

# Long Term Care Covid-19 Commission Mtg.

University Health Network UHN  
on Wednesday, December 9, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 9th day of December, 2020,  
9:00 a.m. to 10:11 a.m.

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1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9 Dr. Joy Richards, Vice President, Patient

10 Experience & Chief Health Professions, University

11 Health Network;

12 Dr. Susy Hota, Medical Director, Infection

13 Prevention & Control (IPAC), University Health

14 Network;

15 Ms. Rebecca Repa, Executive Vice President,

16 Clinical Support & Performance, University Health

17 Network.

18

19 PARTICIPANTS:

20

21 Alison Drummond, Assistant Deputy Minister,

22 Long-Term Care Commission Secretariat;

23 Derek Lett, Policy Director, Long-Term Care

24 Commission Secretariat;

25 Lynn Mahoney, Counsel to the Ministry of Health and

1 Long-Term Care;  
2 Adriana Diaz Choconta, Senior Policy Analyst,  
3 Long-Term Care Commission Secretariat;  
4 Angela Walwyn, Senior Policy Analyst, Long-term  
5 Care Commission Secretariat.

6  
7 ALSO PRESENT:

8  
9 McKaya McDonald, Stenographer/Transcriptionist.  
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1 -- Upon commencing at 8:58 a.m.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, good morning. I'm Frank Marrocco. I'm one  
4 of the commissioners. There's Dr. Jack Kitts and  
5 Commissioner Angela Coke. We are the commission.

6 Thank you for coming. Second time, I  
7 guess, we've dealt with UHN, and it was very  
8 helpful the last time.

9 So we're very, very interested in the  
10 importance of creating these relationships within a  
11 network of people or within a set of people so that  
12 these networks can work when they're called upon  
13 and when they're needed.

14 So the experience that you have with  
15 long-term care homes is certainly something that  
16 we're very interested in, and thank you for coming  
17 and giving us a bit of a briefing on it.

18 We have a transcript. Ms. McDonald --  
19 we post the transcript on our website for  
20 transparency purposes so people understand what  
21 we're doing.

22 And we'd be happy to start as soon as  
23 you're ready to do that, if everybody on your side  
24 is here. If not, we'll wait until we get here.

25 DR. REBECCA REPA: Is Susy here, Joy?

1 I --

2 DR. JOY RICHARDS: Yeah, she is. I see  
3 her.

4 DR. REBECCA REPA: Oh, then we're ready  
5 here.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Good morning.

8 DR. REBECCA REPA: We're ready. So,  
9 Joy, why don't you kick us off?

10 DR. JOY RICHARDS: Great. Well, thank  
11 you very much for the opportunity to come and share  
12 our experiences in both Wave 1 and Wave 2.

13 Just to set a bit of context for  
14 Wave 1, before anything was sort of formally  
15 organized, on a Friday afternoon as the pandemic  
16 hit, our CEO received a call from the CEO of a  
17 long-term care facility that had two sites that had  
18 lost 60 percent of their staff because of the  
19 mandate to have PSWs and staff only work in one  
20 home.

21 And so before any of the sort of  
22 organization of hub and spoke happened, we  
23 volunteered to go in and help this home. So we  
24 were on two sites right at the very beginning of  
25 the pandemic, and this is really where we learned a

1 lot about how to actually behave in this sort of  
2 network going forward. So our philosophy of  
3 care --

4 And both Rebecca and I have long-term  
5 care experience. So 17 years on my end at Baycrest  
6 and a long-term care facility in Montreal so had  
7 some sense of what the culture was like.

8 But the philosophy of care that UHN  
9 adopted was that we were guests in the long-term  
10 care homes. We weren't going in to take over. We  
11 didn't have a mandate to do such.

12 We were in lockstep with them to  
13 support them and that, really, we were guests. And  
14 I kept telling our teams that we had to be mindful  
15 of being in someone else's home and being  
16 respectful of that.

17 We had a mindset of curiosity,  
18 collaboration, and learning. Many of my team on  
19 the ground had never been in long-term care before,  
20 and we were really conscious that acute care --  
21 sometimes things in acute care work really well in  
22 long-term care, and sometimes they don't.

23 And if you just go to the next slide,  
24 actually, Rebecca or whoever. Next one. There we  
25 go.

1           You know, working together, learning  
2 together, trying to find that middle way that  
3 long-term care could cope. And then we, in acute  
4 care, would actually learn together. We had  
5 expertise which complimented, obviously, long-term  
6 care when it comes to IPAC and supply chain  
7 management and some of these things that were  
8 unique to managing a crisis like COVID. We brought  
9 that expertise forward and really tried to build  
10 capacity within the homes around how to do that for  
11 themselves.

12           And we knew that our way of working  
13 needed to be integrated and adapted into a  
14 partnership. So we tried, as best we could, never  
15 to go in with an attitude that we knew best but  
16 that, together, we were going to find our way, and  
17 we were there to help them be successful. And then  
18 we aimed at building capacity and new knowledge  
19 within the partnership.

20           I think UHN and the team on the ground  
21 learned as much as our long-term care partners did  
22 and finding that middle way of where expertise and  
23 structure and acute care worked and where there  
24 were things -- you know, recognizing these are  
25 people's homes. Residents live there.

1           It's a very different philosophy than  
2 acute care, and so coming in with a command and  
3 control kind of mentality didn't always work and  
4 trying to find that way of working together without  
5 overstepping bounds.

6           So the next slide, please.

7           So --

8           COMMISSIONER JACK KITTS: Before you  
9 proceed Dr. Richards, could I ask a question?

10          DR. JOY RICHARDS: Of course.

11          COMMISSIONER JACK KITTS: What was the  
12 relationship between UHN and these two long-term  
13 care homes that reached out for help?

14          DR. JOY RICHARDS: Prior to them  
15 reaching out, we had no relationship with them.

16          COMMISSIONER JACK KITTS: Okay. And  
17 were they private? Not-for-profit? Municipal? Do  
18 you recall?

19          DR. JOY RICHARDS: Oh, gosh. What  
20 is -- I think they're -- I don't know.

21          COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Do you recall the owner?

23          DR. JOY RICHARDS: Yeah. It's Rekai,  
24 the Rekai Centres.

25          COMMISSIONER JACK KITTS: Okay. Okay.

1 Because I understand that UHN does have a  
2 partnership with some long-term care homes; am I  
3 correct?

4 DR. REBECCA REPA: Extendicare.

5 DR. JOY RICHARDS: We do with Lakeside,  
6 Extendicare.

7 DR. REBECCA REPA: Yeah.

8 COMMISSIONER JACK KITTS: Okay. So it  
9 wasn't those?

10 DR. JOY RICHARDS: No, not in Wave 1.

11 COMMISSIONER JACK KITTS: Okay. Thank  
12 you.

13 COMMISSIONER FRANK MARROCCO (CHAIR):  
14 Were they in the neighbourhood, so to speak,  
15 doctor?

16 DR. JOY RICHARDS: Yes, yes. Not too  
17 far away.

18 DR. REBECCA REPA: Re kai? Yeah.

19 DR. JOY RICHARDS: Yeah. So we were  
20 called in on a Friday night. We rallied up a lot  
21 of volunteers to come in because they were so  
22 short-staffed. But we realized early on that we  
23 needed a governance structure so we weren't bumping  
24 into each other and kind of set who would be doing  
25 what.

1                   So this slide really just talks  
2 about -- we had executive sponsors. So in Wave 1,  
3 it was Brian Hodges and myself, and we had clinical  
4 project leadership and working teams on the ground.  
5 So I actually had a team there supporting our UHN  
6 staff.

7                   And then there were working teams  
8 looking at IPAC, looking at supply chain  
9 management, look at staffing, all of the things  
10 that you'll see in an upcoming slide. And we  
11 worked in partnership with the executive  
12 sponsorship of long-term care in these homes, their  
13 own clinical teams, and their own working groups.

14                   So we sort of pooled our resources  
15 together, and this was the governs structure that  
16 we worked under so, again, a partnership.

17                   COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Doctor, I appreciate what you are saying about  
19 command and control. How did you arrive at this  
20 structure for leadership? How did that happen?

21                   DR. JOY RICHARDS: Well, I think it  
22 didn't take us long on the ground to realize where  
23 there were gaps. You can actually -- if you put  
24 the next slide up, the executive dashboard...

25                   So together we developed -- we knew

1 that there were buckets of work that actually  
2 needed to happen on a daily basis. So they were  
3 struggling with their supply chain management.  
4 They weren't able to get some of the PPE that they  
5 needed. We knew we had to stabilize them. So some  
6 of this is sort of "Crisis Management 101."

7 IPAC was a huge issue. Their  
8 facilities in terms of -- we had to set up  
9 temporary showers. Again, we didn't know what we  
10 didn't know in Wave 1. We needed an environmental  
11 assessment to make sure that they were actually  
12 using the cleaning supplies properly and weren't  
13 spreading the virus. They had huge gaps in their  
14 staffing.

15 And so we, together, developed this  
16 dashboard, and this was the touch-base every day  
17 that we used in our huddles. So these were the,  
18 for lack of a better word, indicators that we were  
19 looking for. It was consistent and jointly  
20 developed with our partners in Reka.

21 And so there was no surprises that  
22 these were the things we were looking at. Some  
23 things worked easier than others. For example, in  
24 the environmental services, they had a challenge  
25 with the leadership on the ground, and these folks

1 were not used to working in a crisis like this.

2 And so sometimes we're sort of command  
3 and control with velvet gloves on. So helping them  
4 to come along and really stressing the  
5 importance -- IPAC, particularly, and Susy will  
6 speak to this -- where we had concerns about their  
7 inability, and they just hadn't ever had to manage  
8 like this before. So we stood alongside them and  
9 built capacity as we went.

10 So while it was --

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Was there -- sorry to interrupt, doctor.

13 If you don't mind, it's probably better  
14 if we can ask as we go along --

15 DR. JOY RICHARDS: Sure.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 -- rather than trying to come back.

18 Did you have any -- did they have a  
19 plan? Did they have any kind of outbreak plan or  
20 who was to do what or...?

21 DR. JOY RICHARDS: They did, but it was  
22 quite -- again, you can imagine that, overnight,  
23 they lost 60 percent of their staff. There were  
24 rules that were jointly held. They had very small  
25 and limited infrastructure.

1           And so often their leadership were  
2 managing two or three roles at a time. So you  
3 might have somebody who was doing staffing and  
4 supply chain management.

5           And so recognizing these were things  
6 that they -- you know, they had never had to deal  
7 with such a crisis before, and so we partnered and  
8 stepped our team in alongside them.

9           They did have a plan. They're used to  
10 having flu outbreaks, and so at a smaller scale,  
11 they did have a plan. But they literally lost  
12 60 percent of their staff.

13           It was chaotic, understandably. And  
14 they didn't have the resources or knowledge on the  
15 ground to actually get this under control on their  
16 own.

17           COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Do you have any sense of why they lost 60 percent  
19 of their staff?

20           DR. JOY RICHARDS: Yes.

21           COMMISSIONER FRANK MARROCCO (CHAIR): I  
22 mean, of course, this is quite a come phenomena,  
23 and what we're trying to understand is the root  
24 causes of that.

25           DR. JOY RICHARDS: So the root cause is

1 that, in long-term care -- and I think Rebecca,  
2 probably, will speak a bit more to this in terms of  
3 sort of the system challenges -- is that the way  
4 staffing is done historically in the long-term care  
5 sector is that it's a lot of casual and part-time  
6 roles.

7 And so staff are working in multiple  
8 facilities to make up full-time hours. And so they  
9 would have multiple jobs. And when the outbreak  
10 happened and the mandate came that, in long-term  
11 care, staff could only choose to work in one home,  
12 they went to either the home that they preferred or  
13 maybe had more hours, or they didn't come to work  
14 at all.

15 And so overnight, they literally had  
16 nobody on the ground. They lost -- in this home, I  
17 think they lost over 60 percent of their staff. So  
18 they didn't even have, you know, boots on the  
19 ground to do some of the basics of care.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Right.

22 DR. JOY RICHARDS: And that's the  
23 systemic issue underneath is how we staff and fund  
24 the long-term care.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

2 COMMISSIONER JACK KITTS: Can I just  
3 follow-up? Like, was it mostly because they had to  
4 work at one home only, or were there other factors  
5 that led to this --

6 DR. JOY RICHARDS: No. In this case,  
7 it was one -- two issues: One, that they can only  
8 work in one home; and the other, that staff were  
9 very scared and just didn't come to work.

10 COMMISSIONER JACK KITTS: Thank you.

11 DR. JOY RICHARDS: Okay. So this was  
12 the executive dashboard that we used, and we  
13 touched base on this every single day with Reikai.

14 And we had, you know, sort of three  
15 phases. We were sort of the stabilization phase.  
16 So we wanted to make sure that they were following  
17 IPAC protocols, that they were doing terminal  
18 cleans, they were using the right products, they  
19 had supplies.

20 They were doing line tracking, so we  
21 needed to help them track the outbreak, who was  
22 positive, who wasn't, cohorting patients, helping  
23 them with staffing.

24 Then moving to a steady stage and then  
25 obviously handing off and back to a transitional

1 state and leaving them be.

2 So this actually, dashboard, worked  
3 extremely well. Maybe we'll go on to the next  
4 slide.

5 And this is -- I won't go into any  
6 detail here other than, you know, the stabilization  
7 phase was really doing an initial assessment across  
8 all of the sectors that were on that dashboard.

9 Identifying key priorities -- so  
10 IPAC -- following IPAC, cohorting residents, and  
11 getting environment clean was the one of the  
12 biggest things.

13 We had daily huddles. We worked  
14 closely with them around staffing. And then once  
15 we got things sort of stabilized, you know, looking  
16 at local support, ongoing needs.

17 So some things, they didn't need us to  
18 help with any longer. Other things, they needed us  
19 to stay around a bit longer. And we would pull the  
20 UHN team in. So, for example, environment the  
21 services were instrumental in helping us to build  
22 capacity within the team.

23 And then we transitioned back, handed  
24 the plan off, and to this day are still in touch  
25 with those two. We have a great relationship with

1 these two homes. They really were how we learned  
2 how to manage in long-term care, and I have weekly  
3 meetings with the CEO. They have been fortunate  
4 not to be in outbreak in Wave 2.

5 But built really great relationships.  
6 And the staff that were on the ground from UHN  
7 still keep in touch, and it's a very nice  
8 partnership going forward. If they had another  
9 outbreak -- I hope not -- you know, it would be a  
10 very different transition and partnership in that  
11 home because we have relationships across all of  
12 our teams.

13 COMMISSIONER FRANK MARROCCO (CHAIR):  
14 Do you have a sense of whether the fact that they  
15 did not have an outbreak in Wave 2 was related to  
16 the work that you did with them in Wave 1, or was  
17 it happenstance that -- do you happen to have a  
18 sense of that?

19 DR. JOY RICHARDS: Yeah, I have a very  
20 good sense because I talk about this with the CEO  
21 all the time. I think that they're in good shape  
22 because of our partnership. I think we were able  
23 to put processes and systems in place that they  
24 didn't have before that they continued to have.

25 The daily huddles that happen at the

1 unit level that bring issues at the staff level  
2 escalated up in a short period of time to the  
3 executive are still in place which is really  
4 helpful. And the relationship --

5 When there are little speed bumps along  
6 the way and they've got questions -- you know, I  
7 meet with her once a week. We were meeting with  
8 her twice a week for a while.

9 You know, we can nip some of these  
10 things in the butt. If there's an issue that she's  
11 worried about, we can parachute some of our team in  
12 to help work that through right at the beginning.

13 So I think that that work we did  
14 together has really set them in good shape and has  
15 really helped us to set a model for other homes  
16 that we're now in.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 So it's more than the -- it's more than the  
19 expertise. It's also the ability to lay hands on  
20 people and bring them in as opposed to just simply  
21 recognizing that you need something and then trying  
22 to figure out where to get it?

23 DR. JOY RICHARDS: Yeah, exactly.

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 Okay. The Health Network, presumably, has those

1 resources or at least knows where they are?

2 DR. JOY RICHARDS: Correct.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

5 COMMISSIONER JACK KITTS: On this  
6 topic, can I ask you to go back to the previous  
7 slide?

8 DR. JOY RICHARDS: M-hm.

9 COMMISSIONER JACK KITTS: Did this  
10 performance dashboard exist before you came in?

11 DR. JOY RICHARDS: No. We created this  
12 together with Rekai.

13 COMMISSIONER JACK KITTS: Okay. And is  
14 it continuing?

15 DR. JOY RICHARDS: Yes. And we use  
16 this as a template for all our other homes that are  
17 in outbreak now.

18 COMMISSIONER JACK KITTS: So I'm very  
19 impressed with this dashboard because I think it --  
20 at a glance, you see how the home is doing,  
21 particularly looking for the red colours.

22 So I think -- is this something that  
23 you've passed onto others, or is it a work in  
24 progress?

25 DR. JOY RICHARDS: No, it's something

1 that we put in. We created a playbook that we  
2 shared with the Ministry and the Ontario Health  
3 team after Wave 1 because it worked so well.

4           You know, it's interesting. One of the  
5 things, you know, that -- for example, the  
6 after-death care, one of the challenges -- and it's  
7 not identified here, but one of the things we also  
8 did was support the leadership team and the staff  
9 on the ground around wellness and resiliency  
10 because this was really, really difficult for them.

11           And you know, what was happening is  
12 that some nights there were, you know, eight or  
13 nine deaths a night. And, of course, the funeral  
14 homes would not come into the homes.

15           So staff are often having to prepare  
16 the body of people they had, you know, deep and  
17 lasting relationships with; having to leave the  
18 unit, go down and wait for the coroner -- the  
19 funeral home to come.

20           So even small, little things that, in  
21 the course of every day didn't have an impact, had  
22 huge impacts. So I spoke with the coroner on a  
23 couple of occasions around "was there some way we  
24 could help to facilitate, you know, some sort of  
25 way that this could be handled better?"

