

Long-Term Care COVID-19 Commission meeting

Commission Interview of Dr. Sinha
on Wednesday, September 2, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Microsoft Teams Meeting, with all participants attending remotely, on the 2nd day of September, 2020, 8:00 a.m. to 10:00 a.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 Dr. Samir Sinha, MD, DPhil, FRCPC, AGSF

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11 PARTICIPANTS:

12

13 Alison Drummond, Assistant Deputy Minister,

14 Long-Term Care Commission Secretariat

15 Ida Bianchi, Counsel, Long-Term Care Commission

16 Secretariat

17 Kate McGrann, Counsel, Long-Term Care Commission

18 Secretariat

19 John Callaghan, Counsel, Long-Term Care Commission

20 Secretariat

21 Derek Lett, Policy Director, Long-Term Care

22 Commission Secretariat

23 Dawn Palin Rokosh, Director, Operations, Long-Term

24 Care Commission Secretariat

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1 ALSO PRESENT:

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3 Deana Santedicola, Stenographer/Transcriptionist

4 Lisa Di Felice, Administrative Assistant, Long-Term

5 Care Commission Secretariat

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1 -- Upon commencing at 8:00 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Good morning. My name is Frank
5 Marrocco, Doctor. I am the Chair of the
6 Commission, and the other two Commissioners are Ms.
7 Angela Coke and Dr. Jack Kitts, whom I think you
8 know from a previous or his previous life before
9 the Commission took over his life.

10 Doctor, thanks in advance for agreeing
11 to come and speak to us. You are for all practical
12 purposes the first witness, so we are very grateful
13 for your participation.

14 So why don't we just get started. We
15 would appreciate it if you would tell us whatever
16 you think we need to hear, and then the three of us
17 may ask some questions after.

18 DR. SAMIR SINHA: Sure, okay.

19 And I have been working with Alison
20 before this. I know she did tell me that I am the
21 first person to come before you.

22 So I actually did create a statement
23 for the HUMA Committee federally when they asked me
24 to testify, and I actually just spent the last 20
25 minutes adapting it, so I thought maybe I would

1 start with that.

2 I have the specific questions that you
3 have as well, and then that might just give you the
4 context. That might be helpful, if that is okay.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 That is just fine. And, Doctor, you
7 shouldn't feel constrained by the questions.

8 DR. SAMIR SINHA: Okay, absolutely.

9 And to Alison and team, I will forward
10 this to you right after, if that is okay.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 That is just fine.

13 DR. SAMIR SINHA: Okay, perfect.

14 I am just going to get it up here, and
15 then I will...

16 So I just wanted to say my name is
17 Dr. Samir Sinha. I have a few roles. I am the
18 National Institute on Aging at Ryerson University's
19 Director of Health Policy Research, but I am also
20 the Director of Geriatrics at Sinai Health System
21 and the University Health Network in Toronto. And
22 I have been advising the Government of Ontario as
23 an advisor on health and long-term care, especially
24 around seniors, since 2012 when I helped develop
25 its first seniors strategy.

1 I want to first of all take a moment to
2 acknowledge the nearly 2,072 older Ontarians who
3 have died thus far of COVID-19 in our long-term
4 care and retirement homes, as well as their
5 families and caregivers, and one of the things I am
6 going to say throughout this is I wanted to also
7 mention retirement homes. I know it is not the
8 focus of the Commission, but so much of this work
9 and so many of the issues that I will be talking
10 about today are related to what also happened in
11 our retirement homes, but by treating them
12 separately, I think we have also done ourselves a
13 bit of a disservice.

14 So while I hold many titles, I want to
15 speak to you first and foremost as one of Canada's
16 only 305 geriatricians that work with older adults
17 and their families challenged by complex health and
18 social care issues like navigating their long-term
19 care needs.

20 The aging of Canada's population should
21 be seen as a triumph, as we have extended our life
22 expectancy from 51 years in 1900 to 82 today, and
23 when we established Medicare, the average Canadian
24 was only 27 and would not live beyond their 60s, so
25 it is understandable why the provision of long-term

1 care was not an original priority.

2 While other countries acted clearly and
3 decisively to address these shortcoming as they
4 aged, Canada didn't. Our inaction cumulatively
5 helped to sow the seeds of the tragedy we have been
6 witnessing where 81 percent of Canada's deaths to
7 date from COVID-19 have occurred in long-term care
8 settings and where Canadians as well, in a
9 forthcoming paper we have coming out in the Journal
10 of the American Medical Directors Association, show
11 that Canadians actually had a 77-fold greater
12 chance, older Canadians had a 77-fold greater
13 chance of dying from COVID-19 in a long-term care
14 or retirement home than if they were living in
15 their own homes in their community.

16 So some thought I was being alarmist on
17 April 2nd when I was quoted in The Globe & Mail as
18 saying if my mom was in long-term care, I would
19 pull her out, most Canadians have now come to also
20 appreciate that our long-term care system was
21 utterly ill-prepared to deal with this pandemic.

22 Currently there has been some recent
23 polling that has been done that shows 90 of
24 Canadians are aware of what has actually happened
25 in our long-term care homes, and next week we'll be

1 releasing some polling results we have done through
2 the National Institute on Aging showing that now 60
3 percent of Canadians have told us that they are
4 reconsidering their decision about whether they
5 would want to actually live in a long-term care
6 retirement home.

7 So right now we know that 430,000
8 Canadians have unmet home care needs, while over
9 40,000 are on wait lists for long-term care homes
10 even before COVID. And as the Commission is
11 probably well aware, currently our long-term care
12 wait list in Ontario is about 38,000 people.

13 Of course, most people have the right
14 to pay privately for their own services, but this
15 isn't an option for the majority of Canadians who
16 do not retire with a workplace pension and on
17 average only \$3,000 in savings in the bank by the
18 time they retire.

19 So public long-term care funding has
20 also been inadequate. Its nurses or personal
21 support workers, for example, make far less than
22 they would in publicly funded hospitals.

23 With 80 percent of Ontario's homes
24 before the pandemic reporting trouble recruiting or
25 retaining staff, the majority of workers they could

1 recruit were often racialized women who didn't
2 really have many other options.

3 So we owe a debt to them and the 3,451
4 to date who have contracted COVID-19 and the nine
5 who have died so far in Ontario because they are
6 caring individuals trying to make ends meet who are
7 willing to keep doing this dangerous work. But if
8 we think our usual staffing approaches are the
9 right way to enable a system that we may all need
10 in the future, then we are deluding ourselves as
11 well.

12 Indeed, to contain costs and ensure
13 flexibility, most homes employ these workers on a
14 part-time basis, so many would work across multiple
15 settings, placing them at increased risk of
16 contracting and spreading COVID-19.

17 After SARS, many countries around the
18 world ensured their homes only offered single-room
19 accommodation, and until recently we still had
20 Ontarians receiving care in two, three, and even
21 four-bedded rooms.

22 And altogether these staffing and
23 physical plan deficiencies have become known as our
24 systemic vulnerabilities that led to the rapid
25 introduction and spread of COVID-19 in and between

1 our homes.

2 During a pandemic, quickly applying
3 definitive actions to prevent the introduction and
4 spread of a novel infection based on rapidly
5 emerging evidence is key. This is why I say that
6 BC gets top marks for implementing key preventive
7 measures well ahead of any other province. They
8 stemmed their outbreaks to 12 percent of their
9 homes, while in other provinces like Ontario, 34
10 percent or 480 of our long-term care and retirement
11 homes have now experienced outbreaks. Ontario has
12 the highest rate or proportion of its homes
13 experiencing outbreaks in Canada.

14 Our NIA, our National Institute on
15 Aging, issued its evidence-informed "Iron Ring"
16 guidance on March 27th which informed the Federal
17 Government's April 8th federal guidance, and yet
18 some provinces still hesitated to act on these
19 recommendations for at least another week.

20 Ontario and Quebec, for example, tried
21 to stabilize their situations with the help of
22 hospitals, the armed forces and even school board
23 employees, but this is not seen by anyone as a
24 stable solution for a system that has lost the
25 faith of many of its residents, families and

1 workers that their care needs and safety can be
2 ensured.

3 So where do we go from here?

4 Most experts agree that we'll be living
5 with COVID-19 for awhile. We did better than many
6 other countries in implementing our lockdowns
7 early, allowing us to keep our community dwelling
8 population and elders relatively unscathed, but as
9 we anticipate future waves, we need to take the
10 early lessons we have learned and apply them to
11 further protect the 144,000 Ontarians living in our
12 626 long-term care and 770 retirement homes who
13 have not yet been infected or killed by COVID-19.

14 Our province needs to act more
15 definitively to apply current evidence-based
16 recommendations. We still have inadequate public
17 health data collection and reporting systems to
18 help us understand how and in what ways COVID-19 is
19 affecting our long-term care settings and makes
20 them more vulnerable.

21 The NIA created an LTC tracker for this
22 purpose. This is where the data that I am
23 presenting you today has been collected, all
24 independent of the support of our Ministries of
25 Health and Long-Term Care.

1 While it is good that our Prime
2 Minister and our Premier and our Ministers in
3 Ontario have agreed that long-term care is broken,
4 we need to ensure that we pair our immediate
5 actions with efforts to determine how to best fix,
6 develop and fund long-term care systems that
7 Ontarians should look forward to as we age.

8 In this regard, I am glad that our NIA
9 has been helping to ensure that we can define
10 issues properly, ask the right questions, find the
11 right answers and ways of implementing them as
12 quickly as possible.

13 Much of what we need to do has been
14 well-known for years and luckily isn't rocket
15 science, but it will take political will and a
16 federal and provincial and territorial coordination
17 of effort. My only fear is that with, hopefully
18 the worst of things behind us, we still have key
19 things that we have not yet done to get us to a
20 better state of affairs to handle a potential
21 second wave but also ensure the integrity of our
22 system as sound in moving forward.

23 So I just wanted to open with that
24 statement, but then I wanted to just quickly
25 highlight that what I would like to talk to you

1 about, and we can certainly go to a Q&A format, is
2 in terms of the issues that I think we need to
3 still rectify or resolve right now, there still are
4 current staffing issues that we haven't
5 appropriately addressed. There are still
6 significant issues related to data collection and
7 data transparency that are important. There are
8 still important issues we need to think about from
9 the coordination of efforts that can occur between
10 our long-term care homes, but also local hospitals,
11 Public Health Units, the LHINs and the authorities
12 that they work with so that we can better
13 coordinate response efforts should future outbreaks
14 occur.

15 And finally, we need to really focus on
16 fixing our visitation policies right now that have
17 been rather piecemeal and still rather confusing
18 for families to understand, especially as we look
19 to re-open our homes, but also how do we actually
20 start closing them again in a coordinated way,
21 because that certainly has created a lot of
22 problems for people who haven't actually even been
23 affected by an outbreak but certainly have been
24 affected by not being able to visit with their
25 families and friends.

1 So I will just outline those as core
2 issues I would like to talk further about, but I'll
3 pause there.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 What I think we'll do is we may have
6 some questions and this is a probably good point to
7 find that out, but then, Doctor, if the questions
8 don't take you to something you want to say, please
9 say so and say it because I think we are anxious to
10 receive your views as much as we are anxious to ask
11 questions. So don't hesitate to do that.

12 DR. SAMIR SINHA: Sounds good.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 I guess I'll start. And we will ask
15 questions and we won't ask them in a particular
16 order. If somebody wants to ask a question,
17 they'll ask a question and we'll go back and forth.

18 But what I guess occurred to me
19 listening to you is how do you fix the staffing
20 problem, in your opinion? You have, as you
21 described, people earning perhaps less than they
22 could -- well, earning what they are able to earn,
23 which doesn't amount to a lot and they are trying
24 to make ends meet. How would we recommend to the
25 government that they should address that?

1 DR. SAMIR SINHA: Right. So thank you.
2 So from a staffing issue right now,
3 this is one of our greatest challenges that we had
4 prior to the pandemic, and it is going to continue
5 on, especially in light of the pandemic.

6 I think one of the -- the staff that I
7 shared with you is that prior to the pandemic, the
8 Ontario Long-Term Care Association, for example,
9 and others would report that 80 percent of homes
10 were having trouble recruiting and retaining staff.

11 When you actually look at how staff are
12 actually paid in long-term care homes, many are
13 actually unionized. Many are actually, you know,
14 receiving, benefits, for example, and supports,
15 things like sick days, and I think that is
16 important.

17 But when you actually fundamentally
18 look at how we pay people in Ontario versus kind of
19 other provinces, you'll see that we don't actually
20 have something we have wage parity, so the idea
21 that a nurse, for example, in a home in
22 Saskatchewan is actually making the same as a nurse
23 would actually make in a hospital.

24 And in many parts of the country, what
25 we call wage parity has actually been achieved, and

1 by doing that, for example, you then have less of a
2 situation where even if you recruit someone to work
3 in a care home, you know, they are always looking
4 over their shoulder to see when the local hospital
5 actually has an opening.

6 And that is fundamentally because the
7 care envelope, the funding that we actually provide
8 to publicly funded hospitals, for example, is a far
9 greater or a more generously funded care envelope
10 than what we would actually provide to a long-term
11 care home.

12 So when you actually look, for example,
13 in Ontario, if you look at what the standard wage
14 rate for someone working in a hospital would be -
15 and I am just going to give you ballpark figures.
16 I have been working on this with some labour
17 employment lawyers and experts across Canada just
18 to understand the issue a bit better and to kind of
19 make sure that I understand the facts better.

20 But let's say the average person, for
21 example, in a publicly funded hospital, a personal
22 support worker was making about \$27 an hour. What
23 you will find actually is then you'll find wage
24 rates, for example, in a long-term care home can be
25 upwards of \$5 less an hour. And of course, it

1 depends on if you are working in a private
2 for-profit, if you are working in a not-for-profit,
3 or if you are work in a municipally-funded home.
4 And in some cases, you'll actually find that some
5 municipally-funded homes are actually almost
6 achieving wage parity with a local hospital. So
7 you see funding differentials occurring between
8 homes.

9 Where you actually see the lowest wage
10 rates can actually be in retirement homes where a
11 personal support worker might only be making \$18 an
12 hour, and then many homes actually rely on agency
13 staff to fill in gaps. So if you were actually
14 staffing short for a day or for a shift, for
15 example, you are going to rely on an agency, and an
16 agency in that case might actually be only paying
17 their staff \$15 an hour to come in.

18 So the idea that we, first of all, have
19 these differential wage rates I think are a
20 problem. Some people say or will argue and say,
21 well, when we increase the funding for personal
22 support workers doing home and community care
23 fundamentally by \$4 an hour, it really didn't
24 stabilize the home care situation. So just giving
25 people more money won't do that.

1 But I think the fact of the matter is
2 when you are fundamentally having trouble
3 recruiting people into the field in the first place
4 and retaining them, I do honestly believe that
5 wages are part of this, but wages are only part of
6 the issue.

7 I think the other challenge is that we
8 don't do a good enough job promoting work in
9 long-term care and retirement homes to potential
10 caregivers, and that could be a few different
11 reasons.

12 Number one is that when many folks are
13 training in say schools of nursing, for example,
14 they may have acute care placements in a hospital
15 setting but it is harder to get a placement or it
16 is harder to prioritize placements in long-term
17 care or retirement home settings, for example, so
18 people aren't necessarily getting exposed as early
19 to those opportunities.

20 The pay isn't as attractive, so why
21 would you choose that first when there is a job at
22 a hospital.

23 And I think the other challenge that we
24 have when we think about recruiting and retaining
25 staff in these environments are that we often

1 create barriers, for example, for people to come
2 into these fields. For example, a personal support
3 worker, someone who wants to be a personal support
4 worker would have to undergo a few months of
5 training, and that training can be quite extensive
6 and that unto itself can be a barrier for them to
7 actually come into training.

8 So Quebec, for example, that is trying
9 to recruit 10,000 personal support workers into its
10 long-term care system has offered to actually pay
11 people full-time and I think even cover the costs
12 of their training, so that we don't actually create
13 that barrier, especially for personal support
14 workers.

15 But we should also make sure that the
16 training that personal support workers and nurses
17 get for these settings actually include training on
18 how to care for people who have dementia, how to
19 care for people who have behavioural issues, how to
20 actually have geriatric skills and even infection
21 prevention and control and other basic things that
22 we would think are happening but often are not
23 necessarily happening to the standards that we
24 actually want.

25 So I don't want to just harp on pay. I

1 think pay is part of it, but I think pay alone,
2 without addressing how do we actually better
3 support people entering into the profession; how do
4 we support making sure that not only do they enter
5 but they feel quipped to do the jobs well and
6 properly so that they will feel successful in their
7 work; and then number three, that we are paying
8 them well enough or we are giving them work
9 schedules and supports that actually make the work
10 attractive.

11 So not only adequate pay, if you will,
12 or wage parity, if you will, but also the notion
13 that they don't feel they are working in
14 understaffed homes and they actually feel that they
15 are equipped to do the job. I think that is
16 important.

17 Because the last point is, to you as
18 Commissioners, you will be aware that recently
19 through the Wettlaufer Inquiry there was a request
20 to actually do a staffing review in Ontario, and
21 those results only came out I think about a month
22 or so ago and that is where the panel was
23 recommending that even with the workers that we
24 have, we recommend 4 hours a day minimum care
25 standards for residents right now, where on average

1 we have about 2 and a half hours of direct hands-on
2 care that people will be receiving.

3 I don't honestly know what that magic
4 number is, whether it really should be 4 or it is
5 3.5, but I think the point is there that if you
6 imagine yourself as a worker who has come into this
7 space, has not been adequately trained and doesn't
8 feel that they have the adequate skills and then
9 feels that they are working in a short-staffed
10 environment as well, and then there is a job at a
11 hospital where you are more likely to get more
12 full-time employment as opposed to more part-time
13 employment, for example, it just creates a -- it
14 doesn't create a tenable situation, for example, to
15 have people not only want to be recruited in but
16 then they'll also stay there and work for a long
17 period of time.

18 And so I think it is not only the
19 challenge of recruiting people in, but it is also
20 the retention issues that we have had. And I think
21 if we think about a long-term care staffing
22 strategy, which I think is really important, and
23 perhaps this is our opportunity to start getting
24 that right, I think we have to look at all those
25 elements together and not necessarily in isolation.

1 I think just paying people more and not addressing
2 the other issues is not going to solve these issues
3 that have been well-known for years but I think
4 have been looked at in a piecemeal way and not
5 necessarily in a holistic way as well.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Well, thank you, Doctor. I don't want
8 to monopolize the questioning.

9 Ms. Coke, were there any questions you
10 wanted to ask?

11 COMMISSIONER ANGELA COKE: Just two
12 quick things.

13 One, just following up on the HR
14 issues, your thoughts on the right mix of staff,
15 the right mix of professionals? From what I
16 understand, you know, there is a large percentage
17 of the folks are the PSWs, but in terms of the
18 complexity of the needs of the residents, do we
19 have the right sort of number or balance of types
20 of staff from your perspective?

21 DR. SAMIR SINHA: No, it is an
22 excellent question.

23 I think part of the challenge is we
24 have minimums. We don't actually have kind of, you
25 know, say a recommended -- you know, we say that

1 there needs to be one RN, for example, in a home at
2 any given time, for example, but we haven't
3 necessarily come out and said that for every ten
4 residents, there needs to be 'x', 'y' and 'z', for
5 example.

6 I think there have been a number of
7 staffing studies that have been done, and there
8 actually is good evidence out there. I can't quote
9 it to you directly right now. I am happy to follow
10 up and forward you some examples, for example,
11 where this work has been done to talk about kind of
12 what ideal staffing levels have been done, because
13 this has been studied in the United States but it
14 has also been studied here.

15 You are absolutely right, Ms. Coke,
16 that I think one of the big challenges that we have
17 had in the long-term care system, in particular
18 over the last 10 or 15 years, is we have seen the
19 complexity of the resident population significantly
20 increase over time. We have a lot more people
21 living with dementia in these settings. We have a
22 lot more people living with behavioural issues. We
23 have a lot more people living with more complex and
24 unstable health care needs.

25 But when we start looking at kind of

1 what is the right staffing mix, for example, if you
2 talk - and I am going to say this respectfully - if
3 you talk to the RN group, for example, they'll say
4 we need more RNs. If you talk to the personal
5 support worker group, they'll say we need more
6 PSWs. We need more RPNs. There is a lot of
7 territorial and I have worked very closely with all
8 these different associations and I hear their
9 arguments.

10 I think there is some very good
11 evidence out there that actually speaks to, for
12 example, what would be a better mix, you know, in
13 terms of staff, based on kind of the complexities
14 that we are actually seeing.

15 So I don't think it is a matter of
16 just, you know, more -- like I agree that we
17 probably need more hours of care in a home, number
18 one. We probably need a more enhanced staffing
19 mix. I can't tell you on the spot right now, you
20 know, what does that mean in terms of two RNs
21 versus that.

22 It also depends on skill mix, for
23 example, and scope of practice. What are we
24 actually expecting certain people to do, because I
25 think if you are certainly saying that only RNs can

1 do 'x' and RPNs can only do 'x' and PSWs can only
2 do 'x', then I think you are pigeonholing yourself
3 into a certain staffing formula that actually makes
4 sense.

5 So there has been, I believe -- I have
6 not read the recent report that was done by the
7 Staffing Commission, but I know that there
8 certainly have been pieces published out there
9 speaking to what could more idealized staffing
10 ratios look like, so it is not just a matter of
11 more staff but I think a better improved skill mix.

12 But I think on top of that it is also
13 making sure that those folks working in these
14 environments have the right training and skills.

15 I'll give you one example recently that
16 happened was that a few years ago when I was -- I
17 was always advising the Ontario Government, but
18 they had come out with this plan to hire more Nurse
19 Practitioners to work in long-term care settings,
20 for example, which I thought was great because
21 certainly I think that is a great opportunity to
22 bring a more advanced practice role into these
23 settings.

24 The lead of the Nurse Practitioner
25 Association came to see me because they said, here

1 is our problem is that we have all these NPs that
2 are going to be working in long-term care but they
3 haven't been properly trained on how to work in a
4 long-term care setting or been given training in
5 geriatrics and those sorts of skills. Could you
6 help us out.

7 So I worked actually with U of T to try
8 and create a bit of a boot camp, for example,
9 for nurses working and doing telemedicine and
10 tele-home care in the home care community to learn
11 a little bit about CHF, but that was a one-time
12 funding thing from the Ministry. It wasn't an
13 ongoing way that we could train.

14 And for the NPs, for example, there was
15 never an appetite -- for example, there was an
16 appetite to create the roles and let people hire
17 these folks, but they have been having a huge
18 trouble retaining these folks as well because they
19 are going in unprepared.

20 So just staffing and more people
21 without the right training to understand what to do
22 is not going to be helpful in that way, and I
23 think, again, it really speaks to having a really
24 coordinated human resources approach where we can
25 say what is the right mix that we want to have, and

1 you know, what would that scope of practice be, and
2 how do you adjust it based on specific needs of
3 certain populations of residents as well from that
4 perspective.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Dr. Kitts?

7 COMMISSIONER JACK KITTS: Yes, thank
8 you very much. That was a very comprehensive
9 review of what needs to be done.

10 You introduced this, Dr. Sinha, by
11 saying that we need to apply evidence-based
12 solutions for resolution, and you listed four --
13 you listed staffing, which you just explained the
14 staffing.

15 You also mentioned data, coordination
16 of efforts and visitation policies. My question is
17 are you going to expand on each of those? Because
18 if you are, then I will hold my questions until
19 later.

20 DR. SAMIR SINHA: No, I am happy to
21 move from staffing and briefly just talk about the
22 other three things, if that would be helpful at
23 this point.

24 COMMISSIONER JACK KITTS: If that is
25 what you think is appropriate.

1 DR. SAMIR SINHA: Okay. I am just
2 going to leave the staffing piece by also talking
3 about another staffing piece that needs to be
4 resolved and figured out, if you will, and that is
5 medical direction in homes as well.

6 So a colleague of mine who has been
7 coordinating work for the Ottawa Hospital Group,
8 for example, has been on the phone to me many a
9 time, and I have been working with Revera, for
10 example, where they have been doing a review of
11 medical direction because lot of the issues I talk
12 about that are involved in Ontario are not
13 Ontario-exclusive issues. They are actually
14 uniform issues across the country, and that is the
15 role of medical direction, because we just talked
16 about nurses and personal support workers, those
17 frontline workers, but we haven't really focussed
18 on ultimately, at the end of the day, the care in
19 the home is, if you will, under doctor's orders,
20 for example.

21 And right now, if you actually look at
22 what our standards are, for example, or our
23 expectations are within long-term care homes, I
24 think our policies around medical direction need to
25 be clarified and need to be more firmly in place as

1 well.

2 I know my colleague, Dr. Rhonda
3 Collins, she and I sit on -- she is the Chief
4 Medical Officer of Revera, but she is also the
5 Co-Chair of our Long-Term Care, congregate care
6 table through the Ontario Health, Toronto Region,
7 and I sit on that table. I am the senior clinician
8 lead or senior physician lead for the Ontario
9 Health, Toronto Region, and so one of my roles is
10 to sit on the long-term care table and provide
11 advice to our local region.

12 She and her team have actually
13 submitted document guidelines and recommendations
14 on medical direction to Ontario Health, and I
15 believe via to the Ministry of Long-Term Care as
16 well, to really talk about the importance of making
17 sure that we know what the roles or the
18 expectations are around medical direction in homes,
19 because what we did find or what we did observe is
20 that in many cases, for example, we don't have
21 clear guidelines on how often a medical director
22 should be visiting or, as the primary care provider
23 to a population in a long-term care home, how often
24 should they be expected to be checking in on
25 individuals. If they are unable to provide care,

1 who is the backup person to provide care? How is
2 that care or that coverage regionally coordinated?

3 Because I think one thing that you will
4 hear is that throughout the pandemic, for example,
5 and I know certainly some of the homes that my team
6 at Sinai and UHN supported, we had situations where
7 the doctors, you know, who might have been older
8 physicians themselves, didn't feel comfortable
9 going into the home and providing care. They would
10 only feel comfortable providing, you know, virtual
11 supports via the telephone, for example, and
12 sometimes relying on external physicians, for
13 example, from hospitals or other settings going in
14 and trying to provide that care.

15 So the question becomes what is that
16 mechanism that we have in place to make sure that
17 these clinicians, A, have the right training they
18 need in providing care, you know, geriatric care,
19 care for these types of individuals, but where does
20 it fall in terms of other certain standards that
21 need to be in place, including what their role
22 would be in terms of providing routine care in a
23 non-outbreak situation but then also care in an
24 outbreak situation there.

25 Moving on from the staffing issues,

1 just to focus on data, data was one of these clear
2 issues - and I know this was one of the questions
3 that I was specifically asked, any issues you have
4 observed in getting the information you needed and
5 what you think, you know, needs to be done.

6 From a data standpoint, this has been a
7 real difficult situation, for example, and I think
8 it is still something that the government I think
9 is still trying to resolve in different ways. For
10 example, early on in the pandemic, for example, and
11 I think as many folks will be well aware of, the
12 question was how are we actually collecting data so
13 that we can actually facilitate a realtime
14 response.

15 My desire was to make sure that to
16 support, you know, hospitals that might be involved
17 locally, to support residents and their families
18 who want to have information on what is actually
19 happening in their local home, other homes to know
20 what is happening in their own regional homes as
21 well, Public Health Units, just in the interests of
22 transparency how do we actually make sure that
23 people know, you know, what is happening and then
24 how do we better coordinate our responses.

25 And I think our challenge that we

1 realized early on is that our Public Health Units,
2 certainly in their Public Health responses,
3 whenever there is an outbreak, for example, they
4 don't treat it or they are not in the business or
5 it hasn't been their traditional response or work
6 to actually do realtime reporting. So they are not
7 necessarily or they haven't traditionally worked in
8 a way that they are actually going to, you know,
9 put their reporting together so that by the end of
10 every day or in a realtime method you know exactly
11 what is happening around an outbreak in every home
12 in their region.

13 As I was educated early on, a Public
14 Health Unit, for example, you know, will do the
15 work that needs to be done, but generally, at the
16 end of an outbreak, they'll tally everything up,
17 they'll post it and they'll report it.

18 And that has worked really well in the
19 past, if you will, when there are the usual
20 outbreaks that occur in long-term care homes. But
21 I think during a pandemic there was a greater
22 thirst to say what is actually happening, what is
23 going on, what is the size of the outbreak and what
24 does our local response need to be.

25 And so in this method, I think a lot of

1 Public Health Units started, with time, trying to
2 kind of improve their kind of way of starting to
3 put their information into place.

4 The challenge is it was not clear to me
5 how every Public Health Unit was determining how
6 they would report information, and so there didn't
7 seem to be a standardized or agreed upon approach.
8 And I will give you an example.

9 For example, if there is an outbreak at
10 a home say in Kingston versus a home in Toronto,
11 for example, the Toronto region might report on its
12 dashboard the total number of cases, the total
13 number of deaths, for example, but a different
14 region, a different Public Health Unit might not
15 talk about total cases. They might talk about
16 active cases, for example, so what does the
17 outbreak actually look like today versus what does
18 the outbreak look like overall.

19 And so in that way it becomes hard to
20 understand the size, you know, and the actual
21 situation, and it makes it hard, for example, to
22 compare, if you will, apples to apples that way to
23 kind of get a better handle on what is actually
24 happening, and hard to certainly at some times
25 understand when did that outbreak start and when

1 did that outbreak finish, for example, so just
2 common data elements that would actually be
3 helpful.

4 And the other challenge that we had was
5 certainly the Public Health reporting system itself
6 just became so challenging to use that the Ministry
7 then halfway through reverted to a new system where
8 they decided to have inspectors calling the homes
9 individually, trying to get their information from
10 them in a way that they then said we are no longer
11 going to use the Public Health kind of reporting
12 mechanism. We are now going to start using our own
13 system to try and just call homes and find out what
14 we can from them and then use that in our way to do
15 that.

16 So I think it has been really
17 challenging because we have seen this is the
18 situation that has been happening in long-term
19 care.

20 Retirement homes have been a completely
21 different kettle of fish as well where, again, we
22 haven't actually been -- we have had a lot of
23 challenges collecting data in similar ways as well.

24 And then my ultimate challenge was when
25 the government itself was reporting information,

1 for example, they would often only be talking about
2 long-term care homes. They wouldn't be talking
3 about retirement homes. That may, you know, be
4 inconsequential to you, but my view is at the end
5 of the day, a home is a home is a home. These are
6 congregate settings. They have older people. Yes,
7 70 percent of the people in a nursing home have
8 dementia, but 50 percent of the people in a
9 retirement home do. Yes, most of the people in a
10 retirement home are in a single-bed setting, but
11 you know, the majority of people in a long-term
12 care are too.

13 But many of these homes are adjacent to
14 each other. Many of these homes actually share
15 staff or were sharing staff, for example. So there
16 are homes, for example, that have retirement on one
17 wing and long-term care on the other, and so almost
18 talking about data of one without the other and not
19 having a unified approach to actually share that
20 data and report that data becomes problematic.

21 And part of the problem was, as I was
22 learning along the process, is that at the very
23 beginning of the pandemic it was clear that
24 long-term care homes are required to report an
25 outbreak to the Ministry of Long-Term Care. You

1 know, it is a reportable thing to the Ministry.

2 But retirement homes, which are
3 regulated by the Retirement Home Regulatory
4 Authority and governed by the Ministry of Seniors'
5 Affairs and Accessibility, they didn't have that
6 requirement for retirement homes. So there was a
7 lot of work that then had to be done to try and
8 encourage retirement homes to tell the government
9 what actually was happening, and you can imagine
10 that all of this together made it a real challenge
11 to try and get reliable and clear data.

12 So our NIA then as a result, where we
13 were seeing this issue in many jurisdictions, we
14 actually created a national tracker. We created a
15 tracker where we have actually outlined all 5,801
16 homes in Canada, long-term care and retirement. We
17 have actually created a map which is publicly
18 accessible. It is a Google map. It shows the map
19 of Canada. It goes to your province. We actually
20 have shown the data by Public Health Unit, Ontario
21 Health Region, and we have actually made it really
22 simple for people to understand. You go on a pin
23 of a home. You actually see, for example, if the
24 home is in red, it is in outbreak; if it is green,
25 it means the home is recovered; if it is black, it

1 means the home isn't in outbreak. You have the
2 information for the home; you have their web
3 address; you have their phone number, for example;
4 you know how many beds in total they have; you
5 understand how many total cases there are; you
6 understand how many deaths have occurred, and you
7 know that information by staff and you know that
8 information by that.

9 And the goal of this was that families,
10 for example, could actually get clear, accurate
11 information. They could actually get the
12 information that they were looking for. A local
13 home, for example, if Dr. Kits, for example, had a
14 home just down the way and I saw, Oh, my goodness,
15 you know, his home is in outbreak, I might be able
16 to actually have a better locally coordinated
17 response because at the very beginning homes
18 reporting shortages of PPE or my home and
19 Dr. Kitts' home, for example, might be sharing
20 staff, immediately at a ground level you could
21 start facilitating home-to-home responses.

22 But when we were starting to get
23 involved with hospitals, Public Health Units, other
24 people involved, it is sometimes helpful to kind of
25 see what you are actually dealing with in your

1 local geographical region and what is happening.

2 So this is why we independently created
3 a tracker. We actually were invited and I talked
4 to the Ministries of Long-Term Care, the Ministries
5 of Health and the Ministries of Seniors' Affairs
6 and Accessibility right off the beginning about our
7 intention to create this back towards the end of
8 March. There was a lot of interest from them in
9 even supporting this and even funding this.

10 But what we really saw very quickly
11 through this process was there wasn't a huge
12 interest in transparency. We were working with the
13 local associations, AdvantAge Ontario, the Ontario
14 Retirement Communities Association, with the
15 Ontario Long-Term Care Association. We shared with
16 everybody our interest in creating this instrument.

17 We have created it for the grand total
18 of \$15,000. That is how much we spent creating
19 this. I have a team of volunteers who are
20 collecting this data by looking at media scans and
21 looking at that information.

22 This didn't cost a lot of money, but
23 immediately we started seeing that people did not
24 want to share data. We found that the associations
25 were very reluctant to cooperate and collaborate in

1 this approach because this data could maybe make
2 their homes look bad. You know, outbreaks are not
3 good for business, for example. We started seeing
4 an increasing reluctance through the Ministries of
5 Health and Long-Term Care and Seniors' Affairs and
6 Accessibility to share the data that they were
7 having.

8 As we were developing this and we were
9 showing them what we were doing, for example -- and
10 again, everything we have is publicly accessible.
11 There is no shock factor here. It is just accurate
12 reporting. We found that other ministries like BC
13 and Alberta have been terrific. We will let
14 them -- we send them our spreadsheets, and they
15 actually update them for us and they actually help
16 correct it so that we have clearly accurate
17 information.

18 But I have made several requests to the
19 Ontario Government and I have all this documented
20 in emails asking how do we actually get information
21 and better access to streams to actually make our
22 work more efficient and ensure it is accurate, and
23 those responses still have not -- we still haven't
24 been met with an adequate response.

25 We have had many phone calls with folks

1 like Matt Anderson from Ontario Health who says we
2 are absolutely interested in being transparent, but
3 this data would come from the Ministry of Long-Term
4 Care, the Ministry of Health, the Ministries of
5 Seniors' Affairs and Accessibility and the
6 Retirement Home Regulatory Authority. And I think
7 as you can imagine, any time you make a request,
8 your emails kind of get responded to saying that
9 we'll look into this, we'll get back to you, but I
10 have learned over time in a career in working with
11 government that, you know, not responding is a
12 perfectly reasonable response. And it hasn't been
13 clear why there is a reluctance to participate in a
14 more transparent method of reporting information
15 and data.

16 And my point is that this sort of data
17 and this information, for example, can help with a
18 local grounded response, because one thing that we
19 heard routinely through this period is when the IMS
20 table was created, and I certainly talked with
21 Rachel Kampus, she was my original ADM, interim ADM
22 when I started working with the government in 2012,
23 I sent her our proposal about the tracker and I let
24 her know what we were doing and how it is a
25 resource. She told me she thought it was a great

1 idea and that it could be very helpful as the
2 government created its IMS table to try and help
3 better coordinate.

4 But one of the things that she shared
5 with me and that we readily know is we had this
6 red/yellow/green system that the Ministry of Health
7 had created to try and identify homes that were in
8 crisis, homes that were stabilized, and homes that
9 were, you know, a rising risk or in danger.

10 What was troublesome for me to hear
11 from local homes in the Toronto region and others
12 around was they weren't aware that they were
13 actually being colour-coded. They weren't aware
14 that actually those questionnaires that the
15 Long-Term Care Inspectors were asking them on a
16 daily basis were actually determining their risk.
17 And even when they found out that they were being
18 rated as a red, yellow or green home, they weren't
19 actually having their own status disclosed to them
20 to help them out.

21 And so I think really there is a common
22 theme here that, yes, there has been an interest.
23 Everybody has been interested in collecting their
24 own data, analyzing their own data, for example,
25 looking at it to determine their own things, but

1 there hasn't really been a more public open data
2 response that can help frontline providers and that
3 can actually help everybody look at this data
4 together in a collective way and that can actually
5 better respond, and I think other provinces
6 accomplished this in a more robust way and in a way
7 that worked better that way.

8 I am going to pause there on the data,
9 just in case there is a question before I talk
10 about coordination and visitation.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Dr. Kitts.

13 COMMISSIONER JACK KITTS: That is
14 excellent. And it is my experience as well that
15 there is a lot of data, and I think what you don't
16 hear clearly is who is leading, who is accountable
17 for the data.

18 You spoke to the notion that Public
19 Health Units are accountable for outbreaks, but
20 there is government that is accountable and has
21 data, Public Health, and IPAC, which I think is
22 mostly housed in hospitals.

23 And then there is the leadership, the
24 governance and management of the long-term care
25 home itself, and I may be missing it, but it seems

1 that that's where the ownership should be in terms
2 of the performance of the home and the data,
3 similar I think to hospitals.

4 But did you come across any clear lines
5 of accountability and alignment that really defines
6 where is the most responsible organization? Is it
7 government? Is it long-term care homes? Is it
8 Public Health?

9 DR. SAMIR SINHA: Great question, and
10 so I think part of the issue is kind of I think at
11 a home level, for example, a home absolutely has to
12 report kind, if you will, if they are in an
13 outbreak, for example, they have to report to the
14 Ministry of Long-Term Care. So that is that piece.

15 When it comes to the other types of
16 data that a home would have in terms of their
17 governance, you know, their structures, their
18 staffing ratios, their PPE supply, for example, or
19 even their performance, you know, that is all
20 things that are happening at a home level.

21 One thing that was very interesting
22 when I was working with the associations back in
23 February, for example, to try and help homes kind
24 of work, you know, and get them ready, saying that
25 this is a pandemic and this has now been declared,

1 and I remember doing a webinar for all long-term
2 care and retirement homes in Ontario in partnership
3 with the three associations and some of the key
4 messaging we had at that time and some of the early
5 conversations we had was that one of the big
6 challenges that they had at the time was that homes
7 were very reluctant - and I think this is on the
8 long-term care side, if you will, but also the
9 retirement home side - actually being honest about
10 their PPE supplies.

11 So to your question, Dr. Kitts, about
12 like at whose level do we need to be understanding
13 what that issue is? That would be a home level
14 thing.

15 But homes, for example, I didn't want
16 to tell you, to any of you, that actually the
17 cupboards are bare. We don't actually have PPE.
18 Some homes actually were well-stocked with PPE, but
19 I heard often that many homes were reluctant to
20 honestly disclose their situation principally out
21 of fear that they would be penalized, that they
22 would actually be told by the government, for
23 example, that you are not in compliance with 'x' or
24 'y', even though I think the government genuinely
25 was trying to say this is a no-blame situation. We

1 just really will do well if we know what your
2 situation is. But I understood and I could see
3 routinely through the bulletins I get from the
4 associations that they were begging homes, saying
5 that you have not filled out your PPE reports and
6 you haven't told us what your situations is. We
7 need that information. The Ministry needs that
8 information to be able to tell you.

9 I think when it comes to a higher level
10 about, okay, there is an outbreak and who should be
11 in charge of that data, I think this is where there
12 was a lot of confusion and I think, you know, to a
13 certain extent I think a comedy of errors.

14 I think when I spoke to Matt Anderson
15 early on, and I have a good relationship with him,
16 you know, and asking him about data and what is his
17 take on it, he said to me that at the command table
18 level, one of their biggest challenges during the
19 first month or so of the pandemic, if you will, was
20 just trying to get good quality data, you know,
21 because the command table obviously is dealing with
22 data from a number of different sources.

23 But as I just shared with you, the
24 retirement home situation, well, there wasn't even
25 a requirement for retirement homes to tell the

1 Retirement Home Regulatory Authority. And so there
2 was some work being done behind the scenes to try
3 and change their regulations to require retirement
4 homes to start reporting data into a stream, if you
5 will.

6 And Public Health Units already had a
7 mechanism, but quickly it was being found that that
8 mechanism wasn't timely, it wasn't accurate, and it
9 wasn't that -- or I won't say it wasn't accurate,
10 but I'll say that because it wasn't timely and it
11 wasn't consistent, I think that the Ministry was
12 having trouble trying to rely on that.

13 So I think when you think of the
14 command table itself that was trying to bring
15 together three different Ministries that have a
16 stake in long-term care, the Ministry of Health
17 from a Public Health response standpoint, the
18 Ministry of Long-Term Care from a nursing home
19 standpoint, and Ministry of Seniors' Affairs and
20 Accessibility from a retirement home standpoint, I
21 think you have three different Ministries, and then
22 you have Public Health, you all of a sudden have
23 three different -- there is a real focus as opposed
24 to a definitive we need to have one system and this
25 is how we are going to report.

1 And I think partly, you know, I don't
2 know -- I don't have enough of the inside knowledge
3 to know, for example, that was there kind of a
4 decision at one point saying we need all Public
5 Health Units to report things in a consistent way
6 to try and salvage that, because at some point, for
7 example, there became competing efforts on
8 long-term care reporting and then basically let's
9 just forget the Public Health reporting. Let's do
10 our own long-term care report with a reporting
11 standard in that way, a similar way the retirement
12 home piece, and then only a month or two later or a
13 month or two ago that they started trying to
14 compile that data in a bit of a similar way or
15 demonstrate in a similar way.

16 So to be honest, I think, you know, at
17 an outbreak level and beyond, I don't think it has
18 been very clear, for example, how that data needed
19 to be reported. But then second to that, all of
20 those other aspects from IPAC and that, I know the
21 long-term care, the Ministry itself, they have a
22 Data Analytics Branch, you know, that has been
23 taking a look at their own internal long-term care
24 tracker that they have created and it does have a
25 lot of information there. But to be honest, I

1 don't know at what level that information really
2 gets shared at the regional level, reasonably gets
3 shared, for example, with local hospital resource
4 partners, for example, that are being involved.

5 And I think, again, some really clear
6 clarity about these are the ways that we need to
7 collect data and this is the information that we
8 need to collect would be helpful.

9 I'll give you another just quick
10 example on the data front. Right now I was talking
11 to Michael Hillmer, the Executive Director of the
12 Data Analytics Branch of the Ministry yesterday,
13 because he is very interested in this issue of
14 visitors, you know, visitors coming to long-term
15 care homes.

16 The government is about to announce
17 this week or started announcing on Friday that they
18 will now allow absences, and of course, as many of
19 you will be aware of, we actually closed long-term
20 care homes suddenly to visitors, if you will, a few
21 months ago. When we started re-opening these homes
22 now, I was quite surprised to find out that we
23 haven't actually been -- at the home level we might
24 have been asking homes to log how many visits are
25 you having a day, you know, or how many absences

1 potentially, you know, what types of visits are you
2 having and what is actually happening. Because I
3 think there was a lot of reluctance to re-open
4 homes originally, some homes were saying that we'll
5 be overwhelmed with visitors and we can't handle
6 it; other homes were saying that we don't
7 anticipate it being a problem.

8 But it is interesting that, you know,
9 Michael Hillmer was sharing with me that their
10 current long-term care tracker doesn't capture
11 anything about visitation right now, and we both
12 identified that that's a problem, because right
13 now, as we are worried about a second wave, for
14 example, and the real reason to restrict visitors
15 at the very beginning was we were reluctant to have
16 visitors come into a home that potentially, like
17 staff, could bring COVID into the home, then you
18 might want to be monitoring the volumes and you
19 might want to be monitoring, you know, what types
20 of visits are occurring because, again, a
21 data-driven approach could be really helpful to
22 understand how is visitation impacting potential
23 outbreaks or spread. It could help give us clearer
24 data to understand do visits actually increase the
25 risk of COVID-19. Because great data that we have

1 from the Netherlands say that their homes that
2 re-opened to visitors months ago, for example,
3 during their pandemic, they didn't show that
4 outbreaks were being driven by visitors, for
5 example. And even Quebec made the deliberate
6 decision, because they were so short-staffed of
7 workers, to allow visitors to come into the home
8 and provide care to their loved ones because
9 otherwise they just wouldn't get care at all. And
10 we didn't hear any reported outbreaks.

11 But a good colleague of mine said, But
12 are we even collecting data to actually link
13 whether visitors are linked to outbreaks as well?

14 So there is an interest to say that,
15 again, how are we actually having an open data
16 approach to make sure that we are capturing data on
17 things that matter and that we can actually really
18 evaluate it properly, because I think with data in
19 different silos, data that is being shared in
20 different ways, for example, I think that we are
21 really still having a fragmented approach in
22 Ontario to really say that we are secure with what
23 we have and that we can make the most of what we
24 have should a second wave occur and we are building
25 a local coordination response with local hospitals

1 or Public Health Units in a meaningful way.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Doctor, I did want to follow up a bit.

4 Was there a province that had a standardized
5 realtime data collection and publication process
6 that you thought was worth imitating or copying?

7 DR. SAMIR SINHA: Yeah, to be honest,
8 like I think certain provinces were just -- I
9 always point to BC in terms of BC didn't do what we
10 saw as a geographical, you know, kind of a
11 visualization approach.

12 I mean, BC, what they would do when it
13 comes to long-term care or retirement homes and
14 hospitals, they basically lumped facilities in one
15 batch, for example, and they were clearly updating
16 their data, you know, on a daily and a regular
17 basis in that way.

18 We certainly worked in collaboration
19 with the Office of the Seniors Advocate of BC, you
20 know, to actually make sure that we have the
21 correct information for our tracker moving forward.

22 I don't see any province, for example,
23 that has done a particularly robust way of, you
24 know, showing, for example, geographically.

25 What we were actually quite impressed

1 with was awhile after we had started our own
2 Canadian tracker, if you will, our visualized
3 method of understanding outbreaks in a much more
4 clear and transparent way, for example, the CDC in
5 Atlanta actually came out with something that I am
6 incredibly jealous about, and this is where they
7 actually have an exquisite tracker. It looks very
8 similar to ours. It shows a map of the United
9 States. It shows every single home that has
10 actually had an outbreak and where it is located
11 and very detailed data to actually get that
12 response.

13 I don't know if more recently where the
14 U.S. government has actually decided that people
15 don't have to report their data to the CDC but now
16 towards the U.S. government instead of as opposed
17 to the CDC, I don't know if that has hampered the
18 CDC system.

19 But the CDC system, I thought, which
20 came online after ours - and I am not trying to say
21 that our work was in any way as exquisite as the
22 CDC's work - but I was just really impressed. If
23 you want to have an example of an incredible
24 example of a clear dashboard that could actually
25 give you geographical information to say what was

1 happening in your community, what was actually
2 happening at a home level, I thought that they did
3 an exquisite job with what they had actually
4 created, if you will.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 And I had a second question and it
7 related to staffing, and I don't want to get back
8 into that in a serious way because I know there is
9 other aspects of this that you want to comment on.

10 But was there some place that had found
11 a way to achieve the kind of integrated staffing
12 model that you were talking about?

13 DR. SAMIR SINHA: Yeah, so I think a
14 few examples that I think are helpful, quickly, is
15 that, again, I think, you know, BC, for example,
16 they did a really good job. You know, first of all
17 they -- you know, and I would encourage you to talk
18 to the folks in BC like Isobel Mackenzie, who is
19 the lead of their Office of the Seniors Advocate.
20 She has a very good handle on what happened in BC
21 and what was unique to their response, so I don't
22 want to speak on behalf of them.

23 But what I can tell you is that in
24 British Columbia what worked particularly well is
25 because they actually knew who all of their

1 registered personal support workers were and staff
2 and long-term care workers were, for example, they
3 just took over the employment of everybody. And
4 because they actually had a health authority model,
5 for example, where basically, you know, they
6 actually said, look, you know, our health authority
7 is in charge of staffing the hospitals, the local
8 home care pieces, et cetera, by doing that they
9 were able to redeploy even health authority staff,
10 for example, quickly into local homes that may have
11 needed extra support, but they were able to get
12 their whole staffing situation under control a lot
13 earlier by actually delegating who would work where
14 and to stabilize that approach in a better way.

15 In Kingston, for example, they did a
16 really good job, for example, because again there
17 was a better local coordination of approach where
18 at least between Public Health and the local
19 long-term care homes -- you know, Kieran Moore, who
20 is their Chief Medical Officer of Health for
21 Kingston was able to kind of quickly redeploy their
22 restaurant food inspectors, for example, to
23 actually IPAC coordinators in local homes.

24 And so I don't actually even think that
25 they had to really -- because they had so few

1 outbreaks in the Kingston area, I don't even think
2 they had to compel local hospitals like Kingston
3 General to get involved in that way in a
4 significant way, unlike other regions where you had
5 significant outbreaks, like Ottawa, like Toronto,
6 in that way to redeploy staff.

7 I think that the other great example
8 was say the City of Toronto, for example. So I am
9 the Co-Chair of the City of Toronto Senior Strategy
10 and Accountability table, it is a mouthful, but I
11 work very closely with the newly created division
12 which is called Senior Services and Long-Term Care.
13 And when I was helping to advise on the City of
14 Toronto's local response, for example, we had a lot
15 of great things at our disposal.

16 One is we had the City of Toronto
17 long-term care workers across ten homes and 2,500
18 beds, for example, those are City of Toronto
19 employees. So immediately the City of Toronto
20 could say, right, we need extra staffing, so all of
21 these staff that right now don't have active things
22 to do, guess what, you are all going to work in
23 local long-term care homes that are owned by the
24 City of Toronto. And they could better coordinate
25 PPE purchases. They could better coordinate

1 staffing and response because, again, these are
2 examples where the staffing of a long-term care
3 home could quickly be accommodated by other
4 staffing that were within the remit of that
5 organization, like the City, or in the case of a
6 group like, you know, Kingston, for example, you
7 had a more coordinated approach.

8 And I think when you look across the
9 country, where you have a health authority model,
10 for example, where, if you will, all the staff are
11 kind of employees of the health authority, there
12 was a much easier way to deploy things.

13 I think the challenge that we had in
14 Ontario where long-term care homes really are
15 independently governed organizations like a
16 hospital, even like a Public Health Unit, for
17 example, where you saw readily deployed staffing
18 work was where there was a good relationship, where
19 there was a pre-existing or a very quickly
20 developed relationship.

21 But in other situations where there
22 weren't those deeply formed relationships or those
23 naturally existing relationships, I remember being
24 on calls with the Minister of Long-Term Care where
25 I was begging her at one point to compel the

1 hospitals to get involved. I was constantly
2 getting calls from local long-term care homes that
3 were in crisis. I was calling up CEOs of local
4 community agencies and organizations.

5 You know, we had a Chinese nursing home
6 in Toronto that is very close to my hospital that
7 was having cases and it was a disaster there, and
8 what I was doing was I was calling the -- I am the
9 Honorary Medical Advisor for the Chinese Community
10 Organization here. I called up the CEO and said,
11 Could you get staff in? She did and they got sick.
12 That actually compromised the supportive housing
13 site they had. I then asked the CEO of a private
14 home care company if they could send in people,
15 because if the home had money they could pay for
16 it, and they could only staff up with one or two
17 people. The home was desperate and I was hoping
18 that my hospital, for example, would be able to
19 step in and see where we could deploy ourselves and
20 help out, but there was a reluctance. I think a
21 lot of hospitals were reluctant because they were
22 worried what happens if we have an outbreak here as
23 well.

24 And so this is where I had to, at that
25 point where we didn't have natural relationships

1 and networks -- and in my role working through the
2 Toronto LHIN, for example, you know, I was asking,
3 you know, our LHIN CEO, our OH Toronto CEO to say,
4 you know, we need to start compelling the hospitals
5 to get involved.

6 And so I remember being on a call with
7 the Minister the weekend before or a week or two
8 before Premier Ford announced that hospitals were
9 going to get involved and was basically saying, you
10 know, Look, homes are in crisis. They need staff.
11 People don't want to just necessarily go volunteer
12 and work in these homes.

13 And so I gave her two options at that
14 point. I said either at this point you compel
15 local hospitals to get involved or you get the army
16 involved. And I remember the conversation was like
17 we can't get the army involved, that looks like a
18 failure. And I said, right, you know, so then
19 you've got to compel the hospitals.

20 A few days later, you know, here is
21 Premier Ford saying that we are getting hospitals
22 involved. Of course, hospitals had no clue what
23 that meant. I don't think many hospitals
24 appreciated what does that mean that we are
25 involved as a SWAT team. I know at the LHIN level,

1 the regional level, you know, then it was left to
2 the regions to kind of figure out what a SWAT team
3 means. And you will see that across the province,
4 SWAT teams have evolved organically in different
5 ways and whatever those relationships were. But
6 there wasn't a clear that these are the
7 expectations and these are the roles and
8 responsibilities, because these are all independent
9 authorities.

10 And then obviously the army gets called
11 in. We are now redeploying school board employees,
12 because I think by this point, all of those delays
13 in getting a coordinated effort in place or even
14 thinking about understanding all of these issues I
15 have just talked about as potential liabilities, I
16 don't think they were well appreciated. And I
17 think by the time they were appreciated, I don't
18 think we were acting quickly enough, especially
19 when we didn't have some of those baseline
20 relationships and baseline kind of practices or
21 things in place that could allow us to be nimble.

22 I think we now have an opportunity with
23 all the lessons we have learned through wave one to
24 try and say, okay, you know, it didn't go so great
25 but we are through this, through a bit of luck and

1 through a lot of effort, but now knowing what we
2 do, we need to actually quickly make sure that we
3 have got these pieces in place. But I personally
4 don't have the confidence that we do have that,
5 that we do have those clear issues that I have been
6 talking about - data, coordination and coordination
7 of efforts in place at this point to actually be
8 ready to respond should we have a significant
9 second wave on our hands.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 All right, I don't know if there were
12 any other questions? Yes, Dr. Kitts.

13 COMMISSIONER JACK KITTS: Just quickly,
14 Dr. Sinha, I don't know whether you know enough
15 about Ontario Health Teams, but do you think that
16 that's a solution to the coordination and bringing
17 all affected parties together for a second wave?

18 DR. SAMIR SINHA: Yes and no.

19 I'll say it this way. So right now we
20 have about I think the latest number is about 30
21 Ontario Health Teams. We have others that are in
22 development at the moment.

23 You know, what I can tell you is that
24 back in February, for example, I was asked by the
25 Ministry of Health to provide some further advice.

1 As Health Teams were being formulated, the Deputy
2 Minister had asked my advice and support, you know,
3 to help provide a geriatric lens and advice towards
4 Health Team development.

5 So you have to remember that, first of
6 all, we have a few dozen Health Teams that have
7 been approved, if you will. I think there was a
8 recent announcement that we had I think five or six
9 more that had now been green-lit, if you will, to
10 be Health Teams.

11 But you have to remember that let's say
12 there is 30 Health Teams, I don't know the exact
13 number to date, for example, but that doesn't cover
14 a significant part of the province, and number two
15 is that only I would say about maybe 20 or so have
16 actually chosen the frail elderly, if you will, or
17 older adults as a key focus of their Health Team,
18 of their Health Team work.

19 But the challenge with many of the
20 Health Teams are -- I think one of the benefits of
21 the Health Teams that are in development, for
22 example, or have been allowed to move forward is it
23 has at least brought people together to have
24 conversations about what they want to do.

25 And a great example is in East Toronto,

1 there is the East Toronto Ontario Health Team, if
2 you will, that right now being a team doesn't mean
3 that you actually literally have any control over
4 your resources. It is not that you actually
5 control what happens in the local long-term care
6 home or what happens in the hospital and that. You
7 just have a bunch of partners who come together and
8 said we are going to work together, and probably
9 through that process of working together, they have
10 had conversations. They actually know -- you know,
11 Dr. Kitts is a former CEO of the Ottawa Hospital
12 and probably knows who the CEO of the local
13 long-term care homes are now and the local
14 community agencies.

15 So in that way, frankly, you have some
16 of that baseline relationships and buildings that
17 can actually allow more friendly interactions and
18 more coordinated approaches.

19 So what was a really good example, if
20 you want a good Ontario Health Team example, was
21 because there has been years and years of work in
22 East Toronto building that relationship with an
23 interest in the frail elderly as one of their
24 focus, at the beginning of the pandemic we saw that
25 the Michael Garron Hospital, which is the anchor

1 hospital, they were able to kind of coordinate a
2 local long-term care home response. So I think the
3 eight or ten homes or so in their region, they were
4 more proactive than, before all these other SWAT
5 teams were being created, to be able to work there.

6 But I think that wasn't because of the
7 Health Team. You know, well, I think it was
8 facilitated by their desire to become a Health
9 Team, but it wasn't that this was a funded effort.
10 It wasn't that this was a required effort.

11 So this is where I think that Ontario
12 Health teams can be enablers because they are
13 building local networks. But again, we have to
14 remember that most of the province isn't covered
15 with a Health Team. Even if you are covered with a
16 Health Team, it is not guaranteed that the frail
17 elderly are a focus, and therefore, local long-term
18 care and retirement homes are actively
19 participating in a meaningful way.

20 But I think where there are Health
21 Teams, we should leverage that if that can be a
22 mechanism, for example.

23 But I think, you know, moving forward,
24 I think what is important is to understand how did
25 every Ontario Health region or LHIN respond. You

1 know, what were the things that we learned overall,
2 so what happened in the Champlain or the East
3 Region, for example, versus in Toronto. I think
4 they figured out, because they were given a lot of
5 leeway by the government to how they actually
6 wanted to create their own local response, I think
7 at this point it is better to figure out what
8 worked well and what didn't and what are the
9 lessons we can share, and then what are the things
10 we need to facilitate that future local response.

11 Because right now, for example, I know
12 that my hospital, you know, Sinai Health System and
13 UHN, I think we have been partnered with about 15
14 or 20 or so care homes. You know, most of them
15 were never in outbreak, but we have established a
16 relationship where we were forced, in a good way,
17 in my view, to actually have a relationship with
18 homes, meaning that we actually have made contact.
19 We have determined if they need IPAC support. We
20 have given IPAC training. We have said that we can
21 help supply PPE if you need that. We have done
22 those sorts of things. But to more involved homes,
23 we actually created a much more integrated response
24 to help them get through.

25 The problem is in our local situation

1 in Toronto, for example, I don't think there was
2 necessarily a need for us to create a more in-depth
3 relationship, and I don't know, for example, for a
4 home that we worked with that really didn't have
5 many needs at all and said that we are doing fine,
6 we are good with IPAC and we are good with
7 everything, I don't know if the strength of that
8 relationship is good enough now that if that home
9 entered outbreak tomorrow that we would be expected
10 and ready to response or if we would kind of look
11 to the LHIN first and say, are we expected to now
12 be their resource partner for life or in a coming
13 wave or, you know, what is the expectation of these
14 groups and partners.

15 So I don't think that that has been
16 clearly outlined, and I think that that in the more
17 immediate future could be helpful to really
18 actually help ensure like what are the
19 expectations. And where there might be a local
20 Health Team, an Ontario Health Team, we might say,
21 right, the Ontario Health Team has created their
22 own local effort. I just think the problem is
23 right now we don't have enough of clear
24 standardized infrastructure in Ontario where we can
25 dictate what a common response needs to be.

1 What I think we want to make sure that
2 is in place is that we know that in every part of
3 Ontario where there are homes and there are local
4 partners, what does that local response need to
5 look like. And working at my own level for Ontario
6 Health, I can't tell you confidently in Toronto
7 Region, for example, or in any other region, that
8 we now have it clearly baked that if home 'x' goes
9 into outbreak, this is exactly kind of the way that
10 that local response is supposed to occur with their
11 hospital resource partners or with their OHT or
12 whatever the case is. And I think that would be
13 helpful with clear direction in that way, you know,
14 to move that forward.

15 COMMISSIONER JACK KITTS: Thank you.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 I think you may have covered it, but
18 you did mention local coordination with the
19 hospitals, and I think you have sort of talked
20 about that.

21 And finally, then you were talking
22 about patient visitation policies.

23 DR. SAMIR SINHA: Yes, so one of the
24 challenges that we have had in terms of kind of
25 from a thinking about it at the end of the day,

1 this is all about the residents, right. These are
2 about people who are in these settings and how do
3 we actually support these folks.

4 So you know, as you probably are well
5 aware, the average or the typical person who enters
6 a long-term care home typically is in the last two
7 years of their life. We know that life
8 expectancies are declining. It doesn't mean they
9 are palliative by nature.

10 I know I was certainly distressed when
11 you have heard, you know, we have had various
12 officials who basically have said, Well, you know,
13 if they go a little bit sooner, you know, is that a
14 big deal because they are towards the end.

15 I mean, at the end of the day, yes, you
16 could say these folks are in the last years of
17 their life, but they are not all imminently
18 palliative in that way.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Oh, I am not sure those officials would
21 feel the same way if they were talking about
22 themselves.

23 DR. SAMIR SINHA: A hundred percent.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 They might see the two years as quite

1 important.

2 DR. SAMIR SINHA: I a hundred percent
3 agree. But it was interesting to see kind of I
4 think what was a challenge for me personally as a
5 clinician was I was having a lot of calls with
6 other, you know, kind of geriatric leads at other
7 hospitals across the province who were experiencing
8 a lot of moral distress because they felt that
9 certain partners were not valuing their roles with
10 the long-term care homes as important because
11 perhaps the lives of those patients weren't
12 considered as valuable or those residents weren't
13 considered as valuable because potentially they had
14 a shorter life expectancy ahead. So I agree.

15 I mean, these are deeper issues when it
16 comes to the issues of ageism, and when we think
17 about sectoralism, for example, these are a lower
18 paid, a less respected workforce versus kind of our
19 hospital workforces in that way.

20 But when we come, for example, to the
21 consideration that when we think about these
22 residents and what is important to them, for
23 example, that often at this point when many are
24 living with dementia, many need kind of very
25 specific care needs and those familiar faces

1 around, for example, that, you know, visitation
2 from visitors, whether it would just be on a
3 socialization basis or from a family caregiving
4 benefit, is absolutely important.

5 I think one thing that actually has
6 gone under the radar for a long time, partly
7 because we don't actually measure the number in any
8 meaningful way, is I don't think we have ever
9 actually understood -- we do a good job actually
10 understanding what the residents in these homes
11 look like because I think on an every six months or
12 so or maybe even on a quarterly basis we do
13 something called the interRAI Assessment and this
14 is an assessment that we do to kind of assess what
15 are the care needs of the individuals in these
16 homes, for example, so that we understand what are
17 their limitations, what are their care needs, for
18 example, and that helps the Ministry understand the
19 complexity of the residents in that home. That
20 actually helps inform the funding envelope for that
21 home, the care envelope for that home, but it also
22 helps us appreciate the complexity. And that is
23 when I tell you numbers like 70 percent have
24 dementia, 50 percent are living with behavioural
25 issues, this is where I am getting that data from,

1 because we do a pretty good job collecting that
2 information.

3 Where we don't do a really good job is
4 understanding the role of family caregivers in
5 these settings. A lot of people just assume that
6 when you go in, when you go into a home, well, you
7 have the caregivers there, the paid care providers,
8 the nurses, the PSWs, and the doctors who are
9 providing all of the care.

10 But they forget that a lot of these
11 individuals prior to going into these homes were
12 being cared for by individuals who might have been
13 receiving 24-hour supports from family members in
14 addition to home care workers and other things and
15 that when these individuals go into homes, for
16 example, that they often do have spouses or family
17 members who might be going to visit every day or
18 several times a day, for example, and helping with
19 very essential and personal care tasks, like
20 feeding or dressing or bathing because that person
21 doesn't trust anybody just to come and do that task
22 with them or, frankly, they respond better when it
23 is a familiar face or a loved one doing that care.

24 Some of the care, like feeding, for
25 example, for an individual might take 45 minutes to

1 help them get, you know, a good meal into them, for
2 example, but you can imagine if a personal support
3 worker is caring for up to ten or even more people,
4 they only have a certain amount of time, and the
5 military reports really started reflecting on this
6 in a short-staffed environment how, you know,
7 feeding or basic care needs were being neglected or
8 not being met.

9 I think the challenge we had is at the
10 very beginning of the pandemic, for example, I
11 didn't disagree with the approach of saying that
12 right now, with community spread being what it is,
13 we need to limit the number of visitors' foot
14 traffic going into homes.

15 So when we said, yes, let's actually
16 ban visitors from going into homes, I was fine with
17 that and I think most people were. I am not going
18 to lie to you and say that I was always against
19 that, because I think at that time we were just
20 trying to do the right thing and do the best thing
21 by limiting visitations.

22 I think certainly we did say that if
23 someone is palliative and right at the end of life,
24 we will allow people to go in, you know, to try and
25 visit their loved ones and do that, but I think in

1 many cases we have heard that many families, you
2 know, weren't even facilitated or given that
3 opportunity to go and say good-bye to their loved
4 ones or do that for various reasons.

5 I think more importantly that months in
6 now, as we start to re-open homes, I think the
7 guidance has not been as evidence-based and
8 evidence-informed as we need it to be, and this is
9 the idea that, you know, while we were saying that
10 we are going to allow outdoor visits, you know,
11 social visits, for example, but we weren't going to
12 allow family caregivers to come back in and it was
13 hard to understand kind of what the reasoning
14 around this was.

15 I know certainly, for example, there
16 was the view that, well, if we have family
17 caregivers coming in to care for their loved ones,
18 to help feed them or do things with them in their
19 homes, for example, could that introduce COVID, for
20 example.

21 But again, the evidence was showing
22 from the Netherlands or other countries or other
23 jurisdictions that these family caregivers, they
24 don't want to cause harm to their loved ones.
25 Often, you know, if you tell them and if you treat

1 them like staff saying if you want to come in, we
2 are going to have you learn IPAC procedures; we are
3 going to have you learn how to don and doff PPE; we
4 are going to treat you like we would staff, that
5 these folks, their interest is to help their loved
6 ones out as well.

7 But I think that what we saw was a
8 lot of pushback originally and a lot of
9 non-evidence-informed recommendations. I know,
10 for example, that there was this desire to make
11 sure that every visitor has to get a COVID-negative
12 test within 14 days. Well, I sit on the COVID-19
13 Testing Strategy Panel for the Government of
14 Ontario, and when we heard this requirement, we
15 didn't know where this idea came from. When I
16 talked to the Chief Medical Officer of Health's
17 staff, they didn't know where that recommendation
18 came from. When I talked to -- you know, but what
19 I have surmised is maybe this was more of a
20 political decision to basically say that we want to
21 test people.

22 But even our Testing Strategy Panel of
23 experts, we said that this doesn't make any sense
24 because a negative test 14 days ago doesn't tell me
25 what happened in the last 13 days, for example, and

1 you know, it doesn't ensure and it doesn't give us
2 free will. And even at that point at the early
3 stages we said, even if people are six feet apart
4 wearing masks, for example, we wouldn't require
5 them to get a test. And even as a hospital worker
6 right now, I have never required a test to come and
7 work at Mount Sinai Hospital, for example, you
8 know, in that way.

9 So there was a lot of things that were
10 being decided that weren't really clearly
11 evidence-based in that way and almost things that
12 were overtly restricting visitors, you know, family
13 caregivers from coming into their homes.

14 So one thing is that by being, you
15 know, frustrated as this was rolling out, for
16 example, and seeing a lot the stress, this is where
17 NIA worked, our National Institute on Aging, and we
18 actually solicited the opinions of 60 folks from
19 across the country, infectious disease experts, you
20 know, caregivers, you know, and the associations
21 themselves to come out with evidence-based
22 guidance, if you will.

23 And we shared this with the Ontario
24 Government in advance of actually publishing them
25 because we were actually encouraged by people in

1 the Chief Medical Officer of Health's office to
2 say, please share this. Please help. You know, we
3 could actually use this guidance to try and move
4 things forward.

5 And we were happy to see that Prince
6 Edward Island fully adopted our guidance, if you
7 will. We saw that the Ontario Government started
8 adapting some of its guidance in its second
9 iteration, and we have been told that a lot of our
10 guidance has now been incorporated in what will be
11 released this week.

12 But I will give you this example. It
13 is great that they are going to -- I emailed the
14 Deputy Minister just the other day saying, I hear
15 that you have actually found our guidance very
16 helpful and that I am glad to hear that it is going
17 to be informing new guidelines coming out. They
18 have never called me. My colleague and I who have
19 written it, we said, should we reach out to them?
20 I said, they know who we are. They could call us
21 if they wanted to. But you know, I asked if we
22 could get an advance copy and I said I'll sign a
23 non-disclosure agreement, right, because I am not
24 here to try and scoop or cause problems, but I
25 said, you know, at least our messaging can be

1 supportive and helpful and we can understand and we
2 can know how we can respond constructively. But
3 I'll be interested to see when this is announced
4 later this week what it says and does it fully
5 comply with our guidance or not.

6 But our challenge right now is that
7 this has been an example where I think a lot of
8 family caregivers have been incredibly frustrated
9 because by not being able to get in, back into the
10 homes in a timely way, in a structured way, as
11 other jurisdictions like Quebec, other
12 jurisdictions like, you know, in the Netherlands,
13 for example, who have been doing this for months
14 now and safely, and then finding out this week that
15 the government doesn't have any mechanism through
16 its data collection systems to actually even keep
17 track of visitations or now absences, et cetera,
18 you know, then my big worry now is that it is great
19 that we are finally saying that people can visit
20 their loved ones in homes, that family caregivers
21 can come into homes, but one thing that I have
22 realized is you can have good policy and bad
23 practice.

24 At the home level, what you are seeing
25 is many homes are saying, great, it's great that

1 the Ministry is saying that people can come and
2 visit and have absences, but we don't have the
3 staff and we don't have the resources to facilitate
4 this, and so we can't facilitate this.

5 So we still have many homes that are
6 saying we can only allow you to have one visit a
7 week and 30 minutes, and we can only facilitate an
8 outdoor visit or we might be able to facilitate an
9 indoor visit. And what we are even seeing is that
10 while the policy is permissive in saying that we'll
11 allow more people to come in, many family members
12 are still being shut out because the home is saying
13 that we don't have the resources and they are
14 saying the government won't give us more resources
15 to help out.

16 So part of our guidance recognizes
17 that, you know, the government should be there.
18 While the government has said no expense will be
19 spared and we'll make sure everybody has PPE and
20 we'll support you in this way, you know, a lot of
21 homes are saying that we don't even have the
22 adequate resources to really support and encourage
23 family visits that are happening.

24 My final worry is that without a
25 data-driven approach, without the right resources

1 to support family visiting and this essential thing
2 that is important not only to the residents but to
3 their families and friends in that way, and
4 especially that family caregiving component, we
5 have actually been starting to see the data that is
6 showing that there has been increased rates of
7 malnutrition, increased rates of functional
8 decline, increased rates of behavioural issues,
9 increasing use of anti-psychotics.

10 So some of the homes, like the Peel
11 Region homes that have been sharing their data
12 publicly in the newspaper, are showing that their
13 residents have been declining, you know, that there
14 have been marked declines.

15 Some of the literature that is coming
16 out, there was a big paper that was just published
17 recently, just this past week, which was showing
18 that rates of malnutrition or weight loss have been
19 increasing, for example. That wasn't Canadian data
20 but that was I think U.S.-based data.

21 But we are actually seeing that we are
22 having challenges right now, you know, that are
23 affecting the well-being of these residents as
24 well, and I think that is really challenging to
25 families because they are wondering that right now,

1 if COVID doesn't get them, you know, will these
2 restrictions be kind of what actually hastens and
3 creates that.

4 So we reached out to the Government, to
5 the Deputy Minister to say we would love to work
6 with you because partly - and working with the
7 Ministry of Health - to say if we collect this
8 data, if we can get more data to talk about this,
9 not only will this help us to understand how do you
10 shut down homes, for example, or you know, but how
11 do you re-open them. And if we do have another
12 outbreak, for example, how do we actually do it in
13 a way that can actually be systematic, can be
14 transparent, and can be clear so that families
15 don't feel incredibly more frustrated and residents
16 also feel frustrated as well.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Let me ask the same question
19 essentially that I asked before. Was there a
20 jurisdiction that you felt had captured visitation
21 policies in a way that is worthwhile for us to
22 either copy or look very closely at?

23 DR. SAMIR SINHA: Yes, to be honest, I
24 think everywhere in Canada and the U.S., I mean, I
25 am part of an international research network that

1 basically shares kind of the frustration of
2 visitation policies and these challenges.

3 I think the earliest jurisdiction to
4 get out there and actually do things, you know,
5 were the Netherlands, for example, where they
6 actually just said that for these family
7 caregivers - again, I differentiate visitors, ones
8 who might come by once a week for a social visit
9 versus a family caregiver.

10 But in the Netherlands, they certainly
11 introduced family caregivers in place early on.
12 Quebec actually introduced family caregivers I
13 think out of necessity just to have hands-on care
14 being provided.

15 But I think now, I think, you know, the
16 guidance that our NIA has put out that the Ministry
17 certainly has, I understand that the forthcoming
18 guidance that is supposed to be released this week
19 goes as far as we were saying, that even we believe
20 that family caregivers should be allowed to come
21 into a home during an outbreak, for example,
22 because, again, just as staff can come into a home
23 during an outbreak to provide care, a family member
24 could as well, provided that they are also being
25 taught IPAC procedures, how to don and doff PPE,

1 and that they are compliant with those roles and
2 responsibilities.

3 So I think that there is clear guidance
4 here, but I think we need to be capturing the data
5 around visitations.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 I understand.

8 DR. SAMIR SINHA: And the other thing
9 too is right now, talking to the Ministry of Health
10 folks from the Data Analytics Branch, is that right
11 now, for example, we are not sure, for example, if
12 Public Health, when they are actually investigating
13 an outbreak, so say we have an outbreak in a home
14 and we have three cases, we are not sure -- you
15 know, right now we assume that right now Public
16 Health is trying to determine was it a staff member
17 who brought it in, for example, but we are not sure
18 if they are actually capturing, for example,
19 visitor-related infections or a visitor-induced
20 outbreak, for example, because if we don't have
21 that sort of data, then we are worried that we'll
22 continue to openly villainize, for example, family
23 caregivers as potential risks when they may or may
24 not actually be risks at all.

25 So one of the things we have been

1 talking about is should we also be making sure that
2 when Public Health Units are investigating, have
3 they been capturing any data related to was the
4 outbreak due to a visitor versus a staff member
5 bringing it into a home, for example, and then in
6 that way, you know, are we capturing the data to
7 inform our policies and our approaches moving
8 forward to determine how we should re-open or close
9 homes to visitors themselves.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 All right. Ms. Coke, do you have any
12 questions?

13 COMMISSIONER ANGELA COKE: No, you have
14 captured what I want. I was trying to figure out
15 who is best practice in these areas, and you have
16 answered my question.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Dr. Kitts?

19 COMMISSIONER JACK KITTS: Yes, let me
20 see if I have heard you correctly.

21 So there is now a government policy
22 informed by your group, NIA, that allows visitors;
23 is that correct?

24 DR. SAMIR SINHA: Yes, currently what
25 has been published so far, we are on currently

1 iteration number two of long-term care retirement
2 home and I think group home guidance, if you will.

3 What I do understand is that the third
4 iteration will be released publicly this week.

5 COMMISSIONER JACK KITTS: Okay, and it
6 is based on I think what you said is there is good
7 evidence to suggest that visitor restriction has a
8 negative effect on residents both physically and
9 mentally?

10 DR. SAMIR SINHA: Absolutely.

11 COMMISSIONER JACK KITTS: But there is
12 no real evidence to suggest that allowing visitors
13 causes any harm, particularly in increasing the
14 number of outbreaks; is that --

15 DR. SAMIR SINHA: Right, and we don't
16 have evidence to support that, but being absolutely
17 open and honest, for example, we don't know, for
18 example, how well that sort of information has been
19 collected to say yea or nay to that.

20 But right now we haven't heard of kind
21 of any significant outbreaks occurring in Canada
22 secondary to visitors after we started or since we
23 have started re-opening homes.

24 I think you could imagine that in the
25 early days, for example, in Quebec and Ontario and

1 other jurisdictions, there very well could have
2 been the introduction as community spread was
3 occurring, as we were trying to get a handle, but I
4 think the key I would say since we have started
5 re-opening homes, there hasn't been any clear
6 evidence to suggest that visitors are bringing this
7 into the homes themselves.

8 COMMISSIONER JACK KITTS: But because
9 of that lack of evidence, I think you have said
10 that different long-term care homes are applying
11 the policy in different ways based on their
12 beliefs, and so the policy isn't really as
13 effective as it could be and you are looking to get
14 the evidence to show that it doesn't cause harm?

15 DR. SAMIR SINHA: Exactly, and I think
16 the key is that we would like to be able to -- you
17 know, again, better data collection would actually
18 help us to be able to more definitively answer that
19 question in Ontario.

20 But I think as well, I think what we
21 are seeing again in that line that I have been
22 taught, you know, good policy, bad practice, for
23 example, is that some homes are basically saying
24 that we are protecting our residents, and you know,
25 we are giving them extra protection by really not

1 allowing visitors to come in or really restricting
2 this.

3 Other homes are using I would say an
4 excuse to say we just have insufficient staffing to
5 support this. We would like to do this, and
6 frankly, it is the government's responsibility to
7 give us more funding or supports. And I might be
8 sympathetic to that argument to say if we are
9 saying we want to make sure you have ample supplies
10 for PPE and we are saying to you that this is the
11 way that we recognize and see these family
12 caregivers as essential care partners, we need to
13 facilitate their entry and their support and their
14 training and we should put resources towards that,
15 I think absolutely.

16 But I think right now, what we are
17 seeing ultimately are residents and family members
18 being caught kind of in this situation where, you
19 know, I would say an absence of evidence but also
20 kind of an absence of resources or support are
21 allowing us to facilitate their participation.

22 COMMISSIONER JACK KITTS: Thank you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 All right, anything further, Dr. Kitts?

25 COMMISSIONER JACK KITTS: No, that is

1 good.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Ms. Coke?

4 COMMISSIONER ANGELA COKE: Sorry, this
5 was just wanting to clarify something that you had
6 mentioned when you were talking about integration
7 and coordination.

8 And you know, what I understood is that
9 informally people have relationships and people may
10 have connected, but was the point that there isn't
11 a formalized partner integration strategy and, you
12 know, if there was a more formal understanding of
13 this, you know, that this is who kicks in and who
14 helps who during a pandemic, something that is
15 defined, who do you see as the coordinator of that
16 effort? Is this a LHIN thing or who?

17 DR. SAMIR SINHA: Absolutely, so I
18 think, you know, so it is a good point and I will
19 just expand on this a little bit.

20 So actually, in a few weeks, our NIA in
21 partnership with the Canadian Red Cross are
22 actually releasing guidance on emergency
23 preparedness or emergency preparedness that
24 actually has been endorsed by all the long-term
25 care associations in Canada, including the Society

1 For Long-Term Care Medicine, for example.

2 And originally, this is work that I
3 started -- I sit on the American Red Cross
4 Scientific Advisory Council as their only
5 geriatrician member, and three years ago I started
6 working with the American Academy of Nurses on
7 developing guidance, disaster preparedness guidance
8 in the United States that looks at a number of
9 domains, including health care facilities as well.

10 And one thing that we did focus on was
11 that when you look at the U.S., which has varying
12 levels of policies and guidance, for example, we
13 did focus on legislation in Florida, for example,
14 where a local home has to create a disaster
15 preparedness plan. So they say that if there is,
16 you know, a fire, if there is a flood, if there is
17 a hurricane - I don't know if it extends to
18 pandemics or an outbreak, for example - that they
19 need to have an emergency plan and that plan needs
20 to be actually developed in coordination with their
21 local EMS responder, for example, so their local
22 office of emergency services, if you will, in that
23 way. It has to be signed.

24 So for example, we might say if we have
25 to evacuate the home, we are going to send our

1 people over to this hospital. We are going to do
2 'x', 'y' and 'z'. It is all laid out. And then
3 you have to have approval from your local, you
4 know, emergency response kind of unit, if you will,
5 that way.

6 I know that in Ontario, for example,
7 that all homes are supposed to have a pandemic
8 plan, for example, and I remember, you know, back
9 in February we were asking homes to review your
10 pandemic policies, review your kind of outbreak
11 plans.

12 But to be perfectly honest, I don't
13 know, for example, you know, what needs to be in
14 your pandemic plan, for example. Do our current
15 pandemic plans actually incorporate kind of what we
16 have experienced under COVID-19? Because I think
17 certainly while homes have a lot of experience
18 dealing with various outbreaks, for example, and
19 even with SARS and H1N1, I don't think it
20 necessarily -- like we didn't really have a lot of
21 transmission in long-term care settings with SARS,
22 if at all.

23 We didn't really have -- I think with
24 H1N1 I don't recall how much -- I still was out of
25 the country at that time, so I don't know, for

1 example, how much that was a long-term care issue,
2 if you will, at that time.

3 The point is that right now I think if
4 we look at those local pandemic plans, for example,
5 is this now an opportunity to say -- and what we
6 have done is in this guidance, for example, we have
7 actually reviewed over 5,000 articles related to
8 disasters, like natural disasters, everything from
9 tornados to winter storms to whatever, like heat
10 waves, for example, to also looking at infectious
11 disease, epidemics and pