

Long-Term Care COVID-19 Commission Meeting

University Health Network (UHN)
on Wednesday, January 27, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all
participants attending remotely, on the 27th day
of January, 2021, 9:00 a.m. 10:04 a.m.

REPORTED BY: Helen Martineau, CSR

1 C O M M I S S I O N E R S :

2 Frank N. Marrocco Lead Commissioner

3

4 Dr. Jack Kitts Commissioner

5 Angela Coke Commissioner

6

7 P R E S E N T E R S :

8 Joy Richards VP, Patient Experience &

9 Chief Health Professions,

10 University Health Network

11 Susy Hota Medical Director, Infection

12 Prevention & Control (IPAC),

13 University Health Network

14 Rebecca Repa Executive Vice President,

15 Clinical Support &

16 Performance,

17 University Health Network

18 Joanne Bridle Senior Director,

19 Environmental Services &

20 Nutrition,

21 University Health Network

22

23

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1	A T T E N D E E S:	
2	Alison Drummond	Assistant Deputy Minister
3		Long-Term Care Commission
4		Secretariat
5	Derek Lett	Policy Director
6		Long-Term Care Commission
7		Secretariat
8	Jessica Franklin	Policy Lead
9		Long-Term Care Commission
10		Secretariat
11	Angeline Hawthorn	Senior Policy Analyst
12		Long-Term Care Commission
13		Secretariat
14	Rose Bianchini	Senior Policy Analyst
15		Long-Term Care Commission
16		Secretariat
17	Angela Walwyn	Senior Policy Analyst
18		Long-Term Care Commission
19		Secretariat
20	John Callaghan	Co-Lead Commission Counsel
21		Gowling WLGN
22	Peter Gross	Commission Counsel
23		Gowling WLGN
24	Kavi Savisothy	Commission Counsel
25		Gowling WLGN

1 --- Upon commencing at 9:01 a.m.

2

3 LEAD COMMISSIONER FRANK MARROCCO:

4 Before you start, the UHN's been here
5 before, so I'll skip the formal introductions.
6 There is a transcript, which we post on our
7 website, so that people can see what we're up to
8 and we will do that in this case.

9 Mr. Gross, go ahead.

10 MR. GROSS: Okay. First of all, thank you
11 everybody from UHN for coming to speak to us this
12 morning and giving us your time.

13 And I understand that there isn't a
14 PowerPoint, so we'll have a dialogue back and forth,
15 and if anything I ask you is not clear, please feel
16 free to stop me, jump in, interrupt me. I'm used to
17 it.

18 Who would like to start?

19 MS. HOTA: It's Susy Hota here. We were
20 thinking maybe what we could start with is I understand
21 that the interest and the focus here is on hearing a
22 little more about the experience with St. George
23 Community Care and some of the contributors and some of
24 our thoughts around there.

25 So I was thinking maybe I'd start with what

1 is -- how we synthesized the outbreak and contributors
2 to the outbreak.

3 And then Joanne has some comments, I'll pass
4 it on to her, about the environmental aspects that I
5 think are interesting and relevant. So if that's okay,
6 I'll get started with that.

7 MR. GROSS: That's fine.

8 MS. HOTA: Thank you.

9 So one of the things -- I think there are a
10 few themes that I'd like to highlight that played a big
11 role in how this outbreak transpired. One of them had
12 to do with leadership and I'll start with some of the
13 comments about the leadership, locally at St. George,
14 that I think is important.

15 First of all, I think I mentioned this the
16 last time that we met, but the leadership there is
17 quite a young and inexperienced team. And some of that
18 became apparent in terms of the way that they
19 interacted with their staff.

20 There was a lot of, I think, work that was
21 happening in their offices in the back rooms and less
22 interaction with the frontline staff and so that
23 engagement was a bit of a challenge when it came to
24 trying to hold people accountable. And I do want to be
25 just sensitive, but honest about some of these

1 experiences.

2 And one of the examples of this that I think
3 may have led to some of the transmission that we saw in
4 the outbreak had to do with their, sort of, challenges
5 in implementing staff cohorting, which is really
6 important. That means keeping the staff members to
7 their floors and not having them work elsewhere.

8 We checked in repeatedly through the
9 outbreaks on whether this was occurring and how well it
10 was occurring, and were always reassured that it was.
11 But unfortunately, it was -- the middle of January
12 where we discovered that there was still many instances
13 where people were working on multiple floors. So that
14 was just one example of some of the challenges around
15 there.

16 We had encountered, throughout this outbreak
17 and even prior to the outbreak, some resistance from
18 the local leadership to implement some of the
19 recommendations that we've made. And even just, for
20 example, have us bring a third party in to do HVAC
21 assessments, which has become a standard, routine part
22 of our, sort of, infection control assessments, the
23 passage of assessments that we do for all of our homes.

24 And so that, I think, resulted in delays in
25 actually implementing some important control measures

1 and revealing some of the issues that I'll speak to you
2 around the HVAC.

3 There were also some challenges with
4 leadership on the Sienna end. We did engage with one
5 of the VPs when we, early on, recognized there was a
6 problem with leadership and implementation of some of
7 the measures that we thought were critical to managing
8 the outbreak back in November, but there was really no
9 follow-up and we didn't really get good evidence of
10 change. And it wasn't until things really exploded
11 with the outbreak that we saw more presence of the
12 corporate leadership on site and also present on all of
13 our meetings.

14 And then they really did kick in and I think
15 we got some excellent resources and supports that were
16 put into place. The corporate IPAC support that was
17 brought in has been very helpful in managing the
18 outbreak, as well as the CMO, Dr. Moser, from Sienna,
19 who's really been instrumental in kind of turning the
20 corner and providing a lot of the medical, hands-on
21 even, support when needed at the home.

22 We encountered some issues around
23 communications that I think are actually quite critical
24 because, you know, that's one, of course, the backbones
25 of outbreak management is having good outbreak

1 management team meetings and effective communication
2 amongst the team.

3 They had, at Sienna, actually implemented IMT
4 meetings or I believe it's intimate management team
5 meetings on a regular basis. They do that daily.
6 That's part of their usual operations through this.

7 We were trying to get dedicated outbreak
8 management team meetings to occur so we could not just
9 focus on what the data was, case counts and things like
10 that, but also talk about control measures and, again,
11 have an eye to the implementation and any barriers that
12 were coming -- they were coming across and implementing
13 the control measures so we could troubleshoot together.
14 And it took a lot of convincing to have that happen.

15 And part of the problem was they felt there
16 was too much overlap between these meetings. But what
17 they weren't really seeing is that the IMT meetings
18 were very focused on their KPIs and very
19 metrics-focused. And it was really going, kind of,
20 going through a list of, you know, audits a hundred
21 percent and people weren't questioning how is that all
22 of your PPE audits and your hand hygiene audits are a
23 hundred percent compliant, but we're still facing these
24 problems?

