BOB BELL: -- antigen test that Health Canada has approved, plus the once a week now in Ontario, PCR, the molecular test which is more sensitive. And I think the answer is, as Samir suggested, the more you test, the better it is, no matter what test you're using. Testing every two weeks isn't sufficient. Testing not at all is utterly insufficient. And certainly, testing as often as you can is a good idea.

SAMIR SINHA: But I think part of it is, you know, it's two. It's either you make this choice of testing -- like, you know if you think about it, if you do the math, if you say it's -- you know, to run a PCR test, if you're testing a

hundred thousand workers in Ontario, as we soon will do when we go into lockdown, so you're now doing everybody weekly, for example, it's a hundred thousand tests, whatever you want to say the price point is, whether it's, you know, a hundred dollars per test or 50 when you put all the costs in for getting that nasal swab done and everything and the human resources involved in doing that, you know, you're basically spending, you know, between 5 to $10 million a week to test all the employees.

I feel if you actually gave those employees -- kind of like B.C. did, give them access to more sick days, you know, incentivize them, for example, to, you know -- you know, to be supported to say that, if you are feeling sick, you're not going to come into work, I feel that would be a lot cheaper than the billion dollars we spent in Ontario trying to deal with the aftermath of the outbreaks.

My sense is, you know -- I -- you know, I think if we actually have -- you know, (a) we've talked about, you know, the benefit of more full-time employment. I think we've made it clear that that's -- you know, it's impossible to believe we can get -- that that's the -- you know, you can

do 100% full-time employment. But I feel like if we have a better mechanism to support workers when they're sick -- and this is not just a long-term care issue; it's a broader issue, you know, beyond that -- I think we'd actually have less of a situation where outbreaks were happening in the first place.

But I feel if we don't repair that issue of why workers are coming in sick, I don't think deliberately to cause harm, but because we might be giving them impossible choices to begin with, then our only alternative is to spend a lot of money testing people, and maybe that's more attractive because you only have to do that during a pandemic. If you actually give people better benefits, you have to, kind of, do that forever.

And that's -- I think that's B.C.'s dilemma. I think to Bob's point is B.C.'s been continuing this policy on, and the question is, when the pandemic's over, are they going to say, everybody in long-term care, you know, gets a -- you know, is paid at the highest, you know, full-time rate; We're doing that now; We make that permanent, you know, that's going to be a long-term cost B.C. carries forward, but I think frankly it's

better for its residents and its workers.

I think Ontario is at the point where if we can get a few more months out of this, we'll test like crazy. Then we might just keep up with the same situation we have. And I'm worried that that's not going to create a sustainable long-term care system that can actually withstand another pandemic either.

BOB BELL: Judge, you're --

BOB BASS: If you do it for -- if you do it for nursing homes, you'd have to do it for hospitals.

BOB BELL: Bob, I'm going to interrupt because the counsel, John Callaghan, asked me to make sure that we say one thing, and I know our time's up, so I'll leave it up to you, Judge. He said to make sure that we talked about why redevelopment in Ontario C and D homes hadn't moved forward to this point and did we have an opinion about that. Do you have time for that, or do you --

COMMISSIONER FRANK MARROCCO (CHAIR): No. Sure we do. You know, I think that's probably something certainly you're interested in, and we have an interest in it too, so go ahead.

BOB BELL: So the only thing I would say is that this has been a -- this has been an objective of the Ministry of Health. As you know, when I was there, it was Ministry of Health and Long-Term Care for at least the last ten years. And companies like Revera had lots of proposals in front of the Ministry.

And I can only say that the bureaucratic challenges to the redevelopment proposals were just immense in terms of shifting licences around, was one example. A homeowner would have licences in this small community where there was no longer as big a need for long-term care, would want to consolidate those licences with another home to redevelop to a new home, and shifting those licences was a tremendous problem.

There was also a problem with the construction funding subsidy that I think the current government has now solved, given the 6,000 plus redeveloped homes that were -- or redeveloped beds that were recently announced in October.

So I think apart from anything else, one thing that I would just beg you to consider is lighting a fire under both the Ministry and the Government to say this is an absolute priority.

We've got 38,000 -- or 28,000 licences, pardon me, in homes that are way outdated. We just approved 6,900 licences being redeveloped. This process has to move much quicker. The shifting of licences has to be facilitated. The construction funding subsidies have to be looked at as they're now doing them in terms of where the home is. Is it urban? Is it rural? Is it suburban? Clearly, the construction costs and the capital costs for land are different. But this just has to be a major priority for making long-term care safer in the future. So Mr. Callaghan asked me to make sure I give you that sermon before we finish.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, I guess you can tell him you've carried out your price of admission, I guess, is what I -- I don't even want to contemplate it.

But just before we close, and I do have a, sort of, difficulty with the idea that we can't test. And where you have a test that will give you a result, not instantly, but very quickly --

And, Mr. Bell, I think you were -- did say that testing was something you looked at.

BOB BELL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): I

can't -- is there a barrier?

BOB BELL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there a barrier to doing this?

BOB BELL: Well, the one barrier is that when you look at the approval criteria that Health Canada and the FDA have established for these rapid tests, Judge, they're only approved for use in symptomatic people.

So what the FDA says specifically in each of these is, to be used within seven days of the onset of symptoms, approved for use in that circumstance.

So the issue and all the testing that's been done, the so-called accuracy testing where you look at the sensitivity and the specificity of these rapid tests versus the gold standard, which is the molecular PCR test, you know, they're 85 to 95% accurate within the context of a symptomatic individual.

