Long Term Care Covid-19 Commission Mtg.

Commissioners and Mr. Schlegel
on Tuesday, January 12, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 12th day of January, 2021, 10:00 a.m. to 11:50 a.m.

BEFORE:

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

PRESENTER:

James Schlegel, Chief Executive Officer, Schlegel Villages

PARTICIPANTS:

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

Ida Bianchi, Senior Legal Counsel
Long-Term Care Commission Secretariat

Kate McGrann, Co-Lead Commission Counsel
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Jennifer King, Gowling WLG

Michael Finley, Gowling WLG

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning, Mr. Schlegel.

JAMES SCHLEGEL: Good morning, Dr. Kitts.

COMMISSIONER JACK KITTS: Good morning, Jamie.

COMMISSIONER ANGELA COKE: Good morning.

JAMES SCHLEGEL: Good morning, Commissioner Coke. I need to get names straight here and titles straight, but nice to meet you. I've read your name enough. I feel like I've met you already.

And, Justice Marrocco, and the same goes for you, very pleased to -- very pleased to meet you as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Pleased to meet you. Thank you for coming today.

JAMES SCHLEGEL: My pleasure.

COMMISSIONER FRANK MARROCCO (CHAIR): Is everybody -- Mr. Schlegel, you're here. Were you expecting anyone else?

JAMES SCHLEGEL: You're stuck with me and me only, unfortunately, just myself.

COMMISSIONER FRANK MARROCCO (CHAIR): No, that's just -- that's just fine. So, Ms. Mahoney, why don't we -- well, let me say a couple things, first of all: One, we're very, you know, interested in getting some -- having a granular understanding of what we're -- of what we're trying to study, and so hence, the importance of someone who is actually operating. We need to spread that out a bit. We're interested in the financial side of it, and Mr. Santangeli's assisting us on that. That's why he's on the call.

Janet, whom you can see, is going to create a transcript, and I should say, if, you know, there's anything that occurs to you after that you didn't say during the hour, just advise Ms. Mahoney of it; send her a note, and she'll make sure that we see that. So don't feel that when the clock strikes 11, the screen goes blank, and then that's -- that's the end of the matter.

JAMES SCHLEGEL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): We -- Ms. Mahoney will probably make sure that -- try to keep some order to the presentation. We will -- the three of us will just ask questions as we go along, if that's all right, so that we don't

end up trying to go back and so that we'll do that, if that's okay with you.

JAMES SCHLEGEL: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): And I think -- I think that's pretty much it.

LYNN MAHONEY: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So, Ms. Mahoney, why don't you take over.

LYNN MAHONEY: Okay. Thank you. Thank you, Commissioners, and thanks, Mr. Schlegel. I had an opportunity to spend some time speaking with Mr. Schlegel and discovered that he has a wealth of information on a variety of topics to impart to you, Commissioners. So he and I have -- as I've said, have spent some time speaking, and I know he's going to, I believe, cover most of those in the -- in the presentation he's going to make to you, but he and I have agreed that as he goes along, I'll try to gently remind him of some of the other topics that we talked about and elicit that information for you as well.

So if we could go on that basis, I think we'll start off with his presentation talks about the homes that his family runs in Southern Ontario, and he'll give you a description of that,

and then we'll get more focused into some of the issues that have arisen as a result of this pandemic.

And his involvement, just so you know as well, he has had a great deal of involvement with the -- with the Government and some of the response tables that have been established in the pandemic, so he'll be able to give you his perspective on that as well.

So with that, Mr. Schlegel, maybe you can just begin.

JAMES SCHLEGEL: Okay. Thanks. Thanks, Lynn, and thanks again, Commissioners, for the opportunity to present this morning. And I really hope this can be a dialogue because I think the richness of this process is in the dialogue, and so I'm happy, as Justice Marrocco suggested, to field questions as they come up and create more of a discussion than a presentation.

For the -- for the sake of kind of organizing my thoughts, I've organized it into kind of three categories of -- very quickly, just a bit of an overview of who I am and the Schlegel Village family and organization. I'll do that fairly quickly, but I have some pictures just to give you

a bit of a flavour of kind of what we do because it is a fair bit different than what most other operators in the field do including research into [indecipherable] aging, which I'll -- which I'll describe, so I'll keep that fairly brief but just to give you a bit of a sense of who we are.

LYNN MAHONEY: Jamie, can you share your deck, your screen?

JAMES SCHLEGEL: Yeah. Yeah, I'm going to --

LYNN MAHONEY: Okay.

JAMES SCHLEGEL: -- in just a -- just a moment. Yeah.

LYNN MAHONEY: Okay.

JAMES SCHLEGEL: Secondly, then, as Lynn suggested, I just provided a list of some of the Provincial and local tables, but mostly Provincial tables I have been on in the last year or so that I thought might be helpful just for the Commissioners to have an understanding. Not that it makes me any more of an expert than others, but just to give you a bit of a sense of some of the -- some of the tables I have participated in and tried to contribute to. And then lastly, really getting into some lessons learned and kind of

recommendations going forward, some of which I'm sure have been touched on by other presenters and certainly have been touched on by the interim report issued by this Commission, but I'll try to -- I'll try to highlight some that are particularly relevant.

So I'm going to share screen at this point. Just click on here. Okay. Can people see that okay? Okay. Great.

LYNN MAHONEY: Yeah, looks good.

JAMES SCHLEGEL: Okay. So just very briefly about our organization, and I'll try to keep this part a little bit more succinct, but our vision is actually, I think, an interesting one because it talks about creating a village, a community environment.

When people ask me what work we do as a family, I say -- I actually don't say we're in the healthcare field, although we provide a lot of care. I say that we're really in the community-building field. Really, at essence, what we do is build communities in the form of a village where all villagers, when I say that, residents, team members, family members, volunteers can find purpose and meaning in their lives, can pursue

their passions, can develop meaningful friendships, have opportunity to learn and grow and contribute to their community. And that's really the focus of our organization is creating an environment where all villagers can thrive as individuals, and we create -- we create a village-built forum that encourages that.

I'm proud to say I'm third generation of our family involved in seniors' care going back to my grandparents, Wilfred and Amber Schlegel. They started a small nursing home in London, Ontario, in 1952. In fact, it was very much a family affair.

Just a bit of an aside: Grandpa bought it. It was a private nursing home because the Nursing Home Act didn't exist in that -- at that time. It was a private hospital, and he moved, him and Grandpa -- or Grandma and their five kids, my dad being one of them, right into the nursing home. And they lived right with the residents, and so my dad was in grade 5, so age 10 at the time, so he actually grew up living in a nursing home, not just living there, but also looking -- helping to look after and care for the residents as a youngster, so that's where his passion for this field started was

at very early age as a -- as a young person.

This is my mom and dad and two brothers. We're all involved in the organization. They call me the CEO which means I try to stay out of people's way as much as possible. Twin brother, Brad, in the top right is our VP of design and construction, so he looks after all of our construction projects and has a team of project managers that he works with to do that, and older brother, Rob, in the bottom right is our chief financial officer, so looking after relationships with our lenders and so on.

Dad's really been the visionary of our modern organization, the visionary behind our village concept, the visionary behind the research institute and bringing the worlds of research and practice and training together to drive innovation. He was uniquely qualified to do that in many ways. He was a professor at the University of Waterloo for about 20 plus years in the Faculty of Applied Health Sciences as a social psychologist, was interested in looking at how does the environment influence behaviour of the people that are in that environment.

So this is what he created, the village

concept, which is a campus of care that includes -- I don't know if people can see my cursor, but includes independent apartments. Well, first of all, long-term care in -- on the left side, retirement homes in this -- kind of this 'H' pattern, assisted living and memory care on the second floors, and then supportive apartments and independent apartments sitting in these kind of -- these towers on top of the retirement home. So it's very much a continuum of care from independent living through the long-term care and lots of -- lots of steps in between so that as people age and their care needs change, they can simply move to the same -- to a different neighbourhood but stay within the same community, the same village that they've come to know and become -- be comfortable in and stay with their friends and caregivers that they trust.

The uniqueness of the village design is partly in the campus, but what makes it more interesting, I think, is the -- is the village main street and town square design. The main street starts in the long-term care kind of where my cursor is, then hangs a right and extends through the entire village. It's the social spine that

connects the various neighbourhoods into a village, and the town square is kind of the social centre of the village. Our Italian residents in Etobicoke will call it the piazza. It's the central gathering place of the community. It's also the point of intersection to interaction with the outside world. We have lots of community groups coming in -- this is pre-COVID and hopefully after COVID -- coming in to use our space. So the Lions Club, we formerly maybe met at the -- in the church basement now come and meet on our main street. Our residents can then participate, and because our residents can't get out into the world as easily anymore, we have to bring the outside world in to our residents so they can continue to participate in life beyond the walls of the -- of the village.

So it's very much a social model designed to, through the main street and town square construct, designed to encourage socialization, social connectedness of our residents. We find that what often is most -- the biggest deficit that our residents have when they come to us is disengagement with life. They've often times lived on their own. They've been isolated. They become lonely. They become

depressed in many cases. They've stopped eating, and the downward spiral of health concerns start often times ending up at emerg visit at 2 o'clock in the morning when they're in crisis.

So this design is really intended to reconnect, reengage our residents in life and create opportunities for them to meet new friends, to learn new things, to contribute, to pursue their passions, all those things that make life worth living for. We happen to also provide a lot of care which supports people in pursuing -- in pursuing that objective, so very much a social model.

It's also a research model in that our research is from the RIA, which I'll describe in a minute, conduct the research in our villages with our residents and our team members as co-investigators kind of embarking on a journey of discovery together to learn new and better ways to provide quality of care and quality of life for our residents and then seniors across Ontario and Canada which I'll describe in a moment.

This is kind of a picture of the town square and retirement home. I think that Tansley Woods in Burlington. It gives you a bit of a sense

of the scope. These are relatively large complexes, often times about 200 LTC residents and another 400 retirement and department residents, so 5 to 600 residents is not unusual size for our villages. We typically build them in three phases, I should mention: Long-term care first, and then the second phase, extending the main street including the first tower and the town square; and then third phase is usually the next tower with additional retirement suites.