1                   Of course, it couldn't because we  
2 were -- they were nervous of coming into the homes.  
3 But a lot of these things had huge psychological  
4 impacts and trauma to the staff and leadership. So  
5 we had teams on the ground from the UHN from our  
6 psychiatry department doing, you know, sessions --  
7 individual sessions, to build some resilience.

8                   COMMISSIONER JACK KITTS: How  
9 cumbersome is it for the staff in the home to  
10 provide the data that feeds this dashboard?

11                   DR. JOY RICHARDS: We did this with our  
12 huddle. So we had a standard script that we used  
13 every morning, and they would come knowing that we  
14 were asking the total number of beds, how many were  
15 occupied.

16                   It became kind of -- we had this done  
17 in about 20 minutes, so it just became -- it is our  
18 touchstone to make sure we knew what was going on  
19 at a glance. And when they were really in  
20 difficulty, we did it twice a day.

21                   COMMISSIONER JACK KITTS: Thank you  
22 very much.

23                   COMMISSIONER FRANK MARROCCO (CHAIR):  
24 Commissioner Coke?

25                   DR. JOY RICHARDS: Next slide.

1                   COMMISSIONER ANGELA COKE: I'd just  
2 like to ask a question, if you don't mind. I'm  
3 just curious your thoughts about what sort of  
4 leadership skills and capacity needs to be further  
5 developed, you think, in these homes based on what  
6 you observed here.

7                   DR. JOY RICHARDS: Yeah, it's a very,  
8 very good question. I think, you know, leadership  
9 is key. One of the reasons why we were so  
10 successful in this home is that the CEO and the  
11 nursing leadership were strong on the ground and up  
12 to their knees alongside the staff.

13                   I think, you know, in long-term care,  
14 they never really experienced sort of crisis  
15 management and so having the ability and leadership  
16 to look beyond the immediacy and actually look at  
17 the system, to look ahead far enough to be able to  
18 anticipate, to be able to multitask, and to be able  
19 to sort of set some priorities.

20                   Instead of boiling the ocean -- you  
21 know, it takes leadership to be able to say, you  
22 know, "I've got to get the foundation right before  
23 I can move onto other things."

24                   So there's a sophistication of  
25 leadership. I think what often happens in

1 long-term care is that good clinicians get promoted  
2 to become directors of care or to become executive  
3 directors, and they have had no exposure or further  
4 education around leadership development, crisis  
5 management, conflict management -- you know, all of  
6 those things that, you know, come to the forefront  
7 when you're in a crisis like this.

8           So how do you keep calm and cool when  
9 everybody else around you is losing their head?  
10 And how do you kind of focus people to say "you  
11 know what? We're not boiling the ocean. Right  
12 now, here's what we're focussed on, and here are  
13 the boundaries and bumpers that we're going to work  
14 within."

15           So leadership going forward and  
16 leadership development, in my mind, is absolutely  
17 key. We have -- I see this in our other homes that  
18 we're supporting where these are very novice, you  
19 know, people who are compassionate and understand  
20 the care in long-term care, but they don't know how  
21 to lead or be problem solving or to ask for help.

22           You know, I think part of the  
23 development of a good leader is to know what they  
24 don't know what they don't know and be able to not  
25 be shy. It takes courage to ask for help. We see

1 that many folks are trying to manage on their own  
2 because they either don't want to escalate up to  
3 their executive levels in the corporate structures  
4 or they don't know what they don't know, and they  
5 don't know what to ask.

6 And so part of what we're doing now is  
7 going in and coaching and mentoring alongside to  
8 help them see where their own gaps in knowledge  
9 are.

10 So leadership is key going forward, and  
11 I think, in this sector, there are amazing people.  
12 And there are people who understand and really  
13 bring great value to this sector, but there's a --  
14 you know, I think there's more we can do to support  
15 the leadership on the ground in these homes.

16 COMMISSIONER ANGELA COKE: Thank you.

17 DR. JOY RICHARDS: So I think we've  
18 talked about that. That's just the phases. And  
19 then what we did in terms of the principles around  
20 the models of care when we were up to our eyeballs  
21 in alligators here was we tried to cohort working  
22 with our IPAC team, cohort as much as possible the  
23 positive residents together with consistent  
24 staffing so we weren't causing other opportunities  
25 to spread the virus.

1                   So we did move patients around to  
2 create red zones and keep the staff there and were  
3 extra careful with the PPE and support for those  
4 staff.

5                   And then we looked at -- and I'll show  
6 you in the following slides. We looked at  
7 prioritizing and bundling care. So, you know, at  
8 the beginning, they had no staff. They were  
9 struggling with having registered staff on the  
10 ground. We had some of our own staff pivoted in  
11 there.

12                   And so helping them to figure out, when  
13 they went into a room, how to bundle care when they  
14 were in their PPE so they weren't in and out, in  
15 and out, and in and out. So when they went into a  
16 room and they had their PPE on, what were the  
17 things that they should be doing?

18                   And, now, often in long-term care,  
19 they're quite task driven. So it's all the  
20 activities of daily living. They weren't  
21 necessarily thinking what do I do when I get into  
22 the room so I don't have to be entering and  
23 exiting? Taking the medication in when I go,  
24 changing the bed; providing care once instead of  
25 doing the task piecemeal.

1                   We look at establishing transfers of  
2                   accountability. So making sure from shift to  
3                   shift/nurse to nurse that there was a handoff so  
4                   that there was clear communication about what was  
5                   happening with each and every resident.

6                   In long-term care -- because, for the  
7                   most part, things are often quite stable -- it's a  
8                   bit haphazard how that handoff happens in terms of  
9                   shift to shift or physician to nurse to make sure  
10                  that people knew what was happening on the ground.  
11                  And transfers of accountability related to things  
12                  like PPE counts and to staffing and those kinds of  
13                  things.

14                  And then establishing standard work.  
15                  So every day when you were working with less staff,  
16                  what were the must dos that you had to do that  
17                  would be keeping people safe without all the  
18                  frills?

19                  Clearly toileting and administering of  
20                  medications were key and documentation around that.

21                  So those were the principles we used  
22                  with the homes. And if you go to the next slide,  
23                  we had a -- so it was sort of a command-table style  
24                  where the executive -- those governance models --  
25                  we all came together with the teams daily, maximum

1 30 minutes. It usually didn't take that long. We  
2 had standardized scripts that went through that  
3 dashboard.

4 And the key updates we looked at were  
5 the number of occupied beds -- you can see there --  
6 if there were any new symptomatic patients in the  
7 last 24 hours, any staff, the number of deaths in  
8 24 hours.

9 And those were indicators that we  
10 needed to actually do more PPE or IPAC support. We  
11 focussed on key priorities for the day. So we  
12 weren't boiling the ocean. We kept them really  
13 focussed.

14 And then we, in our huddle, looked  
15 back. So, you know, what things didn't go well  
16 that we needed to improve? And then, looking  
17 ahead, what were anticipated issues that we could  
18 be proactive on?

19 Any questions on that?

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 No, I don't think so.

22 DR. JOY RICHARDS: So what we did -- we  
23 did this at UHN, and we converted this to support  
24 the long-term care homes. In the green phase when  
25 everything is fine, here are the elements of care

1 that would be maintained. As things changed and we  
2 had less staff moving into the yellow phase, here's  
3 what we would be asking them to do and how we would  
4 start to bundle care. Then in the red phase,  
5 here's what we would focus on.

6 And what I did was I took this document  
7 and took it to the College of Nurses of Ontario and  
8 spoke to Anne Coghlan to let her know that, in  
9 these homes, we were going to be functioning in a  
10 very different sort of style and wanted support  
11 from the college in terms of the --

12 The nurses were worried about their  
13 licenses. So I put this on -- I had a long chat  
14 with Anne Coghlan at the college. The college has  
15 this on record that -- if there were issues where  
16 complaints would happen with lack of standard of  
17 care, that this would be taken into consideration  
18 if nurses were reported to the college by families,  
19 for example.

20 So this worked very well, and we've  
21 done this as well at UHN. So the college knows  
22 that these are the situations that we would get  
23 ourselves into and what the expectations would be.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Doctor, do you have any ideas on how you maintained

1 some institutional memory of this?

2 And the reason I ask that question is  
3 we've had the SARS report. Before that, we had the  
4 Naylor report, and I think the Walker report.

5 And when you read those reports,  
6 somewhere along the line, everybody forgot what  
7 they said. And, you know, I was just wondering if  
8 there was -- if it occurred to you that there was  
9 any way of kind of maintaining a sense of this  
10 knowledge.

11 Otherwise, you know, you just repeat  
12 the mistakes of the past. The generation changes,  
13 something happens, and everybody just simply makes  
14 the same mistakes over again.

15 DR. REBECCA REPA: We might get that --

16 DR. JOY RICHARDS: Well, I think --

17 DR. REBECCA REPA: We might get to that  
18 in some of the presentation because I think we have  
19 thought a little bit about why some things were  
20 successful and why some things weren't.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Okay.