25 So there wasn't enough dialogue in those

1 meetings, so it took a while to overcome that, but I
2 think that the focus on the numbers and not so much on
3 the issues was part of what we struggled with earlier
4 on in the outbreak.

5 LEAD COMMISSIONER FRANK MARROCCO: Did you
6 form a view about why you were having -- why you were
7 having that difficulty?

8 MS. HOTA: I think one of the problems was it
9 might speak a little bit to the tension between the
10 local leadership and the corporate leadership. And
11 they're really -- my impression and I'm speaking about
12 my impression, was really that the local leadership
13 felt the Sienna leadership wanted to hear about the
14 numbers. They wanted to hear about the metrics and how
15 well they were doing with the metrics. And they didn't
16 necessarily want to delve into the nitty gritty and the
17 details of, you know, the issues around garbage cans
18 and things like this that really are actually important
19 in facilitating the human factor side of infection
20 control, but they didn't feel it would interest the
21 corporate leadership.

22 And so that was one of the challenges of the
23 IMTs with having such high level representation there
24 and so many individuals. You can't get into those
25 little details that end up making a difference with

1 outbreak management.

2 COMMISSIONER JACK KITTS: Just a quick
3 question, and I apologize if I missed it at the
4 beginning, St. George had a number of outbreaks, one in
5 the first wave, I think, in April and then a few in
6 September and November, December, whatever.

7 Which -- was UHN involved in each of the
8 outbreaks or which -- are you speaking to one
9 particular outbreak?

10 MS. HOTA: I'm speaking to the most recent
11 outbreak which was quite large and I think got some
12 real attention because of the size of the outbreak.
13 The attack rate in that outbreak was quite high in that
14 the number of residents and staff members compared to
15 the denominator was more than you would expect to see.

16 We did get -- we were involved in previous
17 outbreaks there, but they were all very limited. And
18 despite that, we did see some of these issues in
19 earlier outbreaks and tried to resolve and overcome
20 some of them with them. But there were these -- the
21 issue of having resistance to change is something I
22 would say has woven through this entire experience.

23 Many of these other observations only came
24 out when we were able to get in there and provide the
25 kind of support that we're giving now, because if you

1 looked at everything on the surface, if you attended
2 meetings to discuss these problems, you would not see
3 them.

4 COMMISSIONER JACK KITTS: Okay. A lot of the
5 questions now and, the Commission has the same
6 questions is, what did we learn from Wave 1 and did we
7 implement it to try and mitigate Wave 2? So if you can
8 keep that in mind, we're interested in your thoughts
9 about things that should have been done between Wave 1
10 and Wave 2.

11 MS. HOTA: Yes. And as, I guess, a general
12 commentary, many of the things that we speak -- I'll
13 speak about here, we did see some the issues. We tried
14 to address them. Quite often, your assessment only
15 goes as deep as you're allowed to go when you're
16 interacting with individuals at the homes.

17 And we were often reassured that, for
18 example, and you'll hear from Joanne about
19 environmental management in the home, that everything
20 was fine. And even on our site visits, you can't see
21 what the actual practices are unless you spend a lot of
22 time there.

23 So I think that's what this experience has
24 allowed us to see is a much deeper dig into what was
25 actually happening on the ground.

1 MR. GROSS: Dr. Hota, I wonder if you might
2 be able to just step back to the beginning a little bit
3 and just give us, sort of, an overview of what type of
4 homes this is, physical constraints it might have.
5 What makes it unique as far as the demographics, if
6 anything?

7 MS. HOTA: Sure. So St. George is a
8 long-term care home. It has about 200 beds, plus or
9 minus. And it mostly has individuals who are a little
10 bit younger than your typical long-term care home
11 resident, but has more mental health and addictions
12 issues as well as people with a lot of other underlying
13 health problems. So it's a bit of a medically complex
14 population, but mental health and the addictions issues
15 are quite prevalent there.

16 I don't know, Joy, if you wanted to say
17 anything else about the population? I can talk about
18 the physical plant because that was something I was
19 going to get into next anyways.

20 MS. RICHARDS: No, I think you've covered it.
21 There's 268 beds in the home of which -- under the
22 directives of limiting the number of folks in beds is
23 158. So I think you've covered it.

24 It's a younger population. A lot of males.
25 And addiction and mental health issues are the primary

1 concern that cause a lot of the noncompliance on the
2 resident side as a result.

3 LEAD COMMISSIONER FRANK MARROCCO:

4 Before you go, and then I'll let you
5 carry on with what you were doing, do you have a
6 view about whether there's an optimum size?
7 Whether there's a point where these homes are
8 too big based on your experience?

9 MS. HOTA: Yeah, I guess I'll just make my
10 comments and then I'm sure -- I'd be interested in
11 hearing Joy and Rebecca's thoughts on this as well.

12 I think it depends on the population really
13 and what the building's like. It really is dependent
14 on those two factors.

15 For St. George, 268, is that correct, Joy, as
16 the physical capacity? That would be, I think, far too
17 much for what they can accommodate.

18 Joy, do you have thoughts on that?

19 MS. RICHARDS: Yeah, I would agree. I mean,
20 I've worked in really large long-term care homes that
21 have had a thousand beds and the care has been
22 exceptional.

23 I think it really comes back to how the
24 leadership and the design of each of the units are.

25 So in this particular case, this building

1 doesn't really accommodate for folks who have
2 behavioural issues related to addiction and mental
3 health. And a large population of smokers, for
4 example, in this population who want to go outside and
5 smoke.

6 So I'm not sure. It's a really interesting
7 question. I'm not so sure it's about the size. It's
8 about the leadership and the structure.

9 Rebecca may have some thoughts on that.

10 MS. REPA: Just some past life work on
11 optimum size in redesign has said that patients prefer
12 smaller so, you know, 40 to 80 is preferential. And
13 when you look at how patients make their decisions
14 around ranking their selection, they like the smaller
15 homes. They think they'll be a bit more intimate.

16 The efficiency of the funding formula
17 suggests that less than 80 doesn't really make sense in
18 terms of an efficiency point of view.

19 And in order to get the best outcomes with
20 respect to shared resources like physio, and speech
21 pathology and rec therapy, all of which you can't
22 afford for a 40-bed home, 200 is sort of the number
23 that seems to maximize the allied health across in a
24 way that gives residents access to other disciplines
25 other than nursing care.

1 LEAD COMMISSIONER FRANK MARROCCO: I guess my
2 issue was, intuitively you would think the larger the
3 home the more institutionalized it would be. And the
4 smaller, the more homelike it would be. And that's
5 what was prompting my question.

6 MS. REPA: So we're going to talk a little
7 bit about the regs, actually, in our conversation
8 today.

9 So the regulations really do, in design of
10 even in size of building, force you to create those
11 homelike pods. And they're pretty consistent in terms
12 of it isn't, sort of, a hospital-like design where you
13 have rows of beds. Even in a 200-bed facility in past
14 ones that I've been part of designing, they are grouped
15 in pods and smaller groupings, so I think it's possible
16 to do that. I don't think larger necessarily means
17 institutional. Larger sometimes means greater access
18 to resources.

19 So from my perspective, I don't know that
20 size in this case is the issue. I think the regs
21 probably help to make sure that that environment's
22 maintained.

23 LEAD COMMISSIONER FRANK MARROCCO:

24 Okay, thanks.

25 MR. GROSS: Can I ask one follow-up question

1 and then I promise I will not interrupt? You mentioned
2 that a lot of the residents tend to be younger than the
3 average cross-section for a long-term care home and
4 that many suffer from addictions and mental health
5 issues.

6 And I'm just wondering if you have any
7 knowledge, are the staff at that home, do they have any
8 specialized training so that rather than just putting
9 these people away, they can help with their addiction
10 and their mental health problems? Such as, I know
11 wandering is a problem. Or behavioural problems that
12 would prevent cohorting might be exacerbated in a
13 cross-section of residents of that nature. Is there
14 any specialized training or do you know?

15 MS. RICHARDS: I can respond to that. There
16 is not. I think that's one of the challenges. I think
17 they have strong relationships, so they've gotten to
18 know these residents over the years and are very
19 committed to their care. But they do not have
20 specialized training. The leadership doesn't have
21 specialized training.

22 And there are unique needs there, for
23 example, monitoring psychotropic medications and making
24 sure that their medications on the psychiatric end and
25 the addictions end are adjusted to meet their needs.

1 Not good assessments for that either.

2 So I would argue, the physicians are probably
3 not -- they're GPs, they're not specialized.

4 And this home, if I had to recategorize it, I
5 would not actually make it a long-term care home. I
6 would actually have a mental health overlay and a
7 different structure for this particular home.

8 It is very unique from other long-term care
9 homes that we've been involved in.

10 LEAD COMMISSIONER FRANK MARROCCO:

11 Thank you. Dr. Hota, would you like
12 to continue?

13 MS. HOTA: Yes. I will just make one mention
14 of environmental services and the management of the
15 environment, but Joanne will go on to comment on some
16 of these really important points.

17 But what we did uncover relatively late into
18 the outbreak, unfortunately, is that the quality of the
19 environmental cleaning and disinfection in the home was
20 not what we had been told it was or what we were -- our
21 impression was.

22 And in the end, I do think a major
23 contributor to transmission in this outbreak was that
24 we were trying to cohort positive residents, which is
25 the right thing to do, but in doing so, there were a

1 lot of bed moves, and unfortunately not appropriate
2 terminal cleans of those spaces, so the individuals who
3 then occupied the space were exposed. So I do think
4 this played a big role in transmission and is
5 unfortunate that it occurred.

6 We did talk a little bit about -- you asked
7 about the design of the environment and this is another
8 important factor. It's a very old building. It has a
9 lot of multi-bedded rooms and the attack rate within
10 these multi-bedded rooms was virtually 100 percent. I
11 mean, if you shared a room with somebody who had COVID
12 in this organization, you were likely -- you were going
13 to get it.

14 It was very cluttered and it still is. We've
15 been doing a ton of work to improve on this and I think
16 it's in a better place now, but very cluttered
17 environment, lots of wheelchairs and other items, even
18 just chairs and old furniture that was in the
19 environment that made it very difficult to clean and
20 also to manage flow of individuals within that area.
21 And so that was also, I think, a significant factor.

22 The building itself is overall in disrepair.
23 There are some major problems that I think Joanne will
24 speak to perhaps with the physical infrastructure.

25 But also the ventilation. And we did have

1 some difficulty getting in to have an HVAC assessment
2 done, but it was done this month and unfortunately
3 revealed that there was no fresh air coming into the
4 facility.

5 There were some issues in terms of the
6 dampers for the air handling units on the rooftop, the
7 intake, and there was also some mold issues that are
8 being explored and remediated right now. So
9 significant concerns about the quality of the air that
10 was in the facility.

11 I just have a couple of other comments in
12 terms of staffing. You did ask about the
13 appropriateness of the training of the staffing. I
14 think because they had such a large outbreak, it became
15 apparent they also just did not have the number of
16 staff at the time or they had such acutely infected
17 individuals within the home, it was insufficient. And
18 that has been improved upon, but that was a concern for
19 sure in terms of being on top of who is becoming
20 symptomatic and the kind of surveillance needed.

21 And then the resident population we just
22 talked about, but it certainly did make it difficult
23 for us to implement some of our IPAC measures and we
24 had to be creative around how we managed it.

25 And the issue of the smokers wanting to go

1 out for smoke breaks is actually a contributor as well
2 because that took a lot of work to try and design to do
3 in a safe way, given their physical set up.

4 So I think if it's okay with you, I'll pass
5 it on to Joanne Bridle to say something.

6 LEAD COMMISSIONER FRANK MARROCCO: Can I ask
7 one question, Dr. Hota, about the staff? Was there a
8 designated IPAC specialist who ensured that the
9 training and education on using the PPE was up to the
10 speed it should be for -- particularly in the midst of
11 an outbreak?

12 MS. HOTA: So they had an ADOC, an assistant
13 director of care, who was given the title of being the
14 IPAC lead, but unfortunately did not have any IPAC
15 training and was asked to get training repeatedly, but
16 it didn't happen over the course of this outbreak.

17 Beyond that, there was nobody else in the
18 home that had any kind of IPAC responsibility in
19 particular. As I mentioned, they did pull in somebody
20 from Sienna Corporate with IPAC experience and that's
21 been help.

22 LEAD COMMISSIONER FRANK MARROCCO:

23 Thank you.

24 MR. GROSS: Did you have any comments about
25 the medical director that was in place at the time when

1 you arrived?

2 MS. HOTA: I do.

3 The medical director was present at the
4 outbreak meetings, which is a good step, however, quite
5 often disagreed with what public health and what I
6 would recommend. And sometimes was quite adamant about
7 certain measures being in place, certain testing
8 criteria, sometimes questioned whether a positive
9 result was truly a positive result.

10 You know, I'm open to discussions in these
11 meetings, it's the purpose of the meeting so that
12 everyone understands what is happening and why, however
13 at times it was a bit disruptive and that was really
14 the extent of my interaction with the medical director
15 during the outbreak.