Just very briefly, our -- we have 19 sites across Ontario as far west as Windsor, as far east as Whitby, as far north at Barrie but clustered kind of in the GTA area primarily.

We have -- most of our villages are new. We design, build, and operate them ourselves. We have four -- five older long-term care homes that we have acquired over the last six or seven years that we've been planning on redeveloping into our -- into the first phase of a new village, so we have experience operating newer homes. We also have a bit of experience operating older homes that are in transition to redevelopment into a new village.

Just give you a picture of kind of the

activity, the action when -- that you see on main street and in the town square. This is very typical. When people come to tour our villages, they often comment on the vibrancy and activity that they find on main street. This is kind of very typical scene on main street where residents are out in the cafe. They're doing things. Again, these are all pre-COVID pictures, unfortunately, but I hope with the vaccine being rolled out that we can get back to these conditions in the not-too-distant future.

Sorry for the small pictures, but these are some of the pictures of the town square, the large atrium space, the central gathering space; you can see the little buildings on -- in the town square. You can see the store fronts of what looks like a small-town Ontario main street. But, again, it's meant to look like a small-town main street, but it's really meant to function like a small-town main street where residents can, rather than jump in their car and heading downtown to get their groceries or go to the post office or meet a friend at the coffee shop, they can walk out of their room and take their wheelchair or walker and head downtown but have all those same experiences that

have been available to them all their lives, but now it's in a form that they can access at this age and that they can access year-round.

So I like to describe it as allowing our residents to continue to live life as they always have with all the same experiences but now in the form that they can access at this stage in their life.

The last thing I'll say about the model before talking briefly about the RIA is it's also very much a hub model. Dad's always seen our villages as a community centre for seniors who live in the broader community as well as for all ages in the community. So we incorporate things like our health centres right on to our main street. These are typical -- typically satellite family health teams whose physicians provide a medical service to our residents, but they also have typically all ages practices. So young mom and her kids can come to the doctor's office. They happen to come to the local retirement home, and they happen to wait on main street to see the doctor, and they might bump into a resident and strike up a conversation. But it's a way of -- a way of not only providing medical services that are more effective, we think,

for our residents, but also brings the community into our village and connects our residents with the outside community.

We have space for seniors' programs. You know, often times, we partner with seniors centres who are usually in need of space to give them, space so they can program right in our village, so our residents can be part of that, but also, seniors from the broader community come in and use that space as well.

We have day programs in many of our villages, again, opportunities for seniors in the broader community and -- to come and participate in the -- in day program -- in day program services.

We have the RiverStone Spa which, again, is open to the public, so we have lots of people from the public, again pre-COVID, coming in to get spa services. It's available to our residents but also the outside community, another way of bringing the outside community in. We have the Ruby Restaurant, which is a 10th floor restaurant that is a fine-dining experience. You see a picture of it here that is really meant for our residents to be able to kind of get dressed up for a night on the town without ever having to

leave the village, so adult son can come and pick mom up, and rather than having to try to her get into the car and drive across town to a restaurant, they can simply go up the elevator to the 10th floor and enjoy a fine-dining experience. This is also open to the public, and so we have lots of people from the community coming in and coming for a meal.

Interesting how this integrates. I was up in the Ruby Restaurant at one of our villages, again, pre-COVID, and I saw a young couple, just two of them sitting having a meal, and so I was too curious not to ask. So I went over and asked them what they were doing there, and they said, well, they live just in the subdivision next door, and they heard about how good the food was at the Ruby Restaurant, so they thought for their date night, they decided to come and try it out. And as the fellow was saying, he kind of hesitated and said, if you would have told me six months ago, we'd be coming to the local nursing home for a date night, I never would have believed you, but here they were. But a great kind of example of kind of bringing the community in to be part of -- be part of the village.

Another part of the community centres are our living classroom. We have --

LYNN MAHONEY: Mr. Schlegel, can I just ask you a question --

JAMES SCHLEGEL: Of course.

LYNN MAHONEY: -- just since you sort of described the village for the Commissioners and the model of your -- and where long-term care fits within it. Is it fair to say that the -- your family is the -- sort of the shareholder, that this is a for-profit organization?

JAMES SCHLEGEL: Yeah. It's a private, for-profit organization family-owned, so our family owns it 100%, so it's a private-for-profit closely held family business, yeah.

LYNN MAHONEY: And I think you described it for me when you and I spoke. I think you said that, we are for-profit. We do operate more like a not-for-profit, and we're a private organization with a public purpose. Do I have that right?

JAMES SCHLEGEL: Yeah, I would -- I think that's a fair way of describing us. I think others in leadership in the health system, The Minister of Long-Term Care, Minister of Health, and

deputies would probably describe us the same way that, especially with our research institute and the philanthropic initiatives that we've started to drive innovation in the sector and improve quality of life, they see us kind of as an -- a bit of an organization that has one foot on either side of the fence, if you will, between the private-for-profit and the -- and the not-for-profit/public, so we kind of occupy space kind of in between, I would say.

LYNN MAHONEY: Okay. And --

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts had a question.

LYNN MAHONEY: Sorry.

COMMISSIONER JACK KITTS: Jamie, you're probably going to come to this, but in your model, is it -- is it the village or nothing, or do you build pieces of it in certain areas where maybe land is not available? Would you ever build a long-term care home without the rest of the village?

JAMES SCHLEGEL: Yeah, it's an excellent question, Dr. Kitts. We're pretty stubborn about this, and we like to stick to our modeling. So it's kind of the village or nothing.

We really believe strongly in the campus of care model and providing the full amenities that a fully built out main street and town square provide, the richness of that experience. And so we don't kind of build pieces. We build in stages for sure, but we build -- we build all of it.

As we get into areas of the province like the GTA where land is more expensive, we get a little bit more compact. We're looking at even having to do the village a little bit more vertically rather than horizontally. But we haven't strayed from the -- kind of entirety of the village concept.

COMMISSIONER JACK KITTS: Yeah. Okay. Thank you.

JAMES SCHLEGEL: I'll just finish up, Lynn, if that's okay. And then --

LYNN MAHONEY: Yes, please.

JAMES SCHLEGEL: So the [indecipherable] -- so the living classroom is something, again, integrating with post-secondary education, so we have in many of our villages a complete kind of what I'd say is a mini community college campus with classrooms, with skills lab, with computer labs, with student lounge space for

PSW, RPN, RN students. We hope to expand that to food service worker program and recreation therapists as well. But they come and take all their courses right in the village. It's the ultimate in experiential learning. Our residents come down and can be tutors. Nothing like having a resident come down, and which we do all the time, to have them describe what it's like to be on the receiving end of a peri care, for example, to a group of PSW students, always more impactful than simply learning from a textbook.

And students, you know, coming up into the -- into the village to connect with residents, so residents are part of the learning process and part of the teaching environment as well. And you can see some pictures of labs that we have usually in the lower level of our villages so they have their own space, but then they come up.

I had one beautiful example of the integration that happens when you bring students and seniors together. I was walking into our village of Riverside Glen in Guelph one morning. I saw group of what turned out to be RPN students, about six of them, kind of all leaning in over top of a table in our cafe just inside of the entrance

door, and I was too curious not to go over and ask them what they were working on, so I went over, and they explained they were working on an anatomy class, and they had a project to do. And here in the middle of this group of young, you know, 19, 20-year-old females at that time, RPN students, was one of our 85-year-old residents. And all these RPN students were huddled over top of this resident. And I asked what he was doing, and he said, well, it turns out he was a former anatomy professor from the University of Toronto, and he had moved to Guelph to be close to his daughter, and so here he was helping this -- these students with their anatomy project for their -- for their class. And I just saw the joy on his face to be able to continue to teach and interact with these young students, and they were just overjoyed to have this expert at their disposal to help them with their project, so one very simple example of how the worlds of young learners and older adults can intersect in some really fascinating ways.

Just to finish off the overview. Then I'll get into more specifically COVID. We -- our family started the -- it was really the vision of my father who started the Research Institute for

Aging, which is a charitable not-for-profit entity funded by our family but separately governed by its own board of directors and has its own kind of space, just the RAI building that we built, actually, right on the main street of our village at University Gates which is on the campus of the University of Waterloo, so it's got about 60,000 square feet where our researchers have their offices, have their labs. The living classroom exists. We have a research department where older adults can actually stay overnight for research purposes.

And the whole idea of the RIA which is a senate-approved research institute that our primary academic partner is University of Waterloo; our primary training partner is Conestoga College, but we have local partners wherever our villages are, so we have lots of partnerships with other universities and colleges as well.

Our practice partner is, of course, Schlegel Villages, but Dad's vision was to bring the worlds of practice and research and training together to intersect and so -- and do so in a very, very practical way so that our research chairs -- we have 12 research chairs that we fund

another about 35 or so affiliated research scientists conducting research in a whole host of areas with the objective of improving the quality of life of seniors across Canada.

And the researchers conduct the research right in our villages with our residents and with our team members as I mentioned. So they -- so that research informs practice, but also, practice informs research and forms kind of what we study. And the researchers are the richer for it -- richer for it as well. And so what ends up happening is that, as learnings kind of come out of the research, the -- our team members and residents don't wait for the researcher to go off and publish. They apply it in real time, so you get this rapid cycle kind of implementation of innovation that occurs in our villages, but then the idea of the RIA is charitable, so it takes those learnings that had been -- have been -- have been developed at Schlegel Villages, have been tested at Schlegel Villages to see if they can be replicated, the science of knowledge transfer, and then they get disseminated across the health system to benefit seniors outside the walls of Schlegel Villages, seniors living in other

congregate care settings, but also seniors living in the community as well, and there's lots of good examples of that I could share. So this is the idea of kind of knowledge generation. We incubate. We accelerate by testing it. We incubate it in one village, accelerate it, usually test it in two or three other villages, and then we mobilize it. We disseminate it across the system. We see some of our research chairs in the areas of technology, in the areas of workforce development, in the areas of epidemiology, in the areas of falls and mobility, in the areas of geriatric medicine.