23 DR. REBECCA REPA: So if it's okay,  
24 maybe we'll try and address that throughout.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 That's fine. That's fine.

2 DR. REBECCA REPA: Great.

3 DR. JOY RICHARDS: Okay. Next slide, I  
4 think, is the last one, if I'm not mistaken. And  
5 this is just a diagram that was sort of our  
6 framework for helping them to move through the  
7 course of a day.

8 So, you know, shift change, where there  
9 would be transfers of accountabilities happening,  
10 where there would be huddles, where care provision.  
11 It really just is a bit of a roadmap. We used this  
12 at UHN, and it worked very well for them in terms  
13 of a visual of what are the elements and  
14 fundamentals of care that the staff need to be  
15 thinking about.

16 Intentional rounding so that we were  
17 making sure that people were laying eyes on the  
18 residents and making sure hydration and those kind  
19 of things --

20 So this was really just a document that  
21 we use at UHN, and it worked very well in long-term  
22 care. It really helped as a touchstone for the  
23 leadership. We could go back and remind people,  
24 you know, where those transfers of accountability  
25 needed to happen.

1                   So I'll stop there and pass it on. I  
2 think Susy's speaking next.

3                   COMMISSIONER JACK KITTS: Just before  
4 you leave that slide, my quick question is are the  
5 homes still using this model?

6                   DR. JOY RICHARDS: Yes. So what's  
7 really lovely is as we've been in and done deeper  
8 dives and been in outbreaks, we still keep in touch  
9 with these homes. And, of course, Wave 2, we have  
10 relationships with these homes now.

11                   So it's just going back to holding  
12 these up and saying, you know, "are you still  
13 following the daily huddles?" And nine times out  
14 of ten, they are. I meet with the teams on the  
15 ground in long-term care in these homes of outbreak  
16 once a week, so we're able to use this as a  
17 touchstone to come back.

18                   So the homes that were in outbreak that  
19 we had teams on the ground, absolutely still  
20 functioning, and we've pulled it back up in Wave 2.

21                   COMMISSIONER JACK KITTS: So let's look  
22 forward to the pandemic is gone; it's behind us.  
23 Do we go back to the way we were, or is there a  
24 model that, in your opinion, would work best to  
25 prepare us for whatever brings -- whatever wave of

1 pandemic comes next?

2 DR. JOY RICHARDS: I think Rebecca's  
3 going to talk about that. We don't want to go back  
4 to the way that it was. I think this is our  
5 opportunity to drive significant, important change  
6 in this sector, and I'll leave that to Rebecca.

7 She's got a -- she's got our plan  
8 nailed down, so...

9 DR. REBECCA REPA: I'm the closing act.

10 DR. JOY RICHARDS: If we ruled the  
11 world, here's what we would do...

12 COMMISSIONER JACK KITTS: Okay. I love  
13 it. Thanks.

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 Go ahead.

16 DR. REBECCA REPA: There we go. We're  
17 going to hand it over to Susy now.

18 DR. SUSY HOTA: Okay. Great. So what  
19 I'm going to talk about is a little bit of the  
20 specifics of what we've learned over the past two  
21 waves, I guess, of the pandemic with respect to the  
22 outbreaks of COVID-19 across our 15 long-term care  
23 homes, five retirement homes. And, of course,  
24 unfortunately we've had a significant number of  
25 these outbreaks to deal with.

1                   So, Rebecca, if you could advance to  
2 the next slide.

3                   I'll start off by just highlighting  
4 some of the themes that emerged through the  
5 outbreaks as contributors. The first thing I think  
6 comes as no surprise that there was underdeveloped  
7 programs and infrastructure in place to support  
8 infection prevention and control.

9                   And this was special apparent in the  
10 earlier stages of the pandemic where, you know, we  
11 came into some of these homes that were facing  
12 significant outbreaks and very basic IPAC  
13 practices, practices around the use of PPE, were  
14 not in place. And we had to spend a lot of time  
15 and effort to reinforce those kinds of practices.

16                   So examples of the kinds of things that  
17 we saw were, you know, using layers of gowns on top  
18 of each other in an effort to try and streamline  
19 their care or make it easier to do what they  
20 thought they needed to do but actually making it  
21 much more complicated and, of course, much more  
22 risky in terms of transmission of infection from  
23 resident to resident, room to room, and to  
24 themselves, quite frankly.

25                   So there was a lot of focus in the

1 earlier stages on trying to get some of those  
2 fundamentals in place. And then as time has gone  
3 on, that's been less of the issue, thankfully. I  
4 think it's been quite effective to have that sort  
5 of education in place and that reinforcement of  
6 practice.

7           It became, also, very clear that the  
8 model that had been in place with Public Health  
9 being the primary support for infection prevention  
10 and control was really not designed to deal with a  
11 pandemic and probably insufficient in general to  
12 deal with the kinds of infection prevention and  
13 control problems that these homes were facing.

14           There just wasn't enough presence.  
15 There was no on-site presence. And when they were  
16 in outbreaks, it was very difficult to even get --  
17 establish a good cadence of meetings to try and  
18 keep the measures -- keep an eye on the measures  
19 that were in place and help with those, you know,  
20 improvement efforts that you need to do on a very  
21 quick cycle of PSA through an outbreak. So that  
22 was, I think, a big contributor, especially early  
23 on.

24           In the second wave, I will say the  
25 models changed a little bit. And we are working

1 much more collaboratively with Public Health, and I  
2 see that there is a lot more support. So I'm going  
3 to say that that's shifted in a very positive way  
4 as we kind of built IPAC hubs, and Public Health is  
5 definitely more engaged. Although the on-site  
6 presence is still not really there.

7           Prevention was not optimized for the  
8 environment. These are, you know, people's homes,  
9 essentially. So even things like alcohol-based  
10 hand rub was not available at the point of care and  
11 many key places. You know, the type of furnishings  
12 that were there are just not IPAC friendly, and  
13 that speaks also to the physical, planned design  
14 limitations that we're walking into.

15           And I'm sure you've heard a lot about  
16 this but, you know, just the design of these homes  
17 with multi-bedded rooms. And many of our homes  
18 have not able to reduce the census of residents  
19 within these multi-bedded rooms. There's still  
20 three or four people occupying those spaces.

21           And these dormitory-style bathrooms  
22 where they have to share -- you know, amongst  
23 seven, eight, sometimes more residents -- a  
24 washroom with multiple stalls, it's just not  
25 infection prevention and control friendly.

1                   HVAC standards is another area that  
2 we've really kind of put a lot more attention into  
3 in the second wave. In the first wave, we didn't  
4 really go there. But, you know, the evidence has  
5 kind of emerged that ventilation is an important  
6 factor in terms of infection prevention  
7 particularly with COVID and, you know, with a lot  
8 of other things too, frankly.

9                   We've made this a part of our standard  
10 assessments that we actually reach out to the homes  
11 and ask if we could do an HVAC assessment and help  
12 them -- you know, try to optimize as much as  
13 possible. And certainly we've uncovered that, you  
14 know, there is room for improvement in that area.  
15 Many of these buildings are quite old as well.

16                   The other major contributor that we  
17 found were delays in testing, and this applies to  
18 not just the routine surveillance testing that was  
19 happening with staff. But also when residents  
20 developed symptoms or staff members developed  
21 symptoms, we were dealing with turnaround times of  
22 seven days, quite often, when it would go through  
23 the Public Health lab system.

24                   So we really put a lot of effort, in  
25 the early stages of this wave in particular, to try

1 and streamline our approach to help them. So we  
2 would start diverting these specimens bundled to  
3 our own lab where we knew we could actually  
4 guarantee an excellent turnaround time. And  
5 really, the most challenging part of that, which we  
6 continue to work on, is all the upstream and  
7 downstream processes. It's not the testing itself.

8 That -- I think there's been great  
9 strides in all labs. It's about labelling --  
10 getting the labels organized; accessioning; sending  
11 it; making sure that it's received appropriately in  
12 the right spot in the lab; and, you know, of  
13 course, once the testing's done, bundling all of  
14 the results to, you know, actually convey that to  
15 the home. Because, quite often, they're chasing  
16 after to see if samples were actually tested or if  
17 they were negative or if they got lost somewhere in  
18 the ether.

19 Next slide, please.

20 COMMISSIONER JACK KITTS: Dr. Hota,  
21 before you move onto the next slide -- so just a  
22 question about the IPAC.

23 Can you briefly describe the model now?  
24 Before it was Public Health that was responsible.  
25 Now it's a hub and spoke including a hospital IPAC

1 experience.

2 DR. SUSY HOTA: Yeah.

3 COMMISSIONER JACK KITTS: Just briefly  
4 tell us how that works and whether you think that  
5 is the model for the future.

6 DR. SUSY HOTA: Yeah, I do. I'll start  
7 with the last part. Do I think that this kind of a  
8 model has been incredibly helpful, and we've gotten  
9 that feedback as well. And do I think that there's  
10 some definite benefits to taking on this approach.

11 The way we built our hub -- and I think  
12 every hub is a little bit different. So I'm the  
13 medical director for our IPAC program. I'm quite  
14 involved as well, and we've been very heavy on our  
15 leadership team in our hospital IPAC team being  
16 involved with the homes because it's taken us time.