16 LEAD COMMISSIONER FRANK MARROCCO: If I can
17 just -- before we move on.

18 I'm having some difficulty understanding why
19 UHN would be -- having difficulty implementing its view
20 concerning what's necessary to get the outbreak under
21 control.

22 Was the local Medical Officer of Health
23 engaged? Because they can, of course, make orders and
24 was the Ministry's inspectors engaged? Because I think
25 they also have authority.

1 MS. HOTA: Absolutely.

2 LEAD COMMISSIONER FRANK MARROCCO: I'm having
3 a little difficulty understanding why you have to
4 engage in a debate or persuasion with people who have
5 got a real problem on their hands. Can you talk to
6 that?

7 MS. HOTA: I'm happy to try and explain that.

8 So the local AMOH from Toronto Public Health
9 was absolutely involved and continues to be and we've
10 got an excellent relationship and we see things very
11 similarly.

12 And the way that these IPAC hubs have been
13 set up with long-term care homes, they lead Toronto --
14 Toronto Public Health leads outbreaks. We are there to
15 provide recommendations and additional support, so UHN.
16 But we work very collaboratively together in
17 essentially leading outbreak management and infection
18 control advice. Giving infection control advice.

19 It is up to the home to implement all of
20 that. And the homes gave us the impression, when we
21 would check in with them, even with site visits, that
22 these things were underway or had been done. But until
23 you spend the time to actually truly follow up with
24 every detail on that, unfortunately the deficiencies
25 were not apparent immediately.

1 So we found out about some of these things
2 quite late into the outbreak. And it came right down
3 to even doubting the numbers at one point.

4 In early January, they had brought in an
5 interim executive director to help with the situation.
6 And it became apparent as he was going through the
7 numbers, and as things were being reconciled, that the
8 data was not adding up completely in terms of case
9 counts and resolved cases and how we categorized the
10 cases within the home, which was a big eye opener to me
11 because everything depends upon that.

12 We make our decisions depending upon what
13 those numbers are. And it helps to us to understand
14 progress through an outbreak. So we have no way of
15 knowing that the numbers we are being told are
16 incorrect until you really dig deep.

17 MR. GROSS: Were the numbers low balled in
18 your opinion?

19 MS. HOTA: They were actually not off by
20 much. It was a minor reconciliation, but to me that
21 introduced some concern and doubt as to what all of the
22 numbers would mean or the feedback that you get.

23 And it's been a real learning curve for us in
24 terms of the importance of how much on-site presence
25 you need to have in supporting the homes.

1 LEAD COMMISSIONER FRANK MARROCCO:

2 Commissioner Coke?

3 COMMISSIONER ANGELA COKE: Just following up
4 on the question before, what was the involvement of the
5 Ministry inspection folks? So I understand you're
6 saying they have to do the implementation, but who else
7 is checking that the implementation is in fact
8 happening and what consequences if it's not?

9 MS. HOTA: They were present -- the Ministry
10 of Long-term Care inspectors were present at outbreak
11 meetings, so they would hear the updates and they would
12 hear what's happening with the outbreak on those
13 meetings.

14 Beyond that, I'm not sure, Joy, if you have
15 any more information about their involvement.

16 MS. RICHARDS: They do come on site, but I
17 actually think they're not asking the right questions.
18 So I would have thought that they would have had a much
19 better handle on some of the deficiencies in the
20 environment. That they would have a much better handle
21 on issues like falls and pressure ulcers and skin
22 injuries that they don't really report on.

23 So some of the basic care issues that I would
24 expect that usually happens when inspectors come in
25 wasn't happening. Right down to, you know, going in to

1 resident washrooms and rooms to see mold and mildew and
2 reporting those things.

3 So I think -- and I've had conversations with
4 Andrew Wisdom about this. I think how the inspectors,
5 what they ask and what they look for, I think probably
6 could use a review.

7 LEAD COMMISSIONER FRANK MARROCCO: Why
8 wouldn't -- I'm still stuck on the idea that if the
9 acting medical officer of health is engaged and you
10 want to do something to try and get the outbreak under
11 control, I'm having some difficulty with why they
12 simply wouldn't order, under the legislation, order
13 them to do it if there's any kind of resistance.

14 Is there a cultural thing there about making
15 orders? Well, maybe you can't answer. I don't want to
16 ask you an unfair question, so but is there?

17 MS. HOTA: I'm not sure I can answer. I
18 think maybe what I haven't been able to convey well
19 enough is many of the deficiencies and the drivers in
20 this -- what I believe are the drivers in this outbreak
21 were fairly subtle to uncover and they occurred over
22 time.

23 And my impression, maybe it's incorrect, is
24 an order would be issued by public health if something
25 egregious was happening that needed immediate

1 addressing.

2 But, you know, when you're dealing with a
3 series of things that you flag and you're being told
4 are, yes, we understand, we'll take care of that,
5 it's -- you feel like you have to give them a chance to
6 deal with it, perhaps. Maybe that's what it was.

7 And what is the threshold? That's a good
8 question. What is the threshold for escalating it
9 beyond that? Maybe that was -- maybe that's what the
10 problem is, is that it's not always clear that there is
11 a big problem in the implementation side until you see
12 it physically yourself or you see that pattern emerge.
13 And, you know, once we saw the pattern emerge, I think
14 that's where things really escalated.

15 COMMISSIONER JACK KITTS: So can I just
16 follow up on that? So the local public health officer
17 does their job; they lead the outbreak. UHN does their
18 role; they come in and they make recommendations and
19 offer direction. The homes are tasked to execute the
20 recommendations. And where it falls down is nobody
21 checks to see that the recommendations or the actions
22 have been taken.

23 So my question would be, and I think that's
24 where Commissioner Marrocco is going, should someone be
25 appointed to ensure that the recommendations are

1 implemented and would that be UHN?

2 LEAD COMMISSIONER FRANK MARROCCO:

3 You're nodding. You're nodding, yes.

4 But --

5 MS. HOTA: I think, you know, it's been a bit
6 of a perplexing experience, I have to say, through all
7 this. And I've never quite been in an outbreak that's
8 kind of progressed this way.

9 So I'm open to thinking about all the
10 different ways that this could be managed differently.

11 And I don't know if Joy or Rebecca or anyone
12 else has other thoughts about this.

13 Ultimately I'm a big believer of the folks in
14 the home have to be accountable for implementing things
15 in the end. Some of that accountability has to be
16 ingrained there or else the frontline staff there are
17 not going to feel the ownership to do things.

18 So that was really the model that we were
19 trying to operate under for as long as we could.

20 MR. GROSS: So I just have a follow-up
21 question and I apologize if you've answered this.

22 I'm trying to figure out if -- so the local
23 medical officer knows what's going on and is involved.
24 You have calls with the investigations unit or folks
25 from that unit, I guess, on a daily basis.