We have two research chairs in dementia care, such a huge issue, in primary care, in nutrition and aging, and vascular aging as well. And some of our staff team here, there's now a staff of about 30 or so that -- so the RIA is really kind of designed to harness the power of research to drive innovation, initially in Schlegel Villages, but then to benefit the entire Canadian health system.

It's interesting. We really pitched this to the then Minister of Health in about 2010 to build a research facility on the campus of the University of Waterloo, and we needed an allocation

of long-term care beds to do that. And one of the -- one of the arguments we made is that we really felt that Ontario could become a knowledge exporter to the world in terms of how to deliver innovative, high quality care to seniors. And it's interesting how we've had probably about 40 countries or so, delegations from -- countries from around the world coming to the Research Institute to kind of see what we're doing and taking back ideas to their countries because, you know, most -- almost all countries in the world are -- you know, are facing the challenge of an aging demographic and how to best serve the needs of those. So to some extent, that leadership has already started to happen through those -- through those visits.

So, Lynn, that's a bit of kind of an overview. I hope that hasn't taken too long, but I can get onto -- to kind of parts 2 and 3 of my presentation if you'd like.

LYNN MAHONEY: Yes. That would be --

Commissioners, do you have any other questions about the model?

COMMISSIONER JACK KITTS: I have a question, Lynn, if that's okay.

LYNN MAHONEY: Yes, please.

COMMISSIONER JACK KITTS: So, Jamie, I mean, clearly, this is a well-thought-out and proven methodology, and it's very different than what we've heard so far.

My question is for the -- there's very strong proponents about keeping people in their homes as long as possible until they can't be cared for in their homes anymore. This seems to be counter to that in that you would like to attract the elders when they're still mobile and work with them to have a very fulfilling future.

How do you -- how do you have that discussion with those who say, keep them in their homes as long as possible? And I think you would agree, then, at that point, they do need care, and this wouldn't be the right model for them.

JAMES SCHLEGEL: Yeah, it's an excellent question. The -- often -- this is going to sound like I'm bragging, and I don't mean to be, but I often times have residents coming to me after they move in and say, I wish I would have done this two years earlier. I was living on my own. I was -- I was, you know, disconnected from my family who were busy with their own lives, and this is -- in fact, I've had families come to me and say

literally thank you for bringing my mom back to life. She's the mom I knew from 20 years ago I'd never seen again.

So we do create an environment where we think it is valuable for seniors to have that sort of experience.

The reality is that we cannot build enough of these sorts of complexes, and not everyone can afford these sorts of complexes. We're going to have to also be smart about how we leverage these sorts of, I can say, environments to support people living at home.

So I've challenged our organization to say, how do we -- how do we support the 5 or 600 seniors who happen to live and sleep overnight in our village well, but how do we also create an environment where we can support 5,000 seniors who live out in the community who maybe aren't ready or can't afford or still -- you know, are still living an active life at home? How do we continue to support them? So how do we bring them into the village so we -- they can have social programs; they can get meals; they can get medical care; they can access exercise programs so they can live longer and successfully in their house, in their

own home.

So people say to me, why would you do that because aren't you kind of reducing the need for your service? And I say, you know, this is kind of a system approach where we need to do both. We need to build places like this so people can engage actively in life when they need congregate care, but also, we need to get smart about how we also support people living in the community by leveraging these sorts of community hubs to allow them to stay at home longer, in effect, and also use technology?

One of our research chairs is in technology for independent living and looking how do we wire people's homes to be able to support them longer living, so it's a bit of both, Jack, I guess, is what I'm saying. It's -- we need -- we need both, and we need to do both well. And so we see ourselves as contributing to the innovations around living at home successfully as well, not just in congregate care settings.

COMMISSIONER JACK KITTS: Yeah, I think that's well said. It's not either or, but I think we'd have to watch the system close enough that as they were deteriorating or beginning to deteriorate

at home, that they would have this transition.

JAMES SCHLEGEL: Right.

COMMISSIONER JACK KITTS: So stay at home as long as possible but not beyond the point where you can't enjoy what the village brings? Is that --

JAMES SCHLEGEL: Yeah, and if you're one of those 5,000 seniors who live in the community who are coming to the village for meals already or social programs, the transition becomes a whole lot easier because you're already part of -- you're already a member of that community.

COMMISSIONER JACK KITTS: Yeah.

JAMES SCHLEGEL: So it breaks down those barriers, those psychological, you know, barriers that can exist with congregate care settings.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: You spoke a little bit about how you're connecting. You know, you have a health centre and things in there. I'm just curious about your relationship with, for example, the local hospitals and other types of

healthcare providers, how you, you know, do that sort of integration.

JAMES SCHLEGEL: Yes. Thank you. Excellent question and has become increasingly relevant and, in fact, pressing during COVID in terms of our response. So we've had the advantage of developing good relationships with primary care because we've had primary care practitioners right in our village in our health centres.

But also working closely with our hospital partners, we've developed many transitional care programs to address the ALC challenges that hospitals are experiencing and have experienced for some time.

So we've partnered with several hospitals to develop a program where we provide transitional care beds to be able to discharge transitional care or ALC patients into a -- frankly, a more appropriate environment while they wait to go to their ultimate destination back home or into the congregate care setting.

So we've typically had close relationships because of those sorts of programs with our hospital partners so that when COVID hit, you know, those relationships were pre-existing,

and it allowed -- and there was trust there. We could pick up the phone and access their hospital partners quite effectively, so that helped us for sure in dealing with COVID because, frankly, in the first wave and now in the second wave, the assistance of our hospital partners has been very critical. So those sorts of -- that's always been a part of our model, and it served us well during COVID for sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask you, Mr. Schlegel, we've heard a lot about part-time staff, full-time staff, and one of the -- one of the problems is -- from a staffing perspective is too many part-time staff, but what's been your experience?

JAMES SCHLEGEL: Yeah, thanks, Justice Marrocco. It's a very relevant issue, and you can see one of the committees I participate in was the Long-Term Care Staffing Study Advisory Group which issued its report in July, and I believe the Commissioners are well aware of the --

COMMISSIONER FRANK MARROCCO (CHAIR): We're well aware of it, yes.

JAMES SCHLEGEL: And I was pleased to be a part of that, and we talk a lot about

part-time staff. We talk more about the environment, that, frankly, we created for staff because I think the bigger issue is we don't create a very innovative, a very welcoming, very supportive environment for especially our PSWs, and we wonder why we lose 40% of them in the first year that they work in long-term care because we don't create an environment that is very attractive for them to stay or come in the first place.

But with respect to part-time staff, the reality is we run healthcare 24/7, so we need part-time staff. For every full-timer, you need a part-time staff member, and so there's no kind of getting away from part-time staff. We can limit it by combining part-time lines, although then part-timers have to work two weekends.

We've tried that. There wasn't a lot of uptake. We've tried job sharing which, as the workforce gets older, has been -- we have gotten some traction on. We've tried 12-hour shifts which is a way of reducing part-time, but -- and that works well for registered staff, but it doesn't work very well for PSW staff because it is very physically demanding work. I -- every couple of months, I put a uniform on and go work with our

neighbouring team members because I always want to stay close to the front lines, and I'm, reminded, every time I do an 8-hour shift, how physically demanding their work is and, frankly, how incredibly important their work is.

So it's very difficult for a 58-year-old, often times female, to work a 12-hour shift. So I think, Justice Marrocco, there's some things we can do to reduce part-time and add some full-time shifts through some creative scheduling, but we can't get away from part-time work altogether, so then it becomes, how do we -- how do we effectively engage? How do we effectively motivate? How do we create an environment that is -- that is healthy for all of our staff, especially part-timers, to feel motivated and engaged? And I think, frankly, from my standpoint, that is -- that is the bigger -- that is the bigger issue.

COMMISSIONER FRANK MARROCCO (CHAIR): And in terms of a percentage, 50-50?

JAMES SCHLEGEL: Very close to 50-50, yeah; 55, 45, depends on -- depends on our home, but we're somewhere between 55-45 --

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, which is the 55 and which is the 45?

JAMES SCHLEGEL: Fifty-five, so part-time to full-time, so 55 part-time, 45 full-time, somewhere between that and 50-50 is pretty typical because you also have a pool of casual folks that you need to cover sick time and cover vacation time and so on.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

JAMES SCHLEGEL: So not to spend any time on this, but these are some of the tables I've been asked to sit on, the LTC Response Table with -- which Dr. Kitts will know very well, the LTC Retirement Home Operators, COVID Action Table which continues to meet usually once a week; the Ministry of Health OH Focus Group, the Recovery and Planning Table chaired by deputy -- Deputies Steele and Angus, Ontario Health Advisory Group for Matt Anderson, the Pandemic Advisory Group for the OLTCA, and then some other relevant things: I'm involved in the Steering Committee for our local OH Team, Ontario Health Team in Kitchener, Waterloo; sat on the Premier's council for healthcare, back in the early days of the Ford Government; participated in the Staffing Advisory Group; and

also participated in the group looking at modernizing the Long-Term Care Act Development program, so I offer that just for context but not to suggest that I'm an expert in any one of those areas, but I've had some exposure to those -- kind of the workings of the COVID response as well as some of the efforts around staffing and modernizing long-term care design and development, so I can comment on those to the extent --

LYNN MAHONEY: Can I -- can I just ask you some questions about that, please, Mr. Schlegel?

JAMES SCHLEGEL: Sure, yeah.

LYNN MAHONEY: The committee that you were involved in -- and maybe you can identify which committee that is -- I think you had told me that you were asked -- as a long-term care home operator, you were asked to sit on a committee that was dealing with the COVID response. Maybe you could tell the Commissioners about when you were asked to be on that committee, what that committee did, and whether or not there was any other --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- long-term care representatives?

JAMES SCHLEGEL: Yeah, for sure. And Dr. Kitts will be well aware of this that I -- the response table is set up. It's either the first item or the first table listed there, the response table, and that was set up early in the COVID days. And then, after it was up and running for a while, I don't know how long -- I think about a month or so -- there was a -- the chair, Kevin Smith said we should have a -- kind of an advisory group to help provide some advice on long-term care to this group. And so I was asked to be part of that advisory group.

We had one meeting, and then at the end of the meeting, Kevin Smith said, why don't we just kind of suck you all up into the response table and just have you kind of be part of the meeting rather than having separate discussions, so I got kind of pulled up into that response table at that -- at that time, and I was the -- so there was representation from the hospital sector. Some of the key CEOs of the large hospitals at Ottawa, at Trillium, at UHN, at St. Joe's, Hamilton were all part of that for sure.

There were members of -- from Ontario Health and representatives from the Ministry of

Health and Ministry of Long-Term Care, and then I was the -- I was the voice of long-term care. And I think that's one recommendation or suggestion I'd give going forward is to have -- to have, you know, the perspective of folks on the ground, both operators as well as consumers and residents, part of -- part of those tables, I think, really adds value to the discussion.

Oh, and I recognize this was happening in real time. We were learning on the fly, and so this is not about being -- pointing fingers at anyone, far from it. Everyone was doing the absolute best they could.

But looking back, it would have been helpful to have kind of more folks with boots-on-the-ground experience both from an operations as well as from a consumer', resident, patient standpoint.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just -- before we leave that, you said, I think, that the COVID response table was set up early on, and then you were approached about a month later.

JAMES SCHLEGEL: I think it was about a month or two later, Justice Marrocco, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you give me some sense of when that was? You know, the declaration of emergency or whatever is probably mid-March 17th, somewhere around in there.

JAMES SCHLEGEL: Yeah, I think I joined in May. I could -- I should have looked that up prior to this, but I think it was about mid-May.

COMMISSIONER FRANK MARROCCO (CHAIR): No. No. That's fine. Approximately May.

JAMES SCHLEGEL: Yeah. [Indecipherable].

COMMISSIONER FRANK MARROCCO (CHAIR): And were you the first -- were you the first long-term care person associated with that?

JAMES SCHLEGEL: Yeah, I was the -- I was the first and only. Some of the hospitals, Justice Marrocco, would have operated long-term care homes within their corporation, so it's not like -- but they -- but I was the -- kind of the one and only LTC representative in that on -- around that table.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any sense of -- do you know why that might be? I mean, it -- I think we heard from -- I don't have it in front of me, but 7 to 8% of the

healthcare budget is long-term care.

JAMES SCHLEGEL: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): And yet, it's only in May when the input from -- a real on-the-ground input as far as long-term care is concerned is present on that response table.

Do you have any sense of why that wouldn't have been top of mind as opposed to something that was thought of a month or two after?

JAMES SCHLEGEL: Yeah. It's a great question. And this is more, I guess, speculation on my part, Justice Marrocco. I think part of it was in the haste of kind of getting these tables set up quickly to start responding to the COVID crisis that was emerging kind of generally in society but certainly in the health system and long-term care in particular.

I think it was partly due to haste. I think it was also partly due to our health system is still very much hospital centric. We talk a lot about -- in Ontario Health Teams, about a system of care and moving care closer to the patient and so on. But it's still very hospital-centred. And the reality is the hospitals were coming to the assistance of long-term care homes, so they needed

to be at the table. So it was quite appropriate for hospitals to be there.

So I think it was perhaps a combination of all of those factors that led us to that -- to that point of kind of being a couple of months in before the kind of voice of the operating ground was incorporated.

COMMISSIONER FRANK MARROCCO (CHAIR): In terms of, you know, the long-term care residents who died, would it be fair to say that of the people who died in Wave 1, May was kind of too late; May was past the time when those people were likely sick?

JAMES SCHLEGEL: Yes. Certainly, there were residents who passed away after May, and we certainly experienced that to some extent in our -- in our organization. But the worst outbreaks were in, you know, March and April when we were still learning about the virus, still learning that it could spread pre-symptomatically and asymptomatically.

We were learning how important masking was. We were learning that we needed testing capacity. So it was -- it was definitely the highest risk period, the biggest impact in terms of

infection rates and in terms of deaths was in those first couple months for sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

LYNN MAHONEY: Thanks, Mr. Schlegel. So I think you were on to your lessons learned and --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- recommendation, and I would actually -- I think the Commissioners would benefit from your comments right now if we could focus on the committee structure --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- and what you experienced from -- and I would like you to address as well whether or not your observations on these committees that you've sat, these tables that you sat, if you got the impression that the Province was ready for this pandemic and your observations of sort of this committee structure --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- and communications would be helpful as well.

JAMES SCHLEGEL: Sure. And that's kind of my first -- I -- I've kind of divided up some of

my lessons learned into kind of a COVID kind of systemic response, a little bit about some of the misperceptions that continue to persist, a little bit about system challenges, and a little bit about kind of what we've learned as an organization, just ourselves, which you might be interested in hearing about, so I'm happy to chat about any of these, and I won't -- I won't spend a lot of time on all of them because that will -- that will consume too much time, but I'll highlight a few.

In terms of COVID response, certainly, I found a lot of redundancy in the committee structure. I sat on enough tables that I found myself talking to the same issues in two or three different sessions with the same -- largely the same people, the same deputies, the same senior staff at OH.

And I say this -- I say this out of all respect to my colleagues in Government who are doing their level best to manage a very difficult situation, so this is -- this is as much about being self-critical as anything, so I don't -- I don't want it to come across like I'm wagging my finger at my friends in the public service in Ontario Health and so on because that's not the

case at all.

But looking back on it, I think there was a redundancy that -- when there's redundancy, not only do we waste time talking about things more -- you know, more than once, but you end up running a risk of confusion in terms of who's actually following through. And so I think there was sometimes lack of straight-line execution, if I can put it that way, and things that probably we needed to act on more quickly as the science emerged we weren't as fast on.

Part of that was due to the fact that this was an advisory group. The response group didn't make the decisions. It would take its recommendations up to the political decision makers, and then they would do with it what they would. And sometimes that process of recommendation and then decision by the political leadership would take some time. And I wasn't privy to those discussions, so I don't know exactly how that worked.

But certainly, there was lots of times where I thought a more streamlined IMS structure would have led to more effective execution, notwithstanding the fact the science was emerging

and we were kind of learning as we went, but -- so that would be number 1.

Number 2 is, I didn't say it explicitly, but I said earlier, the voice of the folks on the ground, both operators and consumers and families, I think, adds a lot of important perspective, knowledge and perspective to the discussion.

LYNN MAHONEY: Can I ask you, just to interject --

JAMES SCHLEGEL: Sure.

LYNN MAHONEY: -- if you could roll -- and you and I had spoken about the single site --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- initiative, and I think that is one of the matters that were raised on these -- the committee that you sat on, and you had some views as to the efficacy and whether or not this was, in fact, a prudent thing to do and what ultimately happens, so if you can --

JAMES SCHLEGEL: Yeah. No. And, you know, there's always dissenting opinions, and so it's not like I have to always get my way in these things. It's -- the richness is often times in the debate, and I'm not even sure which table it was

at, whether it was the action table or the response table, but it might have been the action table, actually.

But we had this great discussion about, you know, this single-site initiative, and from a Public Health standpoint, there was some logic to it to prevent the spread of the virus between long-term care homes. We were starting to understand that staff members were primary vectors of the -- of the virus, and so to limit the number of workplaces and other thing made sense from a Public Health standpoint. But other factors had to be taken into account: Both the ability for these folks to earn a living -- often times, they're working in more than one place, full-time in one place, part-time in another -- also the ability for these long-term care homes who -- many of whom were in -- not necessarily in staffing crisis, but were -- had strained staffing resources and schedules already, what that would do to them.

Some long-term care homes lost the day after single-site initiative, 30 to 40% of their -- of staff virtually overnight, and so -- and then heaven help them if they went into outbreak after that, after having just lost that many of their

staff, and so we -- you know, many of the most challenging outbreaks that were experienced in the long-term care homes were early on for sure when we didn't fully understand the -- how the virus spread, but also in long-term care homes who were already in staffing crisis, were strained prior to COVID, and then went into crisis with the single-site initiative, and then went into outbreak; and they were already in crisis, I would argue, before the outbreak occurred. And that's where, you know, support from hospitals and others were very -- was very important.

So this was part of the challenge, and I said that -- at the time that if we need to do this from a Public Health standpoint, there's lots of consequences that are going to be negative as I've described to both the system and ultimately the residents as well as to our workers who need to earn a living; and that if we go into single-site initiative, we, at some point, will have to go out of the single-site initiative.

And my concern at the time was that we'll go into it a whole lot easier than we'll be able to come out of it, and that's what's happened because politically, it's very difficult now to

remove that, and so we're kind of stuck with this -- now with good testing, now with better screening, with rapid testing, we can -- we can control things better. And so what we have is situations where staff are working full-time at a long-term care home and part-time at Walmart to make ends meet, and they'd be much safer, frankly, to work in two long-term care homes and that, so these were some of the things we talked about at the time, some of the issues I raised about the single-site initiative.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there for a minute?

JAMES SCHLEGEL: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): The rapid testing --

JAMES SCHLEGEL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- where is that? Is that -- did that -- does that seem to you -- because I notice testing capacity is one of the responses that you -- or one of the lessons learned.

JAMES SCHLEGEL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you see a role for rapid testing, and is it

rolled out now or not? I can't seem to understand that.

JAMES SCHLEGEL: Justice Marrocco, it's in the process of being rolled out. It was -- it was trialed in several long-term care homes across the Province. We were part of that initial trial both to see how it would work and how accurate it was in our settings. So we ran kind of parallel tests where we did the PCR, a kind of gold standard test, along with the rapid testing, and it proved to be actually much more accurate than -- we were led to believe it would be, about 75% accurate, but our experience has been it's been kind of 95 plus percent accurate.