17 Unfortunately, at the point where we  
18 started having to build these hubs, we were already  
19 in significant outbreaks in many of our homes. So  
20 it's been a bit reactive in our approach, too.

21 We're still trying to build the hub.

22 We have an IPAC ICP lead for long-term  
23 care who has been excellent. And she's been, I  
24 think, the glue that's kind of held all this  
25 together through all the different phases of

1 building the program, the ups, the downs.

2 She comes with a background not just in  
3 infection prevention and control but also in  
4 behaviour change, frontline ownership, positive  
5 deviance as it relates to infection prevention and  
6 control. And so she just has a very, I think,  
7 helpful approach when you're going into an  
8 environment like this where it's quite different.

9 It's new to them, and she's very  
10 engaging, and that's really been one of our  
11 approaches to working within these teams. She  
12 works very closely as well with folks from the LHIN  
13 or Ontario Health who are sort of the IPAC clinical  
14 coordinators who come on site when we request and  
15 do education that's quite focussed and do a lot of  
16 sort of observations and feedback as well around  
17 PPE, just general IPAC practices as well.

18 And at times, we also have access to  
19 IPAC extenders who can come on site to do a little  
20 bit more focussed education. But, you know, our  
21 IPAC coordinators have also been very helpful  
22 resources.

23 I will say the part of the model that  
24 is still going to require a lot of work is the  
25 on-the-ground, on-site IPAC specialists. They do

1 not truly exist. I'll be honest. There are people  
2 designated, I think, in many of the homes, but the  
3 expertise has not been built yet.

4 So, you know, it requires a lot of  
5 training, a lot of experience, and a lot of sort of  
6 mentoring to get there. And I think that's going  
7 to be kind of our next phase as we get out of  
8 outbreaks to help with a little bit more.

9 COMMISSIONER JACK KITTS: So the hub  
10 will be the educator of the on-site IPAC people?

11 DR. SUSY HOTA: Yes, the hub will be  
12 the educator of the on-site. I believe that's the  
13 best way to go forward. There are, you know,  
14 online modules and things like that that have been  
15 referenced as being kind of the primary mode of  
16 educating the IPAC specialists in long-term care  
17 homes. That's insufficient in my mind.

18 Part of the reason why -- you know,  
19 it's been myself, the manager of our IPAC program,  
20 and our ICP lead who have really done a lot of the  
21 work around outbreak management, providing IPAC  
22 direction for the homes -- is we recognize that you  
23 have to go on site. You have to be there, and you  
24 have to spend time in the home to truly understand  
25 what the fundamental problems are.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):

2    Yeah.

3                   DR. SUSY HOTA:    Outbreak meetings that  
4    are run, you know, distantly and just kind of go  
5    through checklists do not help you to see what the  
6    actual problems are.

7                   COMMISSIONER JACK KITTS:   Thank you.

8                   DR. SUSY HOTA:    Okay.    So other  
9    contributors -- of course, the resident population  
10   is different, so we can't compare this to how we  
11   actually run IPAC within hospitals.

12                   We've had multiple challenges  
13   maintaining isolation/confinement to special rooms  
14   or areas because, you know, there's a lot of  
15   wandering.   People have memory loss.

16                   While we're doing one site visit in a  
17   home that had an early outbreak, we, unfortunately,  
18   witnessed a resident walking out of an isolation  
19   room that was not his own room, and it had been his  
20   previous room a while back.   And he remembered that  
21   and kept coming back to this room.   And it just  
22   took a lot of attention and special sort of  
23   dedicated staff to one-on-one care to try and  
24   manage some of these issues.

25                   Also, challenges implementing some of

1 the enablers of good practice. So I never thought  
2 I'd spend so much time talking about garbage cans  
3 with people in these homes. But, you know, where  
4 to dispose of your PPE is actually quite important  
5 to enable good IPAC practices.

6 And in some of these homes they had a  
7 hard time finding an appropriate place to put these  
8 garbage bins because the residents would get into  
9 them, and they were worried about the risk to the  
10 residents. So trying to troubleshoot these and  
11 think outside the box in these kind of  
12 circumstances was a large part about what we ended  
13 up having to do.

14 We've already talked a little bit about  
15 staffing shortages and how this -- I don't think we  
16 can underestimate this enough. The fatigue in the  
17 breakdown in practice that can then ensue really is  
18 important. And trying to backfill the positions,  
19 you know, with all the right intentions,  
20 unfortunately left them sometimes with  
21 inexperienced or temporary staff who may not have  
22 felt so engaged or so connected to the home and may  
23 have come with variable IPAC practices. So  
24 sometimes this was actually an added burden to the  
25 existing staff and leadership to try and manage

1 that along with their staffing shortages.

2 I think Joy has spoken a lot about  
3 leadership. This was, to me, probably one of the  
4 biggest contributors. In the areas where we had  
5 significant problems with managing outbreaks, the  
6 leadership plays a huge role in this, and I think  
7 that that's one of the key issues. And then the  
8 whole sort of ambiguous work culture which, again,  
9 is also incredibly important here.

10 Some of our homes were under  
11 corporations, and the policies and the direction  
12 from the corporation sometimes did not agree with  
13 what we would say or what Public Health was  
14 recommending or even what provincial guidelines  
15 would say, quite frankly.

16 And that really put the home in an  
17 awkward position, and sometimes it did feel as  
18 though there was a culture of, you know, fear of  
19 repercussions if they didn't follow what the  
20 corporation was saying.

21 Of course, these are nonclinical  
22 environments, and, you know, they're used to having  
23 a different kind of relationship with the residents  
24 in these homes. And so trying to redirect some of  
25 that and focus it in the midst of an outbreak was

1 an important issue.

2 And, of course, there was less  
3 standardization of processes because they were  
4 managing people and caring for them within their  
5 homes and not really accustom to how you have to be  
6 protocolized in dealing with an outbreak.

7 Yeah?

8 COMMISSIONER ANGELA COKE: I want to  
9 just ask a bit more about the relationship with the  
10 corporate head offices. And what sort of support  
11 was coming from them?

12 DR. SUSY HOTA: Yeah, Joy, I don't know  
13 if you want to speak a little bit about that. I  
14 mean, I think that, in general, from my experience,  
15 they've been trying to support everything that was  
16 required within the outbreaks.

17 But I think that, occasionally, there  
18 was different direction. And just speaking purely  
19 from an IPAC perspective, sometimes, you know, I  
20 think the corporations wanted to help, and they  
21 thought they would be introducing something new to  
22 help.

23 And one of the examples was we  
24 repeatedly come across homes wanting to introduce  
25 these, like, spray disinfections that can

1 aerosolize, potentially cause harm, and we don't  
2 like it. You know, there are a lot of reasons why,  
3 from an infection control perspective, we don't  
4 like spraying as a way to try and clean and  
5 disinfect an environment that could have pathogens  
6 in it.

7           And even though we continuously gave  
8 that recommendation, "avoid spraying; you shouldn't  
9 be using these kinds of products," I think the  
10 corporations were really trying to help and look  
11 for new, novel ways of managing the outbreaks. And  
12 they continuously brought these kinds of  
13 technologies forward, and it left the folks on the  
14 ground feeling quite caught in the middle.

15           DR. JOY RICHARDS: Yeah, I can --

16           DR. SUSY HOTA: Joy, did you have more  
17 to say?

18           DR. JOY RICHARDS: Yeah. I mean, we  
19 were really careful. We wanted to maintain and  
20 actually foster relationships with the teams on the  
21 ground, but there were some times when, despite  
22 trying to move them forward, we needed to escalate.

23           So I always kind of followed the chain  
24 of command. We always worked -- first of all, we'd  
25 go on site. So as Susy said, you know, my team and

1 I would do on-site visits so we could actually say  
2 specifically what we saw.

3 And UHN had our own leadership teams on  
4 the ground, so they would often see things that  
5 would be counterproductive to what the home's  
6 leadership would do. So we sort of got a sense of  
7 what the politics were.

8 And I would just say, you know, "we're  
9 going to pull in your vice president." I'd say in  
10 every situation, it always started a little tense.  
11 But very quickly, I think folks knew we were there  
12 to help and to problem solve together.

13 So now, in some of the homes, we, on  
14 our daily -- our weekly huddles have the executive  
15 team there so that there's not any  
16 miscommunication; that we can say to the vice  
17 president, for example, "we're really concerned  
18 about this particular person's skill set, and  
19 here's a plan. They need mentoring; they need a  
20 learning plan, and they need to take X course, and  
21 that needs to be mandatory."

22 Then the executive director hears that,  
23 the VP hears it, and then we can come back and say  
24 "we had that conversation last week." So it's kind  
25 of building that sense of trust among all of us.

1                   They've been very receptive. I must  
2 say we haven't had any real pushback at the  
3 executive level. It's more at the ED level where I  
4 think they're worried that they don't want to be  
5 seen by their boss as not knowing what they're  
6 doing.