Some of the studies -- and there aren't many that have been done -- there was one down in Arizona and residents at the University of Arizona being tested daily with the rapid tests and also comparing that to a PCR test, and they're nowhere

near as sensitive in asymptomatic individuals. So that's a problem. Presumably, once you become symptomatic, your viral load is higher, and a less sensitive test is able to capture that.

Having said that, a relatively a-sensitive test or a less sensitive test, better than no test.

The other thing that other countries have done who've done massive amounts of testing like China is to use a technique called pooled PCR, where you combine specimens in a single test; most of them are negative. In one test, you've tested ten samples, all of which are negative. And we just haven't in Canada got into pooling PCR which reduces the cost and reagent use by 80%.

So going back to Samir's comment, if we're going to test everybody by PCR at $40 a day, that's expensive. If we're going to reduce that cost to $8 a day, it becomes feasible.

So we haven't had testing strategies that have been specific to the long-term care sector where we're really talking about the issue of surveillance testing as opposed to diagnostic testing.

SAMIR SINHA: And I think to build on

Bob's comments, like, I actually sit on the Government of Ontario's Testing Strategy Panel, so we spent a lot of time looking at long-term care and the two tests that have been -- you know, that have been authorized for use in Canada. And I think -- I think the challenge is, first of all, is that we have a bunch of tests that have been bought by the largesse of the Federal Government. They're almost, like, looking for a purpose, if you will.

And you know, obviously, you know, there's been a lot of considerations about their use in long-term care settings. And the studies that have been done in long-term care settings in Ontario in the cases, you know, of asymptomatic, you know, surveillance testing, they just aren't necessarily showing, for example. You know, there's the risk of both the false positives and the false negatives.

The false positives will shut down a home; it will send an employee home. And in States like Nevada which Bob was referring to, they actually abandoned using these tests for their asymptomatic surveillance testing in long-term care homes just because the false positives and false negatives were too high, and this is where they ran

into trouble.

And so the challenge we've been doing in Ontario is we've said, absolutely, you know, you can try this out, but you want to use a nasal PCR at the same time. The resource utilization becomes high. We've debated, you know, the question about, well, if you do this a few times a week, you know you're doing it more often, so, therefore, you might improve the accuracy because if you missed it once, you might get it later.

The problem is, is that, you know, we're trying to search for a solution for a test that isn't necessarily giving us an alternative to say we can safely go from the PCR to this especially in a high prevalence. So I think our early thinking as a group, I don't know if it's been officially kind of been presented because we were looking at it, again, as of last week. It was saying in high-prevalence areas, we should stick to the nasal PCR. In low-prevalence areas, say, up in rural North, for example, you might want to say, well, you could maybe do this, you know, twice a week or, you know, and try that out because maybe it'll be okay in those settings.

But I think a lot of governments -- and

Alberta's been experimenting with this, and I was commenting on this the other day, is that right now, I think there's a lot of -- you know, people are looking -- you know, like, in a place like Alberta or B.C. or any other province other than Ontario where there is no testing strategy or surveillance strategy in long-term care, I mean, it makes sense to do something better than nothing.

But I think in Ontario right now, certainly, I think even with our -- you know, as Bob was mentioning earlier, even testing once weekly, we're still having outbreaks happening. I think because we still, unfortunately, have a lot of workers who are coming to work sick, unwittingly, you know, and maybe not knowing it, or potentially taking a chance because, again, that issue about, I might not get paid if I don't come in, and maybe this is -- maybe this is actually not really COVID, so I should have a go.

So I think this is the challenge is that we don't actually have the right instruments to make a quick and easy solution especially in high-risk environments like long-term care settings.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right. Well, this has been extremely helpful and a different side of the story and a very important piece.

Angela, Commissioner Coke you were going to ask --

COMMISSIONER ANGELA COKE: Sorry. Just one last question. I'm just interested in whether Revera has adopted most of your recommendations?

BOB BELL: So they have. Many of them were already adopted. They're, obviously, not waiting for us to report. Many of them have. They're continuing to look at the issue that the Judge was just talking about. They're doing -- studying testing techniques currently.

Probably the section that they said they had most difficulty with was Bob's section on recommendations regarding moving to more full-time employment simply because they said, we can't do this on your own; this requires, you know, the co-operation of union leaders as well as the Government funding of the MPC.

So that's probably the area, Angela, where they've been most problematic in terms of their response. They say that they have implemented everything they could, and I think

that's generally true.

COMMISSIONER ANGELA COKE: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And presumably your task your labour relations person with that responsibility to forge that consensus --

BOB BASS: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): -- if you don't have it to start with, which you probably don't.

BOB BASS: Not --

COMMISSIONER FRANK MARROCCO (CHAIR): But in any event, I won't ask Mr. Bass to comment on the utility of labour relations representatives because that would be a conflict.

BOB BELL: He does have a -- you're absolutely right, Judge.

COMMISSIONER FRANK MARROCCO (CHAIR): In any event, thank you all very much for the time and for coming here. It's been helpful. It really has, and it gives us a more complete picture and a bit better understanding. And we'll --

BOB BASS: Incredibly important, Sir, so thank you --

BOB BELL: Thanks for what you're doing.

BOB BASS: -- for your work.

BOB BELL: And the reports you put out so far have been right on the money. So thanks for that.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you.

COMMISSIONER ANGELA COKE: Thank you.

BOB BASS: Take care, Angela.

COMMISSIONER ANGELA COKE: Bye.

-- Adjourned at 4:39 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, 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 22nd day of December, 2020.

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PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Clarifications:

Page 31 / Line 23: The speaker is not Jack Kitts, but it is (Bob Bass).

Page 56 / Line 23: The speaker is not Bob Bell, but is Samir Sinha.

Page 79/ Line 18: It lists Bob Bass as the speaker and it should be Bob Bell.

WORD INDEX