COMMISSIONER FRANK MARROCCO (CHAIR): So it's 95 --

JAMES SCHLEGEL: So based on -- based on that, it's being rolled out. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- 95% accurate?

JAMES SCHLEGEL: Relative to --

COMMISSIONER FRANK MARROCCO (CHAIR): Have they rolled it out?

JAMES SCHLEGEL: So based on that, Justice Marrocco, they are now rolling out the

rapid testing to all long-term care homes for sure. And it's been a very important tool for us to be able to -- not as a -- not so much as a diagnostic tool but certainly as a screening tool to be able to understand, you know, within 15 minutes, whether a person is presymptomatic or asymptomatic but COVID positive.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it would assist with this single-site problem, right?

JAMES SCHLEGEL: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Because then it wouldn't be an issue --

JAMES SCHLEGEL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- because you could test the person on the spot.

JAMES SCHLEGEL: Yes, or test them very regularly and much less invasively. It doesn't require the nasopharyngeal beep (phonetic) swab that the PCR test requires.

COMMISSIONER FRANK MARROCCO (CHAIR): Right. Okay.

JAMES SCHLEGEL: But definitely part of it, so I'm happy to talk about the rest. Certainly, you've heard lots about --

COMMISSIONER FRANK MARROCCO (CHAIR): No. I just wanted to clear that up --

JAMES SCHLEGEL: Yeah. No. I --

COMMISSIONER FRANK MARROCCO (CHAIR): -- because I wanted to make sure I didn't have a sort of superficial --

JAMES SCHLEGEL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- appreciation of something that turns out when you examine it, it doesn't hold up.

JAMES SCHLEGEL: And, Justice Marrocco, it also -- the rapid testing can be used for central caregivers, frankly, for general visitors as far as that goes.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

JAMES SCHLEGEL: So it has -- it has benefits well beyond just staff as well in terms of keeping the virus out as much as we possibly can.

COMMISSIONER FRANK MARROCCO (CHAIR): So you wouldn't have to restrict visitation if -- because you test all the visitors when they try to come in.

JAMES SCHLEGEL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Anybody who tested positive can't come in.

JAMES SCHLEGEL: Right. Yeah. And right. That has -- that has significant staffing implications to be able to staff with a registered staff member to do that testing, but it's certainly conceivable that could be done as part of our screening methodology.

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. Schlegel, do you know when rapid testing was approved by Health Canada approximately?

JAMES SCHLEGEL: Oh, it was -- there was -- there were different -- the ones [sic] that's being rolled out is called a Panbio, but there are other ones that have been used as well. But I think that was -- that was approved fairly early in the game. I was going to -- I'm going to say, like, in the late spring, May, June. I could find that out, but it was -- it's been around for a while. And then, you know, trialing it took a while, and now rolling out's taking a while, but I think it's around --

COMMISSIONER FRANK MARROCCO (CHAIR): So --

JAMES SCHLEGEL: -- May or June, I would say.

COMMISSIONER FRANK MARROCCO (CHAIR): So if it's approved in May or June, and for some reason that approval by, I guess, Health Canada --

JAMES SCHLEGEL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- isn't satisfactory, and they decide to do this parallel testing that you've been describing as pilot projects, how long does the pilot project take before you can draw the conclusion that it's relatively accurate?

JAMES SCHLEGEL: Yeah. The pilots actually went fairly quickly. The Government, to their credit, was in -- was in kind of hurry-up offence at that point, so that happened this -- kind of this fall, like, late fall where we were in kind of November, December those pilots happened. And then once they started getting, you know, results that they were reliable in January, we started kind of rolling them out more broadly.

But the time lag was more between when, I think, Panbio was approved by Health Canada and when those pilots started. I'm not sure what the lag was there, but once the pilots started, it actually went fairly quickly.

COMMISSIONER FRANK MARROCCO (CHAIR):

Thanks.

Dr. Kitts.

COMMISSIONER JACK KITTS: Jamie, do you know if there's sufficient units of this rapid testing mechanism to cover the long-term care homes?

JAMES SCHLEGEL: I don't know that for certain, Dr. Kitts, but I believe from -- I believe anecdotally that they are acquiring enough -- they have acquired or are acquiring enough of these Panbio tests to provide them to all long-term care homes, yes, and retirement homes as well.

COMMISSIONER JACK KITTS: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): So one of the reasons that this is going so slowly may be that there just aren't enough -- they didn't -- we haven't acquired enough of these rapid tests to be able to use them --

JAMES SCHLEGEL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- in the way that we've been talking about.

JAMES SCHLEGEL: Yeah, and it goes back to my first point about, you know, this discussion at the -- around the table to implementation and

execution there. And I realize that there's lags around political decision making and so on, but it seems in some of these cases where the answers are fairly obvious that it took way too long to go from idea to implementation.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

JAMES SCHLEGEL: And I'd say that rapid testing is one of those.

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks very much.

LYNN MAHONEY: Is there any others, Mr. Schlegel, that when you say there's some of these things went slowly from the idea coming forward to the implementation of it and the decision making, any sort of -- I mean, you sat on these tables -- any other things that you can think of?

JAMES SCHLEGEL: Yeah, I mean, ramping up testing in the first instance -- the PCR testing took way too long. Masking kind of -- we kind of fumbled around that for a while. And admittedly, the science was kind of not clear on that for a while, but then, when it became clear, we kind of fumbled around that for a little bit, so, yeah, I

could probably think of a few others, but those are a couple others that come to mind for sure.

LYNN MAHONEY: Can I just ask you about that. You say that the science wasn't necessarily clear. But I know you're well aware of the precautionary principle following on the SARS Report, and I think the lesson out of that is we don't need to have it perfect. We just need to do -- and is -- we need to do what we can as quickly as we can. And as one witness who has come before the Commission has said, you know, the number one job is to stop the -- stop the disease from spreading.

So did you have a sense of whether or not -- I know the science may have been unclear, but was that top of mind sort of not trying to be perfect but just trying to do what --

JAMES SCHLEGEL: Yeah. It's a good question, tough one to answer, but everyone's doing their best for sure, so I don't want to be critical in terms of intentions. I just think that, like, for example, our organization implemented masking of all our staff and strong recommendations for residents to mask probably about ten days before the directive came out from The Ministry of

Long-Term Care, and those were, you know, seven to ten very critical days in -- when you're in an outbreak pandemic situation.

So I don't think it was due to lack of good intent. I think it was more just the movement from idea to decision to implementation that -- and I'm not, you know, privy to all the machinery of government that might slow that down, but it just seemed that in some cases, that movement from idea to decision to implementation, you know, took, you know, weeks rather than days.

LYNN MAHONEY: Took longer than it should have.

JAMES SCHLEGEL: Yeah, and when you're dealing with a -- you know, a virus whose infection rate is increasing at an increasing rate, every day counts, and we certainly know that from the epidemiologist.

LYNN MAHONEY: Can you talk to the Commissioners and tell them what your experience was and your observations about testing capacity and also the availability of the swabs so the -- and the test return --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- rates and how that

contributed and sort of the delays in that process?

JAMES SCHLEGEL: Yeah. So testing, you know, we -- the capacity for testing took some time to ramp up. We had this lofty goal of 20,000 tests per day, which, you know, we were -- started off, like, at 2 and 3,000 per day, and took, like, a long time to get up to 20,000. The -- I think the biggest challenge with the testing has been turnaround times, inconsistent turnaround times.

When you're dealing with an outbreak in a long-term care home, to send swabs due to mass -- you know, from a mass swabbing of all residents only to wait five days for those swab results to come back, those are five incredibly important vital days to be able to understand the extent of the spread.

And I'm actually talking from experience on this one where we're dealing with a major outbreak in Windsor right now in one of our homes and very extensive. It started from, we think, some sort of -- I'm going to say superspreader kind of event, although it's always hard to be definitive on that.

And we did our first swabs and took five or six days to come back, and we were -- and

they came back. There was 50, 5-0 residents positive, went from one case to 50 in -- but it took five, six days to find that out.

So -- and that information is vital for us, obviously, to be able to invoke proper IPAC procedures, know who -- know who needs to be isolated, obviously. Some of these folks were asymptomatic. Some of them stayed asymptomatic who we needed to make sure we protected our team members against it. I mean, it's just all sorts of ramifications from kind of operating with blinders on or operating blindly, I should say, because of -- so that's been the big challenge with testing. Some days we get -- sometimes we get them back the same day. Lots of times, we get them back, you know, three, four, five days later which --

LYNN MAHONEY: And this is still a problem in Wave 2?

JAMES SCHLEGEL: Yes, the example I gave was from Wave 2.

LYNN MAHONEY: Yeah.

JAMES SCHLEGEL: Yeah. Yeah.

LYNN MAHONEY: Okay. What about the availability of swabs?

JAMES SCHLEGEL: We haven't had as much of a -- we've had some challenge with that, but it hasn't been -- it hasn't been a huge challenge for us. We've generally been able to get swabs when we needed them partly because we've had good contacts in with Public Health Ontario, and they've been able to free them up for us, so I know other organizations have struggled with that. We haven't experienced that directly ourselves as much.

LYNN MAHONEY: Can you give the Commissioners some insight into sort of basic pandemic preparedness whether your homes and homes in general were prepared for this pandemic, any drills, any outreach from Government Ministries to ensure you were ready for the pandemic in terms of just --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- basic preparedness including PPE and IPAC?

JAMES SCHLEGEL: Yeah. I'm just going to skip down to Schlegel Villages lesson learned. We actually -- just as a context, we set up this -- within our organization, this was the command table we set up internally to deal with COVID response, so we had centralized -- we had a staffing table.

We had a labour relations table. We had a communications table. We had an administration table. We had external partners' table. We had an IPAC table. We had a decision-making group that all these groups fit into, so we had a fairly structured and, I would say, relatively sophisticated structure set up in response to it, but this is what we --

LYNN MAHONEY: And did you -- when did you do that?