7                   So it's really, again, building a trust  
8 relationship having the ability when you have that  
9 trusting relationship to give them some  
10 constructive feedback and escalate when needed. So  
11 far, it's worked well in the homes that we've been  
12 in.

13                   COMMISSIONER ANGELA COKE: Thank you.

14                   DR. SUSY HOTA: I think this is my  
15 final slide. It just kind of outlines how we've  
16 approached this new work. And, really, coming back  
17 to what Joy started off saying, we based our  
18 approach upon relationship building and engagement  
19 of the teams. This is so fundamental, and it's  
20 kind of our approach with infection prevention and  
21 control at UHN to begin with.

22                   And we were fortunate that we had an  
23 excellent relationship with Toronto Public Health  
24 and continue to build on that as well as within the  
25 homes. And the AMOH from Toronto Public Health

1 who's been working with us on our homes has been  
2 quite fantastic, and we have a very similar  
3 approach, so I think that's really helped when  
4 we're aligned in our thinking. And I don't  
5 hesitate to pick up the phone and send her a  
6 message or call her and vice versa. We consider --  
7 we think that there may be a bigger issue on the  
8 home.

9           Just the early creation of our  
10 community practice -- so we -- prior to the  
11 creation of the hub-and-scope model, Leah, who is  
12 our ICP lead for long-term care, had the idea of  
13 creating a community of practice. And so we've had  
14 a longer period of time to build those  
15 relationships with our homes and with the leads  
16 there as well. And I think they found that very  
17 helpful, and they've learned from each other's  
18 experiences.

19           Working within those individual homes,  
20 really understanding what the unique challenges are  
21 and --

22           You know, what we're applying to one  
23 home is not necessarily going to work in the next.  
24 And so we brainstorm together, and we've talked  
25 about using our outbreak meetings as a way to try

1 and get across barriers to practice. And also  
2 in --

3 This hasn't happened in all of the  
4 homes, but I think this is one of our goals moving  
5 forward, is we have had some really good  
6 physician-to-physician engagement between myself  
7 and the medical director of a home in trouble.

8 And I found that very helpful because  
9 you get a different perspective altogether on  
10 what's happening. And so we've really leveraged  
11 that on a few occasions, and I think that's an  
12 opportunity as well moving on.

13 The on-site presence, really incredibly  
14 important. You have to understand what you're  
15 working with and who you're working with. And  
16 really, also, I think, just kind of developing the  
17 relationship's been very important to have on-site  
18 presence in times of crisis but also outside of  
19 them.

20 We have always made ourselves very  
21 accessible, unfortunately a little bit too  
22 accessible, maybe, sometimes, it feels. But, you  
23 know, we're available 24/7 when there are  
24 questions, and I think that's been helpful as well  
25 for the long-term care home staff and leadership.

1 We also --

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And can I stop you there for a second?

4 DR. SUSY HOTA: Sure.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Was there any problem on the UHN side in terms of  
7 buy-in? Because you're spending time -- and  
8 resources, I guess, in a way, but certainly time --  
9 working on this problem for the best of reasons.

10 But was there any sort of point that  
11 had to be made on the UHN's side to make sure that  
12 there was a continued support for what you were  
13 doing?

14 DR. REBECCA REPA: No.

15 DR. SUSY HOTA: I've never felt that  
16 way at all. It's been incredibly supported. Now,  
17 mind you, at the moment, like I said, we've been  
18 trying to build our hub while doing this very  
19 intensive work. And, you know, we really got hit  
20 with quite a few outbreaks in September and  
21 October. It was very busy.

22 I won't lie. Myself, the manager of  
23 our program, and our ICP lead, we were working  
24 crazy amounts of hours on this above and beyond our  
25 usual jobs. So, you know -- but I think there was

1 recognition from UHN that this was important work  
2 to do and support to hire individuals to help  
3 continue this work.

4 So, you know, that's really what the  
5 plan is, is to build the teams so that we have the  
6 right kind of resourcing to do this work because  
7 it's so -- it's so important, and it is a  
8 gratifying.

9 I have to say I do find it fulfilling.  
10 It's a whole aspect of healthcare that we have not  
11 been involved with, and I think when you see the  
12 opportunity to improve it, it's hard to not want to  
13 do it.

14 COMMISSIONER JACK KITTS: Can I just  
15 ask one more question about IPAC and PPE? We've  
16 heard a lot about the shortage of PPE.

17 DR. SUSY HOTA: Yeah.

18 COMMISSIONER JACK KITTS: You've really  
19 stressed the education of staff to be able to don  
20 and doff and use the PPE safely.

21 DR. SUSY HOTA: M-hm.

22 COMMISSIONER JACK KITTS: Were both a  
23 big problem, or was one more of a problem than the  
24 other?

25 DR. SUSY HOTA: I think in the early

1 stages, availability to PPE was a bit of a concern.  
2 Now it's more of a perceived concern. I mean,  
3 there are supplies of PPE available. We have not  
4 run into that problem. And, you know, we have a  
5 whole system to help support procurement of the PPE  
6 when they need it.

7 I've come across homes that have been a  
8 bit reluctant to change their practices  
9 particularly around reuse of face shields. So, you  
10 know, when they're having problems with COVID, we  
11 ask them to actually discard their face shields at  
12 the end of shift and not be disinfecting and  
13 reusing them because that could be hazardous to  
14 them.

15 And we have encountered a little bit of  
16 pushback on that because of a perceived lack of  
17 supply, but we've been able to overcome that every  
18 single time. So I think once they start to feel  
19 comfortable with it, it enables that practice  
20 change, and it's been fine.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Do you think they should have -- do you think  
23 there's a correct supply of PPE that should be  
24 physically at a long-term care facility? Do you  
25 have a view on that?

1 DR. SUSY HOTA: I think that there  
2 could be modelling exercises to understand that  
3 better, and there should be at each home in terms  
4 of what their needs would be.

5 I will say, you know, right now, we're  
6 very focussed on COVID, and that's the problem at  
7 hand. But as we move forward, there's going to be  
8 a need to build further IPAC programs, and there  
9 are many issues that I suspect are not being  
10 detected and could be managed differently.

11 So I think it would be worthwhile to  
12 kind of think through what those needs are through  
13 COVID as well as longer term at each home.

14 DR. REBECCA REPA: And I'll speak a  
15 little bit about the PPE as well in some of the  
16 final stages. But the reality is there was no  
17 purchasing network within long-term care.

18 And those of us in acute care have gone  
19 to Just in Time inventory two decades ago. So, in  
20 fact, we swung the other way. We've built  
21 Adjusted Case inventory now because Just in Time  
22 inventory failed us.

23 And so we've actually moved away from  
24 having any kind of inventory on site, and we're now  
25 moving back to having some inventory on site. And

1 we're debating whether that 60 days or 90 days  
2 based on, you know, your current use rate.

3 And we had to start anticipating that  
4 for long-term care. So we actually created, in our  
5 own warehouse, a separate supply for long-term care  
6 because it was different material. Not to bore you  
7 with the details, but the gowns are a different  
8 colour, and, you know, they --

9 So basically we started to do that  
10 because we started to think, well, we better just  
11 anticipate for them because we didn't know what  
12 would be coming next.

13 COMMISSIONER FRANK MARROCCO (CHAIR):  
14 Okay.

15 DR. SUSY HOTA: So I do have a few  
16 other points here, but I think covered most of  
17 them. I think the only other one I wanted to  
18 emphasize was the rapid escalation of unresolved  
19 issues.

20 We did a lot of this, and, you know,  
21 sometimes it was a Friday night at 9 o'clock where  
22 we were all on the phone and trying to figure  
23 out -- with Ontario Health, the Ministry of  
24 Long-Term Care, with Public Health -- Toronto  
25 Public Health, trying to figure out some issues

1 that really needed to be escalated quite rapidly.  
2 We never hesitated to do that, and I think that's  
3 helped us quite a bit as well in terms of managing  
4 these outbreaks and their IPAC issues.

5 So I guess -- I think I'll pause there  
6 and maybe hand it over to Rebecca.

7 DR. REBECCA REPA: Okay. So I wanted  
8 to talk a little bit about the concept of system  
9 and the sustainable hardwiring that you've  
10 mentioned in your questions.

11 So I joined UHN a year tomorrow,  
12 actually, and I was actually in my day role for  
13 about six weeks before all of this happened. But I  
14 came from St. -- I came from Hamilton, and I worked  
15 for many years with Dr. Kevin Smith at the  
16 St. Joe's Health System and then moved into an  
17 integrated role with Hamilton Health Sciences for a  
18 decade as well integrating the post-acute world  
19 which is where my experience comes to from  
20 long-term care.

21 And I guess I say that because I feel  
22 like I've grown up in an integrated system, in a  
23 network. And one of the reasons why I think acute  
24 care did so well during the outbreak was we had a  
25 system. We had a network.

1           And I know that Dr. Kitts will know  
2 very well. And, you know, those relationships --  
3 I've worked with Cameron for years. You know, to  
4 pick up the phone and try to figure out --  
5 problem-solving on -- you know, at nighttime, it  
6 would have been not at all surprising for any of us  
7 to do, and we were doing it all the time.

