EXTENDICARE®
... helping people live better

# PRESENTATION TO THE ONTARIO LONG-TERM CARE COMMISSION

**October 8, 2020**

# REPRESENTING EXTENDICARE

## Dr. Michael Guerriere, MD, MBA

- President and Chief Executive Officer of Extendicare (appointed October 2018)
- 25 years experience in medicine and healthcare operations and technology
- Physician with specialty training in Internal Medicine
- Ten years of hospital operations experience, including Executive Vice President & Chief Operating Officer at the University Health Network
- Chair of the Healthcare and Life Sciences Advisory Board, Rotman School of Management, University of Toronto
- Adjunct Faculty, Institute of Health Policy, Measurement & Evaluation, Faculty of Medicine, University of Toronto
- Former Chairman, Board of Governors, Ryerson University

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# INTRODUCTION TO EXTENDICARE

For over 50 years, Extendicare's qualified and experienced staff of over 22,000 employees has been *helping people live better* through a commitment to quality care and service.


## Direct Services to Seniors

### LONG-TERM CARE

EXTENDICARE® ... helping people live better

**58**

Long-term care homes owned

### HOME HEALTH CARE

ParaMed™ Redefining Care

**8M**

Home health care hours delivered (TTM)

### RETIREMENT LIVING

Esprit Lifestyle Communities

**11**

Retirement communities owned

## Contract & Consulting Services

### GROUP PURCHASING SERVICES

SGP | PURCHASING PARTNER NETWORK

**75K**

Third-party residents served

### CONTRACT SERVICES AND CONSULTING

EXTENDICARE assist

**53**

Homes under contract

(1) *Stats as at June 30, 2020.*

# EXTENDICARE IN ONTARIO

- Owns and operates 34 long-term care homes and 7 retirement communities in Ontario
- Delivers 8 million home health care hours of care annually
- Provides contract services to 43 long-term care homes and 5 retirement communities
- Serves thousands of third-party residents through its group purchasing service
- COVID impact has been similar to that of the sector more broadly

| | CANADA | | ONTARIO | |
|---|---|---|---|---|
| | # homes | % | # homes | % |
| Outbreaks involving > 10 residents | 7 | 12.1% | 6 | 17.6% |
| Outbreaks involving <= 10 residents | 9 | 15.5% | 6 | 17.6% |
| No residents affected | 42 | 72.4% | 22 | 64.8% |
| **Total** | **58** | **100%** | **34** | **100%** |

Ontario long-term care homes owned and operated by Extendicare

# PRE-PANDEMIC PREPARATION

## 1. Activated Incident Management System

- National, cross-disciplinary team led by Director of Infection Prevention & Control (IPAC) activated January 27, 2020
  - Daily team calls to monitor COVID-19 developments, track public health directives and modify standard operating procedures
  - Central point of contact for homes; aggregated and distilled evolving public health information and requirements from many sources to facilitate home-level awareness and enable implementation
  - Regular calls between the National IPAC Director and IPAC leads in homes to provide guidance and answer questions

## 2. Centralized PPE Procurement & Management

- Established internal inventory and supply chain management to ensure supply
  - Initiated central tracking of PPE across the network at the end of January
  - Prices skyrocketed and our traditional supply chains failed
  - Our procurement team mobilized to establish relationships with new vendors
  - Purchased everything we could source, often without customary commercial protections and at 20X the usual price
  - Universal masking was impossible before sufficient inventory was secured

# PRE-PANDEMIC PREPARATION

## 3. Pursued Conventional IPAC Strategy

- Implemented standard IPAC playbook
  - Symptom screening of everyone coming into the home (i.e., staff, visitors and suppliers)
  - Symptom monitoring of residents and staff throughout the day
  - Signage and PPE refresher training
  - Mandatory 14-day isolation for new admissions

## 4. Worked to Secure Staffing

- Advised homes to reinforce staffing channels in anticipation of potential challenges
  - Concern that mildly symptomatic staff might come to work prompted new policy in February to pay staff on self-isolation
  - Began efforts to restrict workers in multiple LTC homes by offering increased hours in March, though these efforts were voluntary – government mandate came April 14
  - Single site employment directive put stress on staffing and created local shortages

# OUR EARLY RESPONSE TO THE THREAT OF COVID-19

## w/o Jan. 26

- First case of COVID-19 confirmed in Canada
- Ontario Emergency Operations Centre & Ontario Health commenced daily calls

## w/o Feb. 9

- First cases in LTC homes reported

## Feb. 28

- Health Command Table Established

## w/o Mar. 8

- MLTC instructs LTC homes to begin active screening of all visitors / resident (re)admissions
- WHO declares pandemic March 11