JAMES SCHLEGEL: We did that right away. That was in March, like, the first week, and it stayed -- this group met seven days a week at 8 o'clock in the morning by Zoom for 112 straight days --

LYNN MAHONEY: Okay.

JAMES SCHLEGEL: -- until the first wave was over, and now it's -- and then it met three days a week, and now it's back meeting every day again in Wave 2. And this was what we'd set up as a Wave 1 review. We had working groups in environmental, communication, supplies, sales and marketing, recreation and programming, HR, IPAC, in clinical care, information technology, finance, dining, hospitality, and quality and research.

We had a working group in each one of these providing recommendations to a review panel who further reviewed them. There was about 170 recommendations that eventually got pared down to about 58 recommendations that were in the process of implementing in advance of Phase 2.

One of those ones, Lynn, as you mention, is IPAC. And I would say the long-term care system wasn't as woefully inadequate in IPAC as what some have suggested in the popular press, although -- so we did have IPAC capacity. It's required by the Act and by the regs. You have to have an infection prevention, control program. You have to have someone leading it. That person has to be trained, although it doesn't specify the training.

So what I think lessons learned for us is that one person dealing with IPAC in regular situations in a regular flu season who's leading IPAC is probably sufficient, but the scope and scale of COVID and how it hit LTC and especially the older homes with three and four-bed wards, although not exclusively, just overwhelmed our IPAC capacity. You needed a team of certainly more than one, like, three or four, who all had IPAC

training, expertise.

That's where, frankly, in the second wave, the hub and spoke model parting with hospitals has had some success because you've been able to -- we've been able to augment our IPAC capacity effectively so. We had IPAC, and we thought it was good. We did -- we had a program. What we found is that we need to get a lot better both in terms of on-site capacity, more than one person, clear accountability, and real discipline around audits, not just audits from in-house, but people from our support office coming with an external set of eyes to do the audits of PPE and of donning and doffing and hand hygiene, all these very basic but so critical functions that are kind of the foundation of good IPAC procedures, you know, getting --

LYNN MAHONEY: See status of your PPE prior to the -- at the outset of the pandemic.

JAMES SCHLEGEL: We were very fortunate. We have a triple-A procurement team that worked day and night to secure PPE. We -- in the early stages of the pandemic, we paid, you know, 10 and 20 times what we normally paid for masks and gowns, but we did it. We said we're not

going to -- we're not going to count the dollars at this point. We're going to do what is required to keep our residents and families and team members safe, but we were --

LYNN MAHONEY: Did you understand that you had any obligation to have some stockpile of PPE available in the -- in the--

JAMES SCHLEGEL: Yeah. Some -- for sure some obligation, but, you know, we burned through -- when you're in outbreak for COVID, we burn through PPE way faster than what we normally would, and so it -- we had stocks, but -- and we had -- we -- there was a requirement to have stocks, so they're not any specific requirements about how many, and -- but they were -- they were inadequate. We had to scramble to find new stocks very quickly at the same time as every other organization and every other country was trying to find as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just interrupt for a minute? What do you think would be an adequate stockpile?

JAMES SCHLEGEL: I could certainly -- Justice Marrocco, I don't have a good answer to that question. You know, I think -- you know,

we've -- I can certainly talk to our IPAC folks about that, but, you know, we've taken approaches that, you know, we want to have seven -- a minimum seven days of supply for each of our villages assuming they're in outbreak, so that if they're in outbreak, we have seven days minimum supply, ideally ten, on site ready to go, if there -- if there was an outbreak, so that's our internal standard that we work towards.

LYNN MAHONEY: In any of the work that you did on these -- the response tables, were you aware, Mr. Schlegel, regarding the Provincial stockpile and the fact that it had expired?

JAMES SCHLEGEL: Yeah. Yeah, there's general awareness for sure and just general awareness that there was a huge effort by Government to secure new supply and to, you know, then ultimately make it available to the sectors. So that all did happen, but it took -- it took time, and it wasn't available right away.

And what -- frankly, I think we were all going -- contacting the same suppliers, and so I think we were competing with the Government, in some cases, to buy the stock. But, you know, the Government was very active. They realized this was

a big issue. They had procurement people working on it, so I know that was a big -- a big focus of Government effort for sure.

LYNN MAHONEY: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. Schlegel, this is probably obvious, but am I correct if I assume that once the -- once there's talk of a general -- of a pandemic, that it becomes impossible or it becomes very difficult to resupply yourself with PPE?

JAMES SCHLEGEL: Certainly, in this case, Justice Marrocco, that -- that was -- it's a fair comment that, by the time the world was in the pandemic, the ability to get PPE was severely limited because every hospital, every government around the world was trying to find it.

And we were fortunate we had probably more than most already on hand, and we were able to leverage existing relationships to be able to keep it stocked, so I'm proud to say our staff never went without proper PPE throughout the entire pandemic, but I know, in other cases, that that didn't happen.

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

LYNN MAHONEY: So I know I've taken you off --

JAMES SCHLEGEL: That's okay.

LYNN MAHONEY: -- some of the recommendations and comments that you wanted to make, so maybe we can go back to them and I can --

JAMES SCHLEGEL: Sure. So I'm happy to talk about any of these. The Ministry inspectors could take a whole hour and a half just talking about that, but, you know, they actually switched over for a brief period of time and became resources to long-term care homes especially for accessing PPE, and that was -- that was quite useful. Then they switched back --

LYNN MAHONEY: During the pandemic.

JAMES SCHLEGEL: Yes, the early stage of the pandemic, kind of March, April. Then they slipped back to their inspector roles, and which, you know, I understand the need for inspections not just during normal times but during outbreaks as well.

You know, it was a bit unfortunate how some of that happened, and I've had lots of discussions with the senior leadership in the Ministry of Long-Term Care about how we need to

transform the compliance system to be much different than what it is today.

But, you know, we have -- in an outbreak situation, we have our own audits that we're doing, IPAC assessments that we do every shift every day, so three times a day in every neighbourhood. We have Public Health coming in doing their own audits. We usually have the hub and spoke -- through the hub and spoke program, the hospital team coming in doing audits which, again, very helpful to get those extra set of eyes. We have our support office coming in doing audits, and then the Ministry inspector comes in and does an audit as well.

So in an outbreak, all that takes -- all that takes time, and there's diminishing returns after about the second or third round of audits.

So, you know, then we've had -- we've had Ministry inspectors come in during and after audit -- or during and after outbreaks and issued compliance orders for lack of documentation when we're in the middle of an outbreak, and in a way, that's been very, very demoralizing to the team who work -- often times work night and day through the

outbreak only to -- only to be cited for compliance infractions after the outbreak was over, lost for some wonderful leaders through that experience, and which is very, very frustrating for those of us who want to keep good people in the sector.

So anyhow, lots more I can say about that, but I do comment on the compliance system and how we need to fundamentally change because more inspections and more regs aren't the answer to our challenge in long-term care. I fear that will be the response, but whenever we've done that, it hasn't improved the system at all. And we've had lots of experience in the -- in the sector historically to prove that several times over.

LYNN MAHONEY: Commissioner Coke.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: Yeah, I just want to clarify. You just mentioned that more of the same probably is not going to be helpful, but is this just a matter of people not focusing on the right things?

JAMES SCHLEGEL: Yeah, I think --

COMMISSIONER ANGELA COKE: Is that your point?

JAMES SCHLEGEL: Yeah, and I think -- yeah, absolutely, in terms of the compliance folks, that they were focusing on care plans not being kept up when we were in the middle of an outbreak just trying to keep people alive, to be frank. And, in fact, one of the first directives alleviates some of the burden of documentation requirements, so I'm not even sure why they were issuing COs for that, so again, a disconnect between the reality on the ground and what these inspectors were coming in and looking at, in a way, that was entirely demoralising.

Maybe I could just comment for a moment on that because I think that's really a critical one, and I really made this argument strongly at the Staffing Advisory Group because I think, you know, part of the -- part of the challenge in long-term care is we do -- we really need a fundamental culture shift. And this is not just pointing the finger at government. It's pointing the finger at operators and all participants in the sector because, you know, us as organizations have to also take responsibility for the cultures that we created in the organizations.

But the traditional LTC model has been,

as it typically is in healthcare, very hierarchical, so the PSWs on the bottom rung of the ladder, the person is -- has a very challenging job. They get paid okay but not great. They get -- they aren't acknowledged. They aren't recognized. They have no input into how their work is done. It's very routinized. The only time they get recognized is if they do something wrong, and they get punished for it. And so this is -- I'm pointing fingers at operators here. They get -- they get told by compliance advisors they're not doing a very good job.

So it's very hierarchical. The compliance system is very kind of punishment oriented, seeks to eliminate risk even though we don't live our own lives without any risk. We need to fundamentally change how we approach this sector. We really want to transform it. And I've made this argument to deputy ministers, and, you know, philosophically they agree; it's hard to get there, of course, and cultures -- culture doesn't change overnight, but we need to start on that journey.

We need to move away from an environment of hierarchy, of keeping our thumb on

the PSW, seeing them as a peon rather than the backbone of the wonderful care that's provided in long-term care for the most part. We need to create environments that focus on quality improvement, on innovation, on sharing, on enabling, on resident quality of life.

We shouldn't be focused on zero risk. If that's our objective as a sector, we're going to have the safest long-term care homes in the world that no one will want to live in.

If we do a great job of preserving life to the last second but don't make that preserved life worth living, then we have to ask what we've -- what we've achieved. And I'm not saying we should throw caution to the wind and not focus on risk at all. Of course, we all make risk decisions in our lives, and so should we allow residents and family members to make those risk decisions as well, and we shouldn't have a system that assumes we should eliminate all risk out of it because that's, frankly, not what our residents want. That's not what our families generally want.