8           So I think that was there for us to be  
9 able to action, and it wasn't there for long-term  
10 care. So we have done -- I have done a lot of  
11 thinking. We, really, are on the same wavelength  
12 in terms of --

13           You know, what we were able to extend  
14 very quickly to long-term care was a system. And  
15 to your point about, you know, was there any  
16 resistance internally -- Kevin Smith grew up in the  
17 system. He had that experience at his fingertips.  
18 St. Joe's ran long-term care homes. We ran home  
19 care. You know, he already had that in his mind  
20 when he said "just go and do it."

21           And -- I have to tell you -- there  
22 hasn't been one time, even up until yesterday when  
23 we were talking about vaccines, when somebody said  
24 "who's got the money," and we all just went "I  
25 don't know."

1           You know, it was -- it hasn't been  
2 about money. It's been about parachuting in and  
3 doing what needed to be done.

4           So I wanted to just sort of set the  
5 stage a little bit. And I know, again -- Dr. Kitts  
6 this won't be any surprise to you. But, you know,  
7 the 2000 to 2010 was really the merger of acute  
8 care, and it was building the enabling practices.  
9 And here are a few of examples. There were many,  
10 many of them.

11           But the reason why hospital  
12 restructuring occurred was really two-fold. It was  
13 to build a system and a network that started to  
14 build capacity and build on back-office  
15 opportunities to consolidate, and it also was about  
16 a much-needed capital redevelopment that needed to  
17 occur.

18           And things happened in that decade like  
19 capital-buying groups and joining into procurement  
20 group-purchasing organizations -- common laundry,  
21 imaging, lab, consolidating back office, common IT  
22 systems, warehousing, Just in Time.

23           All of that was part of what we  
24 accomplished in that decade with acute care. And  
25 it was the enabling bits that started us to see

1 that there was this opportunity in building this  
2 network and capacity that we could actually start  
3 to lever.

4 The next decade was really around  
5 integration with the post-acute world, and it was  
6 really about the patient experience, and that was  
7 driven voluntarily. So hospitals -- I went to join  
8 St. Peter's as the president in 2010 to do the  
9 integration when it joined into Hamilton Health  
10 Sciences.

11 And then at the time, the name of the  
12 game was "ALC and flow," and it was really around  
13 the patient experience being stopped and started at  
14 every transition along the continuum.

15 Every time they had to go to a new  
16 facility, they had to wait, and then the whole part  
17 about bringing -- getting to know that patient  
18 again, understanding that health record really was  
19 a new process every time.

20 And there were many examples where  
21 hospitals started to build systems. It was very,  
22 very much what was happening around the world. And  
23 what we saw from there was -- in that voluntary  
24 amalgamation, you know, we really emphasized a  
25 vision of a bidirectional sharing of expertise.

1                   We recognized that the post-acute care  
2 world came with so much expertise and  
3 senior-friendly Alzheimer's. They have a wonderful  
4 approach and goal-focussed care that acute care  
5 could learn so much from in terms of how to treat  
6 patients.

7                   And on the other side, the post-acute  
8 world started to get the expertise of  
9 functionalizing areas in back-office -- food  
10 services, purchasing, facilities, finance, risk,  
11 redevelopment -- areas where they would never be  
12 able to have created that capacity or afforded it.

13                   You know, simple examples -- in the  
14 St. Joe's Health System where I worked and I lead  
15 redevelopment, we would be parachuted into  
16 St. Mary's Acute Care or Dundas Villa's palliative  
17 care redesign.

18                   And, in fact, we were the team that did  
19 the -- in the restructuring eras, we converted  
20 Brantford's acute-care hospital to a long-term care  
21 facility.

22                   We were able to parachute people in  
23 much like we did during this wave with long-term  
24 care because the larger systems could afford to  
25 build the strength in the back office.

1           The other thing that I think we saw was  
2 much better performance metrics in advancing along  
3 the patient continuum, and I'll just use stroke  
4 care as an example.

5           You know, patients would wait up to 25  
6 and 30 days in an acute-care bed to move to a rehab  
7 facility, and time is function in that world. The  
8 longer you wait, the more function you lose. And  
9 the best practice was to be able to move to rehab  
10 beds within five days.

11           And so the only way to do that was to  
12 collapse that stream and make that part of one  
13 organization, make that part of one care path, make  
14 one person accountable across all of the streams of  
15 care and really push towards the best outcomes for  
16 patients.

17           The other, I think, professional  
18 practice standards and staff ratio and -- I would  
19 add in there -- leadership -- we had such movement  
20 across the continuum in leadership and in roles  
21 that allowed us to not only build capacity and team  
22 members but also bring and pepper best practices  
23 into new parts of the system, again a little bit of  
24 what we've seen this time around.

25           Scope of practice and using best

1 practice and case management -- so learning from  
2 the post-acute world we've been able to learn a  
3 lot, even to help us, in acute care, manage  
4 patients differently. And, of course, slow and  
5 bundled care came out of that.

6 The other thing I would add about that  
7 is what happened during those voluntary  
8 integrations -- many of those systems actually had  
9 long-term care in them.

10 So I'll use the St. Peter's example.  
11 St. Peter's was a complex care site, 220 beds. It  
12 also had 220 beds in long-term care.

13 When the voluntary amalgamation  
14 happened, we severed that relationship with  
15 long-term care, and we did that -- and I would say,  
16 in the St. Joe's example, the corporate structures  
17 are completely different, and there's no  
18 corporate -- there's no -- there's the system  
19 relationship, but the corporate-legal relationship  
20 does not extend to long-term care or to home care.

21 And the reason it doesn't is two-fold.  
22 One, because the fear of harmonization of wage  
23 salary is across that continuum, and it did happen  
24 in post acute. So we know it would happen. And  
25 the fear would be that we would be -- and the fear

1 of, you know, the loss of autonomy within long-term  
2 care as it related to the 2007 Act.

3 And I think the Act also had another  
4 impact which was it started to reassign the  
5 responsibility for placement from acute care from  
6 post acute to community care access. And so we  
7 actually, I guess, disassembled the system that was  
8 being built in senior-friendly ageing care in order  
9 to facilitate some of this integration into the  
10 acute-care stream.

11 And what I would say is the  
12 unintentional consequences of that are that system  
13 no longer had the larger capacity to be able to  
14 draw from, and the patient flow was more disjointed  
15 because not only did we not do the placement  
16 anymore, but the placement and the easy flow from  
17 the acute-care world to a designated long-term care  
18 home became not available to them.

19 And so as an example, you know,  
20 patients would have liked to have seen -- if I show  
21 up at St. Joe's, then I'll get to go to the  
22 St. Joe's Villa. But as most of you know, that's  
23 not possible.

24 What happens is you go into the  
25 community care access database, you pick five

1 sites, and you start to, then, be allocated through  
2 a system of equity as to where you will go. And I  
3 think that broken chain is something I would see as  
4 a huge opportunity for correction.

5           And then the third thing that I would  
6 mention is the post-acute world is filled with an  
7 environment that is a different type of care than  
8 acute care. It does have congregate dining. It  
9 does have congregate rehab facilities and  
10 congregate social activities with a focus in rec  
11 therapy and other types of therapy.

12           And we did not see the same outbreaks  
13 in those environments that we saw in long-term  
14 care. And I know that there's a feeling that that  
15 environment led to some of the problems that  
16 occurred in long-term care, and I would really hate  
17 for us to institutionalize long-term care in a way  
18 that somehow undoes some of the wonderful elements  
19 of that residential environment.

20           But I think what you've heard Susy and  
21 Joy speak to is that there's probably a way to  
22 preserve the best of what's there and help to  
23 augment it so that it's a safe and viable  
24 environment for residents going forward.

25           And so I think when we talk about

1 what's the next step in continuing the journey --  
2 and, you know, having grown up in a system that  
3 evolved and continued to have all of these elements  
4 in it, I feel so passionate about the fact that if  
5 there's a next step, it's about -- it's about  
6 building that branch to the next part of the  
7 journey. And that bridge might look different  
8 depending on whether it --

9           You know, the municipal homes or  
10 private homes or homes that are faith-based like in  
11 the St. Joe's system, the actual bridge could look  
12 different. But the tethering is what helped  
13 long-term care come out of this quickly.

14           The SWAT team that the larger system  
15 could bring to the problem-solving, whatever the  
16 problem is, ultimately had three big benefits.  
17 One, the benefit was to care unto people in the  
18 areas of better flow, better training, better  
19 alignment with professional practice, better  
20 connection with physician models, better IPAC, so  
21 everything on the clinical side. It's a bit of a  
22 menu depending on the problem or the crisis of the  
23 day.

24           And then the sustainable side which is  
25 really that back office around making sure that

1 those standards of -- to the question of, you know,  
2 is there a recommended inventory to be had, or what  
3 are the facility maintenance standards?

4           You know, this is a -- the back office  
5 and environmental standards side is, again, what  
6 we're very good in. And I think there's an  
7 opportunity to advance those standards just based  
8 on having that continuum extend. And we did see  
9 that in the post-acute amalgamations of the last  
10 decade. We did see that improvement.