## Apr. 8

- MLTC mandates universal masking in LTC

## April 15 /16

- Government announces *COVID-19 Action Plan for Protecting Long-Term Care Homes*
- Direction to test all LTC residents and staff when a home is in outbreak
- Single site employment mandated
- Introduce mandatory isolation for admissions

## w/o Jan 26

- Activated Extendicare Incident Management System
- Participated in daily calls with Ontario Emergency Operations Centre
- Initiated regular COVID updates with home leadership

## w/o Feb 2

- Commenced active screening of all visitors / contractors entering EXE homes[1]
- Initiated central tracking of PPE across the network
- Distributed signage / refresher training materials re: donning and doffing procedures to homes

## w/o Feb. 9

- Implemented full pay for employees who needed to quarantine (regardless of STD eligibility)
- Began establishing relationships with new suppliers as PPE supply channels started to fail

## w/o Mar. 15

- Implemented mandatory isolation of new admissions / readmissions [1]

## Mar. 23

First Extendicare outbreak declared

## Mar. 25

- Asked staff to disclose other employers [1]

## Apr. 6

- Launched universal masking after sufficient PPE inventory secured [1]

## Apr. 19

- Conducted first round of comprehensive testing enabled by new directive

[1] Measures later mandated by government

# KEY CHALLENGES:

## ASYMPTOMATIC SPREAD RENDERS SYMPTOM SCREENING INEFFECTIVE

Frequency of asymptomatic transmission rendered traditional IPAC measures (e.g. symptom screening and cohorting) ineffective in controlling spread once it had entered a home.

- **Symptom focus:** Traditional strategies for managing outbreaks depended on symptom screening and tracking
- **Limited Testing:** In March and April testing was limited to 5 tests per home – once COVID was confirmed, testing stopped and cohorting was managed by tracking symptoms
- **Asymptomatic Spread:** Reports suggest 15-30% of transmission is pre-symptomatic or individuals who never develop symptoms
- **Atypical Symptoms:** Where symptoms were exhibited, they were often atypical for a respiratory virus, particularly in the LTC resident population, and not initially recognized as COVID related
- **Comprehensive Testing:** When we started testing all residents and staff, we discovered that the virus was much more widely spread than previously thought