And so, you know, this whole culture change away from an institutional model of care to a social model of living is one -- is a journey we

have to start on as a sector. Again, it's not just about compliance. That's part of it. The Government has a role to play, but so do all participants in the sector, including operators first and foremost, and that we started on that journey. We've been on that journey for now ten years to shift from an institutional model of care to a social model of living, but as a sector, we need to travel that -- travel that journey together.

I fear that if we don't start there, we can change a lot of other things, but if we don't change the fundamental ethos of the system, you know, attracting people in the sector, keeping good leadership, all these other things that are so important will become very, very difficult to do.

You know, we wonder why we have a health human resources challenge in long-term care. Well, just look at the environment we create for our staff to work in, the compliance environment, the engagement or lack of engagement, the lack of input they have into their work, the lack of decision making they have, all of the things we've been working as an organization to try to move decision making into the neighbourhoods for our

team members to make. They're the ones that know the challenges and the -- what the solutions are way more than an administrator sitting in an office.

So why don't we -- why don't we actually equip them and give them the confidence to make those care -- point of care decisions within parameters, of course. It will make their jobs more meaningful. It will lead to better care. It will lead to better quality of life for our residents.

But we're too hierarchical, and we don't -- we don't see the value and the potential that our PSWs have to bring their full potential to the work that they do. And so these are some of the -- you know, so we need to get better at IPAC. We need to -- you know, we need to get more funding so we can have better clinical capacity for sure. You know, the acuity and complexity of residents has far outstripped our funding for the last 20 years. Lots of people have raised that alarm, and COVID has laid that bare, no question about that, and --

LYNN MAHONEY: Can I ask you just for a minute, Mr. Schlegel, and sorry to interrupt you,

but I think it's something that is important for the Commissioners to understand.

Can you explain to me on that issue of funding, and you and I have spoken about it. Can you -- and you raise it in your slides about the funding of the for-profit homes and how the for-profit homes earn their profit.

Could you please explain to the Commissioners how -- if you would, please, how a for-profit operator, which would include your organization, and I understand it's a family-owned business; you're the shareholders -- how you earn your profit, how -- based on the long-term care funding that you receive, if you could do that, please?

JAMES SCHLEGEL: Sure. So as has probably already been explained to the Commissioners, we operate with an envelope system in long-term care. There's lots of nuancing, but just at a high level, we get funded by the Ministry of Long-Term Care for the nursing envelope and for the PSS, the personal supports envelope, the recreation envelope, and also for raw food.

We get set amounts of dollars, adjusted a little bit of nursing for levels of care, but we

have those pots of money, and we have to spend those pots of money on nursing and personal care, so our nursing staff and our PSW staff and related supplies and equipment and so on. That's a flow-through envelope. If we don't spend it, we give it -- we give it back to the Government.

So our incentive is to spend every last nickel to provide care to residents and to provide recreation services to residents and to provide meals to residents. So those are the three buckets that are flow-through. You either spend it, or you -- or you lose it.

So this notion that somehow operators are cutting corners on care so they can increase their profits is fundamentally not accurate. The envelope system, even if -- even if operators were inclined to do that, want to do that, they couldn't do that with the envelope system.

LYNN MAHONEY: And you -- and you report back, and the Commissioners had a presentation by the Ministry about the funding envelopes.

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: And you report back on those three envelopes, the nursing and personal

care program and support services and raw food, and you report back and have to -- you report annually on it, and your reports are audited. And you had to report back on exactly the spending that you've done or you've returned the -- if you don't spend --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- you return the money to the Government, correct?

JAMES SCHLEGEL: That's right. And the Government, they have their finance office, and they look at it, and once in a while, they'll come back and say, that education amount that you included in your envelope actually doesn't qualify, and it gets kicked out.

LYNN MAHONEY: Okay.

JAMES SCHLEGEL: So sometimes that -- sometimes that happens, so it's subject to their scrutiny and their change as well, so those envelopes are both audited as well as scrutinized by government and when we -- when we submit.

So -- and if we underspend, we have to give back the dollars, and sometimes we spend all of it, but they kick out some of them -- some of the expenses as not qualified, and then we have to

give the money --

LYNN MAHONEY: Okay.

JAMES SCHLEGEL: -- give them the money. So it's a fairly rigorous -- fairly rigorous --

LYNN MAHONEY: So that's those three envelopes --

JAMES SCHLEGEL: Yeah.

LYNN MAHONEY: -- but it's the fourth envelope --

JAMES SCHLEGEL: Yeah. So the fourth envelope is the other accommodation envelope which is notionally the co-payment of residents, so residents who are paying a co-payment for their standard or semi-private or private room, those dollars are essentially what the operators have to fund the, if you will, the hotel, the physical environment; housekeeping; the maintenance of it; the servicing of the debt; the depreciation; the capital; expenditures; the food; the food services, the same except for raw food which is a separate envelope; the laundry services; the administrative services, et cetera.

So notionally, the Government pays for the three envelopes that are flow-through. The

residents pay through their co-payments pay for the hotel service. It's not quite that simple because there's some Government funding in the other accommodation as well for property taxes and a few things, so it's not -- but just high level, conceptually, that's kind of the way it -- the way it works, and so we have to, as part of our annual report or ARR, report on the three flow-through envelopes as I describe, but also, we report on the fourth envelope, the other accommodation envelope as well. So we report expenses for housekeeping, expenses for maintenance, expenses for dietary, food services, expenses for laundry, expenses for general and administration and facility costs, utilities and so on, property taxes, interest on debt, and so forth.

So all of those are separate lines that we -- we report on so the -- so the Ministry has full visibility, if you will, on, you know, what, if any, margins that the operators are making on the other accommodation because that's where we can make the margin to --

LYNN MAHONEY: Can you --

JAMES SCHLEGEL: -- to return to shareholders.

LYNN MAHONEY: Can you explain that to me? Can you explain how -- so I understand that you have to report through on what you are spending, but how, then, can we see what is the return to the shareholders? And if you could, if you would, give us -- give the Commissioners an idea of what that return has been to shareholders at least for your organization.

JAMES SCHLEGEL: Sure. Yeah. So happy to share. So I liken long-term care from a financial standpoint to a regulated utility where the Government's incentive is to pay enough of a return to keep the sector engaged and attract capital to build new homes and so on, which we need to do more of, but also not to spend any more than what's required to overspend to give too generous of a return.

So our returns in our sector, it varies depending on our Village location and size of home and so on. All that plays into it. But it's kind of in that 7 to 8% return range. It depends a little bit on the denominator used, obviously, but that's kind of -- typically, it's probably 6 or higher, but certainly less than 10. So when we do it, it's typically in the 7 to 8% range.

So the -- if I can be relatively forthright, it's a low return, high risk in terms of reputational risk and also other risk sort of endeavour. We're in it -- because I ask myself sometimes, why do we put ourselves through the regulatory burden, the 1,400 regs that we have to do, the five weeks of compliance, the inspections that we go through every year, the critical incidence reports, why do we do this? Because it's integral to our village, our campus of care model. It's low return, a lot of aggravation and a lot of work, a lot of risk. But we believe it's in the importance of our modeling, so it's -- we hang in there and do it.

The reality is the other parts of the continuum are private pay, and they earn a higher return than the long-term care piece, so we can kind of average it out to make it all work in our -- in our circumstance. And the long-term care is important to us because it's the healthcare anchor for our campus of care.

Lynn, do you want me to comment any further? That's -- I'm happy to comment more on how all that works, but --

LYNN MAHONEY: Just for my own sake,

maybe everybody else is clear, so the other accommodation envelope, and you say it consists largely of the resident copay, and then the Government tops up as is necessary, but then you report back on what you're spending out of that envelope, and you account for it.

And is it -- is it fair to say that is the Government able to tell from the reporting back that you do on that fourth envelope how much of a profit margin, if I will, that the -- that the home is taking out of that envelope?

JAMES SCHLEGEL: Yeah. They have full -- they have full visibility on it in two ways: We report through the annual report, as I mentioned, so it breaks out everything, our other accommodation revenue and all the expenses related to it, so they have full visibility on that.

And also, we do a kind of a trial balance dump, if you will, twice a year through the MIS system. Hospitals are required to do something similar, and so they have access to many of our trial balance accounts through that as well.

So there's kind of two different ways they really have complete visibility. So there's no -- there's no black box here. There's no kind

of hidden treasure or pot of gold or anything. It's all very well and transparently reported, and it's -- it's an open book to the Government. They know exactly what the returns are by operator.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: I'm just wondering, would it be clear sort of what proportion of that is reinvested back into the business?

JAMES SCHLEGEL: Sure. In our case, it all is. We don't take any dividends out as a -- as a family, so we reinvest it in capital expenditures. We reinvest it in the Research Institute which is philanthropic, granted. We reinvest it as equity into new projects, so we basically recycle the dollars, if you will, Commissioner Coke, to reinvest in our -- in our new projects.

So as we earn a return on our investment, we take that and use it as equity for the next project, the next phase, or the next new project.

COMMISSIONER FRANK MARROCCO (CHAIR): And is the idea behind that, apart from the

improvement in the business, that it increases the value of the business to the shareholders? Is that --

JAMES SCHLEGEL: Yeah, it does for sure. As we -- as we grow, it expands. You know, I really -- without being too cute about it, Justice Marrocco, I -- you know, I see it as an opportunity to continue to expand our mission. If we think our mission is a noble one, which I believe it is, then why would we, within bounds, within kind of staying within our means, continue to grow, to bring that mission to more -- to more people?

So for us, it's really mission-driven. You know, as dad said, he could have stopped after the first village and had a very comfortable life. He wouldn't have lived in a different house or driven a different car, so we could have stopped after one or two villages, left it at that and been -- lived comfortably and been satisfied, but it's really been -- it's really been a mission-driven growth that we've continued to embark on.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

JAMES SCHLEGEL: Lynn, is there more you'd like to -- for me to say? I'm happy to -- as I say, I'm happy to answer whatever questions. I'm not -- I don't want to hide anything. It's -- I want to be as open as possible to help the Commissioners.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we certainly don't think you're hiding anything, so don't worry about that.