11           I've worked in -- I led both --  
12 along -- post-acute as well as community care  
13 integration, and we did see that those standards  
14 raise for everybody.

15           And then I think the last point is  
16 about risk management. And so there's, again, a  
17 depth in the acute care world on risk management.

18           You know, part of our jobs is to be  
19 able to see around corners and see through walls.  
20 And so, you know, it's great for work; not great if  
21 you're -- you know, you risk manage your home. But  
22 it is something that we are trained to do.

23           And so being able to bring and  
24 anticipate -- just even to the conversation about  
25 buying PPE for long-term care on Spec because we

1 just know that it's probably going to be needed.  
2 And I think that that's some of the advantage of  
3 the system.

4 And so I guess if I had a dream for  
5 long-term care, it would be to somehow build those  
6 bridges that help them tether into a larger system;  
7 that they learn to build those networks; they build  
8 those relationships so that they can pick up that  
9 phone at whatever point and, whatever the problem  
10 of the day is, they have that ability to reach you.

11 And so I think we would end with that  
12 because I think we all really do feel that it was a  
13 tragedy of what occurred. And to care for those  
14 who cared for us is the highest honour, and I think  
15 there's a passion.

16 And I think we want to leave you  
17 with -- we feel that there were really good people  
18 with really great intentions. And then the systems  
19 and the processes failed with this kind of crisis,  
20 and we were thrilled to be able to help. And we  
21 think we have some suggestions of how we could  
22 hardwire that going forward.

23 COMMISSIONER JACK KITTS: Could I ask a  
24 question? Could you go back two slides, please?

25 DR. REBECCA REPA: That one?

1                   COMMISSIONER JACK KITTS: Yeah. I  
2 really enjoyed your evolution of health care from  
3 2000 to now.

4                   DR. REBECCA REPA: You probably  
5 remember it all.

6                   COMMISSIONER JACK KITTS: Yeah. I  
7 lived in it, and it's been very good.

8                   If you were to take one more step into  
9 2020, there would be a bullet down there under  
10 "flow and bundle of care" called Ontario Health  
11 teams.

12                  DR. REBECCA REPA: M-hm.

13                  COMMISSIONER JACK KITTS: Can you give  
14 me your opinion or thoughts on whether that is a  
15 model that is going to satisfy a lot of the things  
16 that Dr. Richards, Dr. Hota, and you have presented  
17 today that would create a system?

18                  Do you think the Ontario Health teams,  
19 in your opinion, is the way forward to achieving  
20 success?

21                  DR. REBECCA REPA: So there's some  
22 really good literature on systemness around how to  
23 get the best results, and I'd be happy to share it  
24 with you, and I actually did a summary of the  
25 literature at some point.

1           The reality is a structured formal  
2 governance structure is the most solid way to get  
3 the results you want. And as you know, the Ontario  
4 Health teams are very much a voluntary,  
5 connectiveness and a network. And I think there's  
6 great value in terms of bringing teams together and  
7 setting some common goals.

8           But I think when I -- when I think  
9 about long-term care and I think about where we  
10 want to get to, the literature would show that a  
11 structured governance relationship is the strongest  
12 tool to being able to achieve that.

13           COMMISSIONER JACK KITTS: And I think  
14 that they're aiming for a structured relationship  
15 down the road. Is that your understanding or not?

16           DR. REBECCA REPA: It's so early days  
17 with us in terms of doing that, and right now, it's  
18 very much a voluntary structure. And, of course,  
19 primary care --

20           I mean, you're speaking about the other  
21 branch which is the other branch to primary care  
22 which is a hugely important one as well. And  
23 probably -- we didn't really speak to that, but  
24 that's another important piece as well. And I  
25 would see that the Ontario Health teams really is

1 going to be focussing on helping us get that front  
2 in.

3 I'm not sure that we're focussed on the  
4 part of the journey that is the long-term care  
5 journey. Could it be? You know, I haven't really  
6 thought a lot about that because I -- you know,  
7 working in the system in St. Joe's, I think I  
8 probably had that framework in my head.

9 COMMISSIONER JACK KITTS: Yeah.

10 DR. REBECCA REPA: But it probably is  
11 worth some thought.

12 COMMISSIONER JACK KITTS: Yeah, if I  
13 know Dr. Kevin Smith well -- and I do -- you  
14 probably were functioning like an Ontario Health  
15 team several years ago in St. Joe's.

16 DR. REBECCA REPA: We were, and the  
17 leadership in the St. Joe's model -- and I was  
18 sharing this with Susy and Joy -- the people who  
19 have taken leadership over the home care and the  
20 long-term care were actually people who grew up in  
21 acute care. And so the beauty is you get to  
22 stretch.

23 And, you know, I always said -- I did  
24 all the high-tech programs in acute care. I did  
25 imaging and redevelopment and all the capital. And

1 all of a sudden, I wanted in search for -- you  
2 probably know Brenda Flaherty. And, you know, my  
3 goal was to learn from her the high-touch areas,  
4 and there's no better person in the province to  
5 learn the high-touch areas from than Brenda.

6 And that was what was available in the  
7 St. Joe's system for leaders to be able to go into  
8 those high-touch areas, have a huge competency, but  
9 an opportunity for learning for themselves and be  
10 able to then, you know, blend that practice to a  
11 new product.

12 COMMISSIONER JACK KITTS: Thank you.

13 COMMISSIONER FRANK MARROCCO (CHAIR):  
14 This governance structure -- one of the impressions  
15 I'm getting is that these problems are better  
16 worked out locally rather than over -- than  
17 centrally. Do you have a sense of that, whether  
18 that's correct or not?

19 DR. REBECCA REPA: I think it's through  
20 a network, whether it's locally or not. So I would  
21 tell you that in the last two weeks, we've been  
22 asked to be the procurement agent for the Trillium  
23 Gift Of Life and mostly because they don't have  
24 anyone to connect to. And they really just are  
25 really worried that they're going to run out of

1 supplies and no one's going to help them.

2           And so we just said, you know, "here's  
3 our phone number. If you have any problems, you  
4 can call it 7 days a week, 24 hours a day. We'll  
5 get you what you need."

6           And I think -- they're not in our  
7 geographic local community, but they're in our  
8 network of programs, particularly because of our  
9 transplant program. So I think it is about being  
10 able to be available to people so that they can  
11 start to build that network.

12           You know, one of the reasons why I  
13 think we were successful even on the PPE side was  
14 we were just a couple weeks ahead of everyone else,  
15 and that was because of a network that was  
16 established, you know, across the province that,  
17 within hours, people who knew everybody was texting  
18 everybody trying to get the most recent  
19 information.

20           And we were just able to cut down, you  
21 know, that lag time that would have slowed us down  
22 and made us not as successful on the buying side of  
23 the equation. So I don't know that it's geography.  
24 I think it's about network.

25           COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay. Thank you. Well, is that -- is that the  
2 last slide?

3 DR. REBECCA REPA: That is the last  
4 slide.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Well, I don't think we have any further questions.  
7 Well, this has been extremely helpful. I've found  
8 most of the presentations helpful, but this has  
9 been very helpful in terms of making concrete for  
10 us some sense of a model that works and that would  
11 be an improvement.

12 And so we will be giving this a lot of  
13 very serious thought and very well may come back to  
14 you for some elaboration because this makes an  
15 awful lot of sense.

16 DR. REBECCA REPA: I'm happy to share  
17 some of the literature, if it's of interest.  
18 Please reach out, and I'll dig it out of my files  
19 and send it on.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Well, our executive director, Alison Drummond, will  
22 communicate with you to get that, or someone on our  
23 behalf will, in any event. And we very much  
24 appreciate that, too.

25 So thank you very much. Thank you for

1 the time, thank you for the presentation, and thank  
2 you for the thought-provoking ideas that are  
3 contained in it.

4 DR. REBECCA REPA: Well, it's our  
5 pleasure.

6 DR. JOY RICHARDS: Thank you for the  
7 opportunity. Thank you so much.

8 COMMISSIONER FRANK MARROCCO (CHAIR):  
9 Bye-bye.

10 COMMISSIONER JACK KITTS: Thank you  
11 very much.

12 COMMISSIONER ANGELA COKE: Thank you.

13 DR. REBECCA REPA: Bye-bye.

14 -- PROCEEDINGS CONCLUDED AT 10:11 A.M. --

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1 REPORTER'S CERTIFICATE

2  
3 I, MCKAYA MCDONALD, Chartered  
4 Shorthand Reporter, certify;

5  
6 That the foregoing proceedings were  
7 taken before me at the time and place therein set  
8 forth, at which time the witness was put under oath  
9 by me;

10  
11 That the testimony of the witness  
12 and all objections made at the time of the  
13 examination were recorded stenographically by me  
14 and were thereafter transcribed;

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

18  
19 Dated this 9th day of December, 2020.

20  
21 

22  
23 \_\_\_\_\_  
24 NEESONS, A VERITEXT COMPANY

25 PER: MCKAYA MCDONALD, CSR

CHARTERED SHORTHAND REPORTER

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