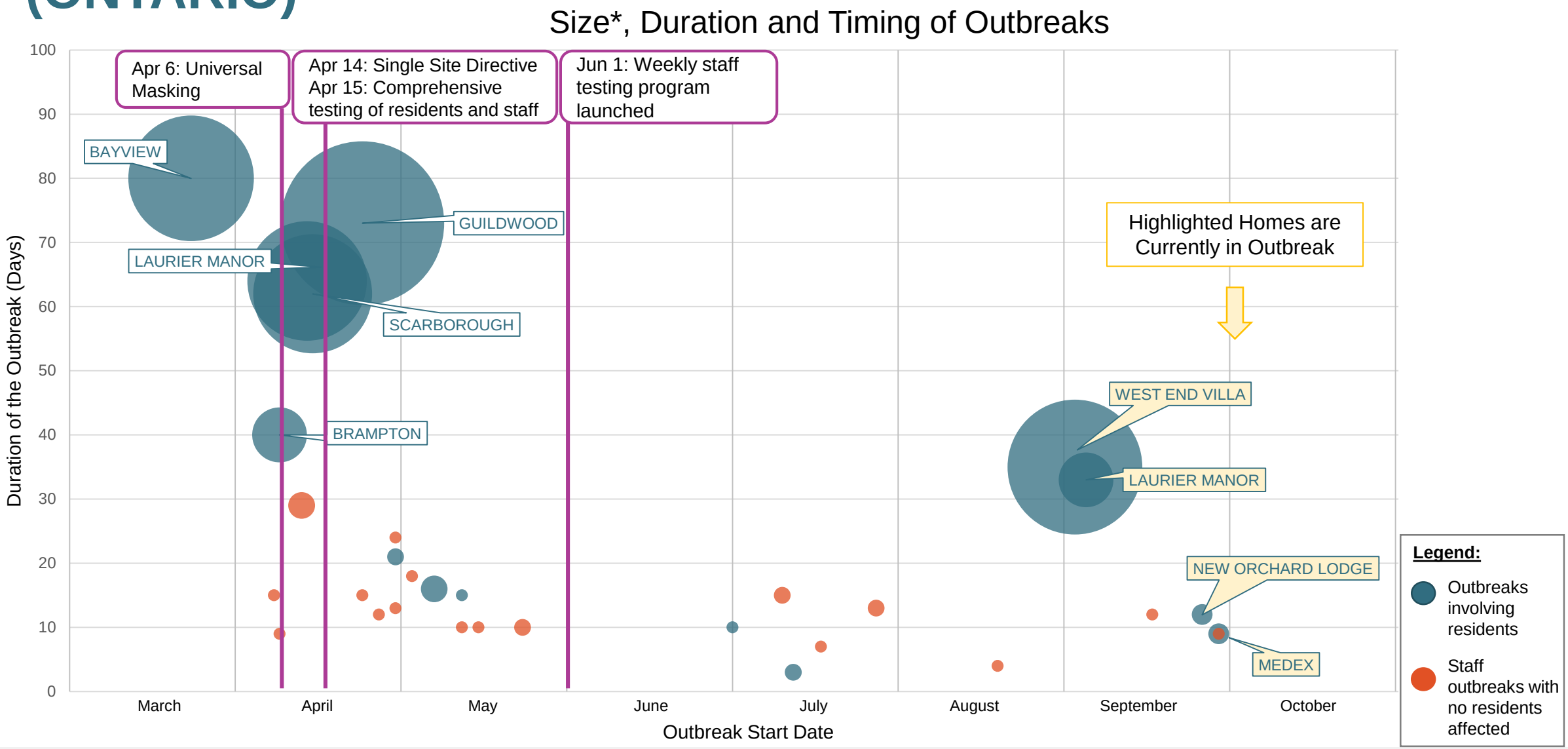
# KEY CHALLENGES:
## OLDER HOMES MAKE CONTAINMENT DIFFICULT

- **IPAC is always challenging** in long-term care
  - Limited IPAC expertise: LTC homes have limited specialist IPAC resources and registered staff
  - Dementia: Two thirds of residents living in long-term care have dementia – high incidence of residents who wander or have behaviours that are difficult to manage (i.e. isolate)
  - Physical needs: Many residents have care needs that require significant physical intervention making social distancing nearly impossible
- **Shared rooms:** Older homes (i.e., Class C) have more shared rooms (e.g., 3 and 4 bed ward rooms) and substantially less floor space per resident than newer homes
- **Limited space:** Donning and doffing of PPE is more difficult in narrow hallways with limited space for staff
- **“Home” design elements:** Many home design elements and features (e.g., carpet) that are conducive to creating a “home” atmosphere for residents make IPAC difficult

# KEY CHALLENGES:
## STAFFING CHALLENGES BECAME CRITICAL

- **Unprecedented Shortage:** Although we had lost staff in prior outbreaks, we had never experienced anything like the speed and scale of this pandemic
- **Various Drivers:** Unlike previous outbreaks where staff shortages were driven primarily by illness, the COVID-19 pandemic introduced new factors:
  - Extensive self-isolation requirements
  - Single site employment directive
  - Childcare issues at home
  - Canada Emergency Relief Benefit
  - Agencies overwhelmed by simultaneous requests from many homes
- **Fear:** The uncertain nature of the virus and the speed of spread caused fear that drove further absenteeism, compounded by:
  - Perceived PPE insecurity
  - Lab tests not available to monitor spread
  - Deaths of health care workers elsewhere
- **Overwhelmed Resources:** The unprecedented number and scale of outbreaks overwhelmed the shared corporate IPAC, clinical and HR resources that have served us well for decades
- **Pre-existing issue:** Pre-existing staff shortages exacerbated the problem

# COVID-19 OUTBREAKS AT EXTENDICARE HOMES (ONTARIO)




*Size of bubble is a function of total COVID positive residents and staff

# OUR RESPONSE TO STAFFING CHALLENGES

- **Regular testing:** Implemented weekly on-site testing for all staff
- **Higher wages:** Applied premium wage rates to outbreak homes, with 1.5 times pay for regular shifts and double regular rates on weekends
- **Hotel accommodations:** Supplied hotels for those who needed to isolate from families or were willing to travel to help at another home
- **Overstaffing:** Endeavored to overstaff where possible to address increased outbreak workload and mitigate against loss of staff
- **Recruiting:** Centralized recruiting and engaged external consultants to support staff and manage back-to-work campaigns
- **Solicited home health care staff:** Ran a campaign to recruit ParaMed staff to work in long-term care homes in outbreak
- **Agency staff:** Engaged all agency staff available, typically at 1.5 times standard rates
- **Paid leave:** Offered fully paid leave for those infected or isolated (regardless of whether employee was otherwise eligible for sick leave or short term disability)
- **Single Site Options:** We offered full time hours to retain staff who were working at more than one site

# HIGHLIGHTS OF OUR SECOND WAVE PREPARATIONS

**1 — STAFF TESTING PROGRAM**

Weekly testing of all staff in Ontario (bi-weekly in Ottawa at the request of Ontario Health / PHOL)

**2 — LIMIT ADMISSIONS TO 3 & 4 BED ROOMS**

Restrict occupancy to two residents per room and move residents from those rooms as beds become available