LYNN MAHONEY: I believe there's two issues that I just thought you could briefly comment on, if you would, please. One is the issue of the role of the physicians in the long-term care homes and your experience during COVID and any recommendations you may have around that.

And then the other one that I would like you to comment on is your observations about the communication and the direction from public health units given the fact that you have -- your villages are sort of across Southern Ontario, your observations about the different public health units and their role in the response to the pandemic.

JAMES SCHLEGEL: Sure. Firstly, with respect to physician engagement, I actually have it

listed in a couple of locations, certainly under system challenges.

So we had -- again, COVID laid bare some of the -- some of the shortcomings of our current system, certainly in terms of funding, definitely in terms of older B and C-homes. We redeveloped the D-homes back in the early 2000s, many of which were municipal homes, but we, as a sector have not -- have not funded adequately the redevelopment of B and C-homes, so that's a huge issue in terms of not just where -- responding COVID but infectious disease outbreaks generally and quality of life for residents.

But one of the areas that was, I think, shown to be a weakness in many cases was physician involvement. We had many cases, several cases where we went into outbreak, we lost a significant number of our staff as single-site directive. We lost some of our staff when we went into outbreak because they were plain scared, and they didn't -- they just didn't want to put themselves or their families at risk.

And in some cases, we lost our physicians who maybe stayed tenuously tethered to the home through some virtual visits, but we needed

our -- we needed our physician leadership to be front and centre in the home helping to care for residents who -- some of whom were becoming very ill and also being there for staff to demonstrate to the staff that, hey, this is the proper PPE, the proper procedures; we could keep everybody safe, and we can provide good care.

And so I think it laid bare the lack of physician engagement, generally, in the sector and the -- the not -- atypical, at least, arrangement as, you know, you hire a couple docs, the one -- the medical director and one that helps to do attending work. And, you know, one might be retired, but they want to keep working a bit, so they do this on the side, or one's a primary care doc, but they do it -- they do it on the side because they like seniors or for whatever reason, and they come in for, you know, a couple half days a week, and they see residents. They issue -- they write some scripts, and then they leave again, and the nurses do the -- they follow those orders.

They're not really part of a team. They have kind of limited connection to the residents, and not to say that they're not committed. We have some wonderfully committed

docs, but the system doesn't really set up kind of an active engagement where the physician is actually -- feels part of the team; they attend the IPAC meetings; they attend the quality meetings; they know the residents; and most importantly, they know the team. They know the nursing leadership, and they know the PSWs in the neighbourhood who are the worker bees and who are the eyes and ears, frankly, of the doc and the nurses in the resident rooms.

So we've actually worked on some models with Dr. George Heckman who's a geriatrician, one of our research chairs at the RIA, to look at how do we -- how do we actually develop different models that allows the physician to be more engaged, that allows them to be more part of the team so that when crises like this hit, they're already part of the team and nothing changes as compared to them being kind of -- kind of flying in and out of the home but not really all that committed -- and I'm being a bit harsh here -- and not really feeling part of -- part of the endeavour. And so it's kind of easier for them, then, just to walk away from it when the going gets tough, if I can put it fairly bluntly.

So I think -- I think, you know, how we remunerate, how we engage, how we include as part of the team physicians, how we connect them to hospitals maybe in terms of credentialing, I think there needs to be a major rethink on that one, for sure.

LYNN MAHONEY: And then the second issue that I asked you to comment on is your observations of the roles of different public health units.

JAMES SCHLEGEL: Sure. Yeah. So there are 35 different public health units in the Province as the Commissioners know. Public Health Ontario is a -- kind of an umbrella organization, as you know.

The challenge is that every public health unit operates as their own little chiefdom and the prince of the chiefdom is the Chief Medical Officer of Health. It's important to give authority to chief medical officers of health. It's important to give authority to public health units. I'm not suggesting that's not important. Of course it is.

But there is a lack of unified action in public health units from the very beginning, and

again, granted that there was lots of ground shifting underneath our feet. We were learning as we were going.

But to this day, there's still all sorts of inconsistencies between public health units. We operate in several of them, and so, you know, things like as simple as what constitutes an outbreak. In one public health unit we'll have a single case of a team member who tests positive with the weekly testing. In one public health unit, that will be -- send us into enhanced monitoring or suspected outbreak but not into full outbreak. In another public health unit, that will -- that will send us into an outbreak. Another one, they'll send us into outbreak but only for that one neighbourhood, not the entire village.

So you'll get three different responses to the exact same event depending on what public health unit you're in. And an outbreak is, you know, you can say, well, it's just -- they're just declaring outbreak, but it has huge --

LYNN MAHONEY: M-hm.

JAMES SCHLEGEL: -- implications for visitors, for staff, for leadership. It has huge implications. So, you know, another example would

be, you know, resolving team members who have tested positive. Some public health units have said after ten days and symptom free, you can go back to work.

Others said, no, no, no. No way you can do it after 10, but you can do it after 14 days. Some have said, no, you can't do it after 14 days. You have to get a test, and if it's negative, then you can go back to work.

And still, others have said, no, you need a double-negative test after 14 days to be able to go back to work.

So again, you have four or five different definitions of resolving team members in different public health units, and this is a time where we're desperate to get our team members back. Obviously, we want to do it safely. We don't want to put them or residents at risk, but shouldn't we be able to say, okay, here is the best practice; here's what the science is telling us? Let's do it all consistently.

Because I have to believe that, of those four or five different scenarios, one of them was the best practice, and the other three were just somebody's opinion, but there was no ability

for PHO to issue -- other than guidance and suggestions, no ability for Public Health or the Chief Medical Officer of Health for the Province to issue any sort of directives to the public health units. And I think that's a real shortcoming when we're trying to mobilize concerted action across the Province in a pandemic scenario.

It has ramifications in other -- at other times, non-pandemic times, but it really, to me, proved to be a very significant shortcoming of our system the way it's organized.

COMMISSIONER FRANK MARROCCO (CHAIR): Where there are different directives from different local medical officers of health, is it not correct -- or do you understand it differently than I do that the Chief Medical Officer of Health can resolve those conflicts by issuing his own directive?

JAMES SCHLEGEL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): So that's what should happen when there's a --

JAMES SCHLEGEL: Well, the --

COMMISSIONER FRANK MARROCCO (CHAIR): -- conflict. Sorry, Justice Marrocco. The Chief Medical Officer of Health of Ontario can issue

guidance, as I understand it.

But, Dr. Kitts, you may correct me if I have this wrong, but my understanding is that there is not a direct line authority between the Public Health Ontario and the Chief Medical Officer of Health and the Chief Medical Officer of Health in each public health unit. It's a dotted line, but it's actually not a solid line that public health units have to receive a directive -- for example, to give one example, there was a Ministry directive -- it was either Ministry or a Chief Medical Officer of Health directive, maybe the latter, around updating our visitor policies. This was kind of after Phase 1, and we were in the lull before Phase 2, and then that was implemented across the Province. And then one public health unit came and said, well, we're going to actually not allow general visitors even though they were not in gray or red; they were yellow status. They said, no, we're going to do it differently. And we said, well, how does that work? There's a Provincial directive. And the answer back was, no, the public health -- the local public health unit can do kind of what it wants.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, I think maybe -- I appreciate what you've said about that, Mr. Schlegel. We'll take a look. I'm curious about that.

JAMES SCHLEGEL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So we'll deal with that without burdening you about -- with it further.

JAMES SCHLEGEL: Sure.

LYNN MAHONEY: Well, Commissioners, those were sort of the highlights of the issues. We have the presentation of Mr. Schlegel. I don't know if you have any other comments. I think we could stay with Mr. Schlegel all day and pick his brain on his experiences in Wave 1 and Wave 2. And I appreciate how forthright you've been about the issues.

I don't know, Commissioners, if you have any other questions for Mr. Schlegel at this time?

COMMISSIONER FRANK MARROCCO (CHAIR): I don't -- I don't think --

Oh, Commissioner Coke.

COMMISSIONER ANGELA COKE: I just was curious as to how you fared in terms of outbreaks and deaths relative to others.

JAMES SCHLEGEL: Yes, thanks, Commissioner Coke, and Ms. Mahoney asked me the same question, and, you know, we fared somewhat better than others in the first wave. Kind of -- second wave is still kind of ongoing of course.

But we were not spared, so it's not like we kind of emerged unscathed by any stretch. We had three of our homes, Commissioner Coke, in the Etobicoke, Mississauga area that had extensive outbreaks with loss of life. We had other outbreaks that were much more minor and where you have one or two cases that we were able to control. But in that high transmission area of kind of West Toronto where those homes were -- and again, those outbreaks started in April before we fully understood how to control the virus asymptomatically and pre-symptomatically.

So although we did perhaps better than general, we were still hit, and we learned lots. And we continue to try to get better for sure. But we've had our fair share of challenge, and we've had our fair share of loss and our fair share of grief as we mourn with our teams and our family members the loss of some of our -- some of our residents.

COMMISSIONER ANGELA COKE: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think that concludes the questions.

And, Mr. Schlegel, on behalf of the Commissioners, thank you very much for your presentation and for giving us some very direct and clear answers to questions we very much appreciate. It very much helps us as we worry our way through this problem. It's very helpful for us that -- to meet with you.

And thank you for your time and for the obvious effort you put into the presentation.

JAMES SCHLEGEL: Yeah, my pleasure. Thank you. And if there's any follow-up information you'd like from me and something that I wasn't clear on or a question that comes up, please don't hesitate to reach out. I'm happy to provide whatever other additional information you'd like.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

Commissioner Kitts, you wanted to --

COMMISSIONER JACK KITTS: No. That was --

Thank you very much, Jamie. That was

excellent. We've learned a lot and very much appreciate it.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

COMMISSIONER ANGELA COKE: Thank you.

JAMES SCHLEGEL: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye, everybody.

JAMES SCHLEGEL: Good-bye.

-- Adjourned at 11:50 a.m.

REPORTER'S CERTIFICATE

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Dated this 13th day of January, 2021.

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