1 Did investigations ever come into the home to
2 see whether an order by them to -- an order to comply
3 was necessary? Did anybody show up on the ground to
4 back you up and to go check for the mold in the
5 bathrooms, to see if there was garbage cans where they
6 needed to be, from the Ministry?

7 MS. HOTA: From the Ministry? I don't think
8 so. I think they're there now. Is that correct, Joy?

9 MS. RICHARDS: That's correct. There's an
10 advisor on site now for two weeks.

11 But we were having conversations. We met
12 weekly with Ministry and public health and UHN to talk
13 about all of the homes and we did raise this, but to my
14 knowledge, there was no one on the ground during this
15 timeframe actually following up.

16 MR. GROSS: And does that surprise you?

17 MS. RICHARDS: No.

18 MR. GROSS: Why not?

19 MS. RICHARDS: Well, I think to speak to the
20 broader culture in long-term care, there is a sense,
21 particularly in some of these smaller homes or homes
22 that are under corporate management, that they don't
23 want people poking around.

24 And so they say what you want -- what they
25 think you want to hear and they don't want external

1 people coming in. They manage under a bit of a cone of
2 silence and there's a lack of a sense of urgency.

3 I think the thing that always struck me with
4 St. George is that we were really, really concerned and
5 we couldn't somehow get the leadership on the ground or
6 corporate leadership, because before the voluntary
7 management order, we did escalate up through the senior
8 team that there was sort of a lack of urgency across
9 all of the leadership, both locally and at the
10 corporate level, that this was a big problem.

11 So I think it's not unique to St. George. I
12 think it's a culture in long-term care where it is a
13 homelike environment, there isn't the same knowledge
14 base, particularly on the clinical side, around some of
15 these medical assessments and care assessments that
16 need to be done. So I do think it's a broader cultural
17 issue in long-term care.

18 LEAD COMMISSIONER FRANK MARROCCO:

19 It's a strange thing, though, because
20 in your own home if you have -- if you think
21 there's a mouse in the house, you turn the place
22 upside down trying to get rid of it, let alone a
23 virus that's capable of killing people.

24 I don't know what lengths you would go to in
25 your own home if you thought that that was the case.

1 It's not just -- it's not just confusing or perplexing
2 to UHN, it's perplexing to us.

3 But anyway, I'll let you carry on.

4 MS. RICHARDS: I'll just make one last
5 comment.

6 LEAD COMMISSIONER FRANK MARROCCO: I don't
7 understand it myself.

8 MS. RICHARDS: Yeah, I think part of it is
9 what Susy talked about before is the inexperienced and
10 young leadership team on the ground. I actually do
11 believe they were, quite early on, overwhelmed and
12 their way of coping was just to kind of pretend it
13 wasn't there. So I do think leadership plays a key
14 role, as we talked about at the beginning of our
15 discussion.

16 COMMISSIONER JACK KITTS: And just to
17 confirm, nobody from corporate came to the rescue until
18 much later and even then needed to be coaxed when UHN
19 was in there?

20 MS. RICHARDS: Correct.

21 MS. HOTA: Correct. And fairly early on, we
22 did engage in ongoing discussions with a VP in
23 corporate because we were concerned about some of the
24 leadership issues, but I did not see more on-site
25 presence or presence at outbreak meetings until much

1 later.

2 COMMISSIONER JACK KITTS: So that coincides
3 with the culture of secrecy and lack of urgency?

4 MS. RICHARDS: Correct.

5 MR. GROSS: And I take it, you were -- it was
6 well-known that they, as a home, were classified as
7 high risk for an outbreak since May?

8 MS. HOTA: Yes.

9 MR. GROSS: And inspections never showed up,
10 to your knowledge?

11 MS. HOTA: I was unaware of any.

12 MR. GROSS: So I wonder if -- there's a lot
13 of probably interest in what Joanne has to say.

14 Is there anything else, Dr. Hota, that you'd
15 like to say?

16 MS. HOTA: I'm all done.

17 MR. GROSS: Okay. Joanne, what can you tell
18 us?

19 MS. BRIDLE: Thanks. I see there's an
20 interest in environmental services.

21 MR. GROSS: There is. I think there's great
22 interest.

23 MS. BRIDLE: Thank you.

24 To echo the themes that Susy and Joy both
25 brought forward, I do believe that those themes of

1 resistance and this culture of keeping outsiders away
2 and uninformed, and gaps in communication and junior
3 leadership all are huge contributing factors, not only
4 in this outbreak, but the foundation that set the ball
5 in motion when we came on site in December during this
6 large outbreak.

7 Prior to the outbreak in May, and again in
8 October, my team and I did try to go on site and
9 complete the environmental portion of the IPAC check
10 list and faced an awful lot of resistance from the
11 on-site leader at that time.

12 We were able -- some of my team were able to
13 go on site for very brief visits that were very tightly
14 controlled.

15 As I reflect, I believe had we had more
16 opportunity and more willingness and collaboration,
17 some of the underlying gaps in the environmental
18 services program may have been resolved before the
19 outbreak and perhaps may have helped eliminate some of
20 the contributing factors.

21 Environmental services is a really crucial
22 piece of the IPAC measures and operationalizing those
23 IPAC measures. And on-site was a true gap between the
24 IPAC directives and operationalizing those.

25 So when we came on site, realized that there

1 was some really apparent gaps that were contributing,
2 and I'll go through a few of those.

3 The first -- from where I sit, my concern is
4 that these are all quite simple things and also go back
5 to some of the junior leadership and inexperience,
6 unfortunately.

7 Before I go into them, though, I will say and
8 I do need to say, that the team that are on site for
9 environmental services, as well as senior director
10 we're working with now on site for Sienna, have been
11 very responsive. So as we've brought these concerns
12 forward, as we've brought them forward, they have been
13 very open to helping us get things done. It's
14 unfortunate that we weren't in that position prior.

15 So one of the things is proper selection of a
16 disinfectant for an outbreak. When we went on site, I
17 was told that the disinfectant in use had a one-minute
18 kill time; observed that the disinfectant was not being
19 used and applied properly. And as soon as I saw the
20 disinfectant, realized it's actually a product that has
21 a five-minute kill time. Surfaces were wet, I
22 observed, for about 30 seconds. And that was the
23 product being generally used to disinfect all fomites
24 in the organization.

25 So raised that concern immediately. They

1 switched to a product with a one-minute kill time. We
2 trained all of the home staff and the agency staff on
3 proper application of the disinfectant to ensure that
4 any bacteria and viruses on the surface would be killed
5 within one minute.

6 MR. GROSS: And just to be clear, they had
7 the disinfectant in stock --

8 MS. BRIDLE: Absolutely.

9 MR. GROSS: -- is that correct? They just
10 weren't using it.

11 MS. BRIDLE: Correct. Storeroom full of all
12 kinds of things.

13 So, you know, I don't want to speculate as to
14 why they were not using the right product, but it's
15 unfortunate. And when I explained why we needed to use
16 it, how to use it, it was no problem, we made that
17 transition in one day.

18 And then it was reinforcing it with the staff
19 to ensure that the application was saturated properly
20 so that the disinfectant would work.

21 One of the other immediate observations is
22 that the staffing levels were quite low. On a routine
23 basis prior to the outbreak in the home, and there's
24 five floors in the home and there are 21 or 22 beds on
25 each floor with 40 to 41 residents, and the prior

1 staffing levels was one housekeeper per day per floor,
2 which is not sufficient to meet HYDAC best practices by
3 any means to properly clean each room, as well as the
4 common areas, the nursing station, dining areas, on
5 that floor.

6 When we went on site, that one housekeeper
7 was on per day as well as an agency person doing high
8 touch cleaning on each floor, raised that concern. And
9 the contractor, Marquis, did begin to bring in extra
10 agency staff after they were swabbed. Within a few
11 days, those staff were on site so we could train them
12 and ensure that the rooms were being properly cleaned.

13 Through that process, it was also quite
14 apparent that the staff that were on site also needed
15 training. I was continually and unfortunately told
16 that the staff were trained and knew what they were
17 doing, but it was quite apparent by observation that
18 that was not the case. So we've been able to work that
19 forward and ensure proper training is in place. That's
20 still a work in progress.

21 But to Susy's point, I think we both share
22 the concern that the lack of proper terminal cleaning,
23 with all of the bed moves, is a factor in the spread of
24 this outbreak.

25 The level of cleanliness across the building

1 was very low. At the same time, as Susy alluded to,
2 the daily IMT meetings, or Incident Management
3 Meetings, reflected really strong environmental audit
4 scores.

5 So they were doing glo germ audits, so
6 fluorescent marker audits on surfaces, five to ten
7 audits a day, and those scores, most days, tended to be
8 in the 80s or 90s, which would indicate that touch
9 surfaces were being wiped. However, there were no
10 audits being done of the actual cleanliness and a full
11 audit of the space.

12 Because of the high amount of clutter in the
13 building, the staff were unable and uninterested to
14 move all of this extra furniture, all of this extra
15 clutter and boxes to properly clean areas, so that's
16 been a huge focus of the team.

17 The housekeeping carts were dirty, the brooms
18 were broken, their micro fibre was worn out, so they
19 also didn't have the tools to be able to clean
20 properly. So we've been able to get some of that
21 changed as well.

22 As Susy mentioned, the leadership team as a
23 whole are quite young and inexperienced and
24 environmental services is no different. So certainly
25 no disservice to the folks, but the supervisor on site,

1 and this is her first job out of college so it's great
2 that she does have the two-year college program for
3 environmental management, and she reports to the
4 environmental service manager for the home who is
5 Sienna. So you've got two different contract groups
6 looking after environmental management in the home.

7 So there's a bit of a disconnect there and
8 there's also some concerns about gaps in the scope
9 between who does what between Marquis and Seinna.

10 There has been some mention of the regs. And
11 one of the concerns that I have is the regs really,
12 from an environmental are the other accommodation
13 envelope manager, being environmental services, laundry
14 and maintenance, that individual is to have completed
15 two years of post-secondary education and have two
16 years of supervision.

17 There's no requirement for that individual to
18 have any training in environmental services management
19 or maintenance management.

20 In 92 of the regs, I do see that as a gap,
21 particularly in contrast to dietary, where the dietary
22 manager is to be a registered dietician or have their
23 CS&M.

24 Those frontline staff in dietary need to have
25 completed their food handler. There's no requirement

1 for the frontline environmental services staff to have
2 any training.

3 And so to have frontline staff that don't
4 have proper training, to have managers who don't have
5 any credentials in the field, I'm concerned that sets
6 the provincially long-term care for failure.

7 MR. GROSS: Joanne, am I correct that when
8 you arrived, the IPAC lead had no training whatsoever
9 in IPAC? Is that correct or am I misstating that?

10 MS. BRIDLE: Yes, that is true. So there was
11 a corporate resource from Sienna that was on site and
12 that corporate resource does have IPAC training. And
13 at the point that I arrived on site, our UHN IPAC lead
14 for LTC had been on site as well.

15 LEAD COMMISSIONER FRANK MARROCCO: We've
16 heard this before. Is there some reason why there
17 would be a person in charge of IPAC who doesn't know
18 anything about IPAC? Is there a shortage of these
19 people? Why?

20 MS. HOTA: I think that's part of the
21 problem. So there aren't people with IPAC training who
22 are waiting in the wings for a job. It's -- there is a
23 shortage of individuals who are already trained and
24 have experience in the field to hire.

25 But I think the problem here was, you know,

1 the individual who's assigned this was asked to get
2 specific IPAC training and did not carry through. And
3 they're just -- I think it speaks to a lack of
4 accountability because that was not managed. So that
5 was part of the problem.

6 LEAD COMMISSIONER FRANK MARROCCO: So in
7 addition to whatever inspection and follow up the
8 Ministry is undertaking, the corporate ownership is not
9 following up either. Otherwise they would have
10 realized that the IPAC person who was supposed to get
11 some training had not taken the initiative to actually
12 get the training.

13 MS. RICHARDS: Well, the IPAC part of the
14 role is added to an assistant director of care role.
15 And so it's a bit of an off-the-side-of-the-desk.

16 So if you were to ask that person, she would
17 have seen herself as the associate director of care,
18 assistant director of care and, on the side, IPAC.

19 So we had been pushing in November for this
20 person to get trained up. But I think the gap in the
21 system is that there needs to be dedicated IPAC -- a
22 role specific to IPAC in each of these homes, not an
23 add on to other clinical or environmental roles.

24 MS. BRIDLE: And the other piece of that that
25 I see as a disconnect because it really is a chain and

1 we need to break the chain of transmission with
2 infection. Even if there was an on-site IPAC person,
3 that person needs to be linked very closely with the
4 environmental services management team to
5 operationalize those directives. What we have seen,
6 unfortunately, is a lot of time in the office by IPAC
7 people trying to fix line lists.

8 So our UHN IPAC lead has been very
9 instrumental in working with me and then I leading the
10 on-site environmental team to be able to get proper
11 operational practices in place under direction of IPAC.
12 But if we sit back and look at it, it feels quite
13 broken had we not been there.

14 One of the other things that feels concerning
15 is the -- is really the staffing levels and being able
16 to meet a level of cleanliness and standard.

17 As you know, the regs don't outline a
18 standard for cleanliness in acute care. Our goal and
19 our direction is to follow the PIDEF best practices.
20 And we use those as our standard and requirement for
21 cleaning. There is no such requirements in long-term
22 care, so unfortunately it feels that there isn't as
23 much of a focus on cleanliness and proper disinfection
24 and infection control practices in long-term care. And
25 consequently, the staffing levels, because they are

1 also not outlined in the regs, suffer. That other
2 accommodation envelope tends to get broken up into many
3 different ways.

4 If we were to contrast that to dietary, the
5 dietary regs are very clear, and there's five or six
6 pages if you're to print it off in the regs for
7 dietary, that clearly outline the expectations around
8 how you manage a food service operation. How you
9 manage hydration in a long-term care home.

10 And so the dietician hours are a formula
11 based on the number of residents in the home. Thirty
12 minutes per resident per month. The dietary manager
13 calculations are also very clear as well as the
14 credentials that I've mentioned.

15 The frontline dietary staffing levels are
16 also very clear. They are a formula. And what is in
17 and out of that formula is quite clear. That time is
18 only focused on resident food production service.

19 If you contrast that to a very small section
20 in the regs around housekeeping, there are no standards
21 around staffing levels. The home's expected to have
22 practices and processes documented around cleaning and
23 that's it. There's no standard for staffing levels.
24 And there's no such standard for what those cleaning
25 levels should be.

1 So I'm concerned that the regs set an
2 underlying framework to the situation we've walked
3 into.

4 MR. GROSS: I think Rebecca has been waiting
5 patiently and I think she probably has some valuable
6 information for us.

7 May I turn to you, Rebecca?

8 MS. REPA: Of course. And I think when we
9 came before, I think we were -- we wanted to leave a
10 message about long-term care as part of a bigger
11 system. And I think in the conversation today, we
12 really want, I think, to leave a message about thinking
13 about the regs as a lever for change.

14 And I think one of the pieces that I think is
15 also a contributing factor, and that's in the regs, and
16 in fact UHN is building a new long-term care home, and
17 we're at the state of which we are going to working
18 drawings.

19 And the Ministry standards, as you all are
20 aware, the funding model and how design and staffing is
21 done is well embedded in a funding model.

22 And in the design model, the design specs for
23 Ministry of Health, Long-term Care are shared rooms.
24 And I think in all of our experiences, and we've had a
25 few conversations offline to think this one through,

1 that it's the shared room, not necessarily the shared
2 washroom, but the shared room that I think people feel
3 contribute towards the -- this infection and IPAC
4 standard and across the long-term care home.

5 And we're worried a little bit that -- and I
6 don't think the Ministry -- we've been told that the
7 Ministry doesn't have any plan at this point to change
8 those building designs.

9 And so unless we have a way of -- there's
10 probably two sides of this. Unless we have a way of
11 either informing the design regs, we're going to
12 continue to create facilities with shared double
13 occupancy. And that will certainly be an improvement
14 over those homes that are right now 3-bed or 4-bed
15 rooms.

16 But the flip side is if we go into
17 outbreak -- and as you also know there is a threshold
18 for occupancy that is long-term care homes have to meet
19 for their funding. And so the flip side is that if we
20 do create semis in buildings going forward, then we
21 have to be prepared to think about the fact that when
22 we do get into outbreak and we use best practices, that
23 those semis have to become private, and then therefore
24 the threshold number of occupancy will drop during that
25 time and homes can't be penalized for it because then

1 they won't do the right thing.

2 And so somehow the regs, the funding formula
3 and human behaviour, I think, are all sort of
4 interwoven.

5 And I think housekeeping presents a really
6 interesting example because they aren't spoken to in
7 detail in the regs and then you can see how it's become
8 almost the primary contributing to what we're seeing.

9 So I think, you know, our key messages are
10 that we think the regs can be a way forward. And we
11 would -- we would like some consideration around how,
12 if not in the regs, then in the application of how
13 residents and outbreaks are treated in homes in the
14 funding formula would be balanced off to deal with
15 that.

16 I think it is going to be a hard decision
17 around planning decisions around single bed, even
18 single bed shared washroom designs, because I think
19 clearly the private pay for semi-private and private is
20 a key factor in how homes are funded.

21 And so I don't think we have the answers, but
22 I think we have a sense of what those levers are.

23 And we did have a sort of a fulsome
24 conversation. I think what has been really obvious for
25 us, and we've done this in our acute care world for

1 quite some time, is that it's pretty natural for the
2 people on the screen today to have come together to
3 talk about this always.

4 When we jump into -- when we jump into an
5 infection problem in the world that we had, it didn't
6 take us long to get this group together, almost
7 instantly, to look at how things could be resolved. I
8 think that system, again, doesn't exist in long-term
9 care. And so they don't have that depth to be able to
10 pull quickly from and I think that's the message that
11 we wanted to leave last time, but I still think is an
12 important one to embed in this conversation.

13 And I would just ask my colleagues whether we
14 missed anything that we wanted to make sure that we
15 kind of thematically left with the group today? Maybe
16 to Joy or Susy or Joanne?

17 MS. RICHARDS: Joanne, I was just wondering,
18 is there anything else in some of our learnings in the
19 environmental services around laundry and others that
20 you may want to just flag for the Commissioners?

21 MS. BRIDLE: Absolutely, thank you, Joy.

22 So we did also recognize immediately there
23 was some big concerns with laundry on site. Laundry
24 was going upstairs wet and we were getting that
25 reported from multiple floors. And upon investigation,

1 it was apparent that the laundry room was quite
2 overwhelmed. So we made some changes to what was being
3 washed and what was being used as disposable, isolation
4 gowns being one example. And quickly went through and
5 did some process change.

6 In terms of infection control, the biggest
7 concern was throughout this outbreak, the home was
8 continuing to use the laundry chute to get laundry from
9 the fifth floor and each floor down to the laundry
10 room. The chute door was left open and staff were
11 working directly adjacent to that door. And, you know,
12 I'm unable to attribute as to if that was part of the
13 challenge, but staff in that work area were COVID
14 positive. So had to make some very quick changes.
15 Moved the laundry to soluble bags so that it would come
16 down -- the laundry would come down the chute in a
17 sealed bag that would then go directly into the washer
18 to try to improve some of the infection control
19 practices around laundry and linen.

20 And we are in the midst of getting the chute
21 out of use and considering other options because there
22 is also cross over clean and soiled in that area.

23 COMMISSIONER JACK KITTS: Can I just come
24 back to Rebecca's comments on design?

25 I think -- so hospitals are -- new hospitals

1 are being built with single rooms and single washrooms.
2 And I think we would all agree that is the ideal for
3 long-term care. And if we're going to treat our elders
4 like ourselves, that would be a bold change and a
5 recommendation that would really do a lot to help them
6 in times of outbreak.

7 We've also heard about the isolation and the
8 human contact. So at most, I think you said, Rebecca,
9 we could allow two bedrooms or semi-private, but they
10 would have to be designed be able to cocoon them really
11 in the midst of an outbreak, so you really have two
12 smaller rooms within that larger two-bed room.

13 MS. REPA: So in one of our long-term care
14 homes, we actually have something called a semi where
15 it's two private rooms that share a bathroom. And in
16 our conversations in preparing for today, we talked
17 about -- we believe that's a better situation than two
18 people sharing a room and a bathroom. And we believe
19 that because of the number of touch points in the room.

20 We also know from a patient experience,
21 patients and families perceive a single room with a
22 shared bathroom differently than a shared room and a
23 shared bathroom.

24 There seems to be -- and what we're worried
25 for sure about is in order to make a design achievable

1 from the funding formula, you need to be able to follow
2 the regs. We couldn't afford to make a single -- an
3 entirely single room, single washroom.

4 And as you know, people wait on wait lists
5 for rooms. And they're not waiting long for privates.
6 They're waiting longer for ones that are semis and
7 certainly ward is the longest wait list because people
8 can't afford the premiums associated with it.

9 So when you design the home, you weight the
10 privates to the semi-privates based on what the funding
11 model will get you.

12 And so the preferred for sure would be to do
13 a private room, private washroom, even a private room
14 shared washroom. But there wouldn't be enough people
15 waiting in the list that could afford that.

16 So much like in hospital, and I know you'll
17 appreciate when things go to single room and single
18 washrooms, we lose on preferred accommodation, but we
19 also know that it's the right thing to do and we have a
20 bit more buffer than the long-term care does to absorb
21 that loss. That same situation plays out in the design
22 of long-term care.

23 And I think the gold standard would be single
24 room, single washroom. I'll let Susy weigh in on the
25 single room shared washroom, double room shared

1 washroom debate. We have had that. It's certainly
2 better than what exists in many of the C homes today.

3 So the question is, would you bring the C
4 homes up to a standard that doesn't meet today, or
5 would you bring them right up to a today's standard?
6 And when the regs were rewritten in the early 2000s,
7 that's basically what it was doing.

8 Susy, the comment about single room shared
9 washroom, double room shared washroom.

10 MS. HOTA: Yeah, I think I agree with you in
11 terms of the hierarchy of what we would prefer from an
12 infection control perspective. The best, of course,
13 would be single rooms with their own dedicated
14 washrooms, that would be ideal. But if that's not
15 available, separating people and being able to isolate
16 in place is really critical, so having the two single
17 rooms and having a shared washroom. You can always
18 bring in bedside commodes or things like that if you
19 need to separate out the toileting.

20 So I think it would make a big difference
21 from the infection control perspective and from our
22 experience at St. George that I described where
23 roommate transmission was incredibly common.

24 COMMISSIONER JACK KITTS: So there are three
25 levels of escalation or deescalation. The ideal to --

1 I'm trying to get the ceiling and I think I'm hearing
2 that no more 3-bed or 4-bed rooms, regardless.

3 MS. HOTA: Right.

4 COMMISSIONER JACK KITTS: And the worst case
5 would be two in a room, but the ability to isolate them
6 in times of outbreak.

7 MS. REPA: I think it's two -- so the way our
8 semis work in our current long-term care home that we
9 have is two separate rooms with a washroom in between
10 and that's called a semi.

11 In our new build, the semis actually going to
12 be a washroom with two people in a room. And that's
13 less desirable from a patient experience perspective
14 and an IPAC perspective. But unless the regs were to
15 change to help guide that, it's not affordable to do it
16 the other way.

17 COMMISSIONER JACK KITTS: So you're building
18 the third most desirable model.

19 MS. REPA: That's correct.

20 COMMISSIONER JACK KITTS: And that's because
21 of the regulations.

22 MS. REPA: That's because that's what the
23 regulations will fund. So the funding, you get a
24 premium to build as part of the capital submission, and
25 that's basically what it will fund.

1 COMMISSIONER JACK KITTS: Okay, thank you.

2 LEAD COMMISSIONER FRANK MARROCCO:

3 Well, I think, Mr. Gross, is that it?

4 MR. GROSS: Mr. Commissioner, I believe it
5 is, unless the Commissioners have any follow-up
6 questions? I don't.

7 I certainly want to express my thanks on
8 behalf of commission counsel for those of you that
9 spent your time preparing for this and attending and
10 for those that are simply watching, thank you for
11 coming this morning.

12 LEAD COMMISSIONER FRANK MARROCCO:

13 Well, assuming the other Commissioners
14 don't have any further questions, thank you for
15 this. This is very helpful from our
16 perspective.

17 I don't think we quite appreciated, for
18 example, the extent to which the existing regulations
19 will dictate the type of structure that's constructed,
20 regardless.

21 And it does make sense that money will
22 influence behaviour, so thank you for bringing that to
23 our attention.

24 The other issues that you encounter in trying
25 to resolve the outbreak we continue to wrestle with

1 because I think we're probably more the command and
2 control model rather than endless negotiations.

3 I won't say much more than that because I
4 can't presume to speak for the other Commissioners or
5 to say we've reached a conclusion on that, but, as you
6 may have gathered from the questions, some of us are
7 more into issuing orders than debate.

8 But in any event, thank you very much for
9 your time and thank you for what you're doing.

10 COMMISSIONER JACK KITTS: Yes, thank you very
11 much.

12 COMMISSIONER ANGELA COKE: Thank you. Very
13 helpful.

14 --- Meeting ended at 10:04 a.m.

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1 REPORTER'S CERTIFICATE

2
3 I, HELEN MARTINEAU, CSR, Certified Shorthand
4 Reporter, certify;

5 That the foregoing meeting was taken before
6 me at the time and date therein set forth;

7 All discussions had by the participants were
8 recorded stenographically by me and were thereafter
9 transcribed;

10 That the foregoing is a true and accurate
11 transcript of my shorthand notes so taken. Dated this
12 27th day of January, 2021.

13
14 

15
16 _____
17 PER: HELEN MARTINEAU
18 CERTIFIED SHORTHAND REPORTER.
19
20
21
22
23
24
25

1 C L A R I F I C A T I O N S :

2 p. 35 line 2 "PIDAC" not "HYDAC".
3 (Provincial Infectious
4 Diseases Advisory
5 Committee).

6 p. 37 line 23 "CSNM" not "CS&M".
7 (Canadian Society of
8 Nutrition Management)

9 p. 40 line 19 "PIDAC" not "PIDEP".
10 (Provincial Infectious
11 Diseases Advisory Committee)

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