**3 — STAFFING & RECRUITING**

Add extra front-line staff to every home

**4 — ENHANCE IPAC CAPABILITIES**

Refresh training of all staff on Infection Prevention & Control procedures

**5 — INTERNAL COVID RESPONSE TEAM**

Establish mobile leadership team prepared to provide on-site support to homes in outbreak

**6 — MEDICAL DIRECTOR & SPECIALIST CARE COVERAGE**

Ensure medical directors are prepared to visit a home in outbreak; recruit Chief Medical Officer

**7 — STRENGTHEN CONNECTIONS WITH HOSPITALS**

Establish relationships and outbreak escalation protocols before they are needed

**8 — FAMILY, RESIDENT & TEAM COMMS**

Conduct virtual town halls meetings with families in addition to written updates

**9 — PPE PANDEMIC SOLUTION**

Stockpile PPE centrally, to be readily deployed wherever it is needed

**10 — 2020 INFLUENZA VACCINATION PROGRAM**

Drive annual influenza vaccination campaign, recognizing its increased importance this year

# ROOT CAUSES OF LARGE OUTBREAKS

**Homes with the most severe outbreaks typically experienced a convergence of five factors:**

1. Lack of access to sufficient testing or significant delays in receiving results
2. Significant delays in getting access to outside help – i.e., IPAC resources, medical oversight, direct care staff, environmental services and cleaning
3. Large proportion of staff lost – resulting in fewer staff to provide resident care and new recruits or agency staff who were less familiar with the home and IPAC practices, often leading to breakdowns in IPAC protocols and discipline
4. Older C class homes with shared bedrooms/bathrooms – difficulty cohorting and isolating positive residents facilitated spread
5. High rates of transmission within the communities surrounding the homes increased the likelihood of asymptomatic positive individuals bringing the virus into the home

# RECOMMENDATION 1:

## GIVE LTC THE HIGHEST PRIORITY ACCESS FOR TESTING

- Guarantee 24-hour turn-around for LTC resident and staff tests, as it is key to minimizing spread in the most vulnerable population
- Test all LTC staff weekly, particularly in regions with growing incidence of new cases and community spread
- Prioritize LTC for point-of-care testing as it becomes available
- Testing of health workers in LTC allows for early detection and removal of the virus from homes before it can affect residents

# RECOMMENDATION 2:

## IMPLEMENT STAFFING STUDY RECOMMENDATIONS TO INCREASE STAFF SUPPLY AND CAPACITY

- Provincial staffing study released July 31 in response to the Gillese Inquiry recommendations is an excellent analysis that captures the needs of LTC very well
- First priority is increasing the supply of PSWs in Ontario
- Launch province-wide preceptorship program in partnership with colleges and LTC providers to increase supply of workers in the immediate term, with longer-term path to PSW and RPN credentials
- Second priority is to provide additional funding for more hours of care
  - Workload is a major driver of attrition and turnover
  - More staff would also improve resiliency – any challenge out of the ordinary exceeds current staff capacity (e.g., outbreak or increased resident acuity)
- Additional funds for higher salaries would assist with attracting and retaining care givers in the sector

# RECOMMENDATION 3:

## STRENGTHEN RELATIONSHIPS AND INTEGRATION WITH THE REST OF THE HEALTH SYSTEM, PARTICULARLY HOSPITALS

- Make regional IPAC team available for deployment to any home with more than 5 positive resident cases within 24-48 hours
- Ensure IPAC leads for each home have an established relationship with the IPAC team in the local hospital
- Establish partnerships between LTC homes and local hospital networks for clinical matters and support for residents
- Invoke temporary LTC management contracts if there are leadership gaps (e.g., due to illness) or other lack of capability (e.g., staffing capacity) to protect residents in the midst of an outbreak
- Implement regional Chief Medical Officer model for long-term care proposed by OLTCC

# RECOMMENDATION 4:
## REPLACE ALL C BED HOMES

- Redevelopment funding program announced by the Province will replace 1/3 of C-beds by 2025 – this is a major step forward but will leave many old homes in operation for far too long
- Triple the current commitment to enable replacement of all C-bed homes by 2030
- Limit occupancy of all 3 and 4-bed rooms to 2 residents until replacement homes are built
- Fast track approvals on new bed licenses to address severe capacity constraints on acute care hospitals

# WE ALL HAVE A SHARED ENEMY:

## THE NOVEL CORONAVIRUS. WE NEED TO WORK TOGETHER AS A SYSTEM TO OVERCOME IT.


- Globally, COVID-19 has had a devastating impact on long-term care homes, staff and residents.
- Canada's management of COVID-19 is better than many other countries but there is room for improvement.
- The second wave is here.  We must urgently apply the lessons we learned during the first wave to address the continuing threat to the seniors population.
- The long-term care sector needs more help. We are better prepared than we were at the start of the pandemic, but there remains a significant risk.