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

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

BEFORE:

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

PRESENTERS:
Dr. Joy Richards, Vice President, Patient Experience & Chief Health Professions, University Health Network;
Dr. Susy Hota, Medical Director, Infection Prevention & Control (IPAC), University Health Network;
Ms. Rebecca Repa, Executive Vice President, Clinical Support & Performance, University Health Network.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and

Long-Term Care;
Adriana Diaz Choconta, Senior Policy Analyst,
Long-Term Care Commission Secretariat;
Angela Walwyn, Senior Policy Analyst, Long-term
Care Commission Secretariat.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 8:58 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, good morning. I'm Frank Marrocco. I'm one of the commissioners. There's Dr. Jack Kitts and Commissioner Angela Coke. We are the commission.

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

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

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

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

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

DR. REBECCA REPA: Is Susy here, Joy?

I --

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So the next slide, please.

So --

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

DR. JOY RICHARDS: Of course.

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Okay.

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

DR. REBECCA REPA: Extendicare.

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

DR. REBECCA REPA: Yeah.

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

DR. REBECCA REPA: Rekai? Yeah.

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

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

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

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

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

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

So together we developed -- we knew

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

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

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

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

were not used to working in a crisis like this.

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

So while it was --

COMMISSIONER FRANK MARROCCO (CHAIR): Was there -- sorry to interrupt, doctor.

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

DR. JOY RICHARDS: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): -- rather than trying to come back.

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

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

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

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

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

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

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

DR. JOY RICHARDS: Yes.

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

DR. JOY RICHARDS: So the root cause is

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

state and leaving them be.

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

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

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

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

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

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

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

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

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

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

The daily huddles that happen at the

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

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

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

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

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

DR. JOY RICHARDS: Yeah, exactly.

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

resources or at least knows where they are?

DR. JOY RICHARDS: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

DR. JOY RICHARDS: M-hm.

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

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

COMMISSIONER JACK KITTS: Okay. And is it continuing?

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

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

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

DR. JOY RICHARDS: No, it's something

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

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

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

DR. JOY RICHARDS: Next slide.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Any questions on that?

COMMISSIONER FRANK MARROCCO (CHAIR): No, I don't think so.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, do you have any ideas on how you maintained

some institutional memory of this?

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

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

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

DR. REBECCA REPA: We might get that --

DR. JOY RICHARDS: Well, I think --

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

That's fine. That's fine.

DR. REBECCA REPA: Great.

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

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

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

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

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

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

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

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

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

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

pandemic comes next?

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead.

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

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

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

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

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

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

So there was a lot of focus in the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

experience.

DR. SUSY HOTA: Yeah.

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

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

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

Unfortunately, at the point where we started having to build these hubs, we were already in significant outbreaks in many of our homes. So it's been a bit reactive in our approach, too. We're still trying to build the hub.

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

building the program, the ups, the downs.

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

Also, challenges implementing some of

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

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

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

that along with their staffing shortages.

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

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

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

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

an important issue.

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

Yeah?

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

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

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

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

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

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

DR. JOY RICHARDS: Yeah, I can --

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

We also --

COMMISSIONER FRANK MARROCCO (CHAIR): And can I stop you there for a second?

DR. SUSY HOTA: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Was there any problem on the UHN side in terms of buy-in? Because you're spending time -- and resources, I guess, in a way, but certainly time -- working on this problem for the best of reasons.

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

DR. REBECCA REPA: No.

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

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

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

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

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

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

DR. SUSY HOTA: Yeah.

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

DR. SUSY HOTA: M-hm.

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

DR. SUSY HOTA: I think in the early

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scope of practice and using best

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And so I think when we talk about

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. REBECCA REPA: That one?

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

DR. REBECCA REPA: You probably remember it all.

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

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

DR. REBECCA REPA: M-hm.

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

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

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

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Thank you.

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

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

supplies and no one's going to help them.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. REBECCA REPA: That is the last slide.

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

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

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

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

So thank you very much. Thank you for

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Bye-bye.

COMMISSIONER JACK KITTS: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you.

DR. REBECCA REPA: Bye-bye.

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

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, Chartered Shorthand Reporter, certify;

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

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

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

Dated this 9th day of December, 2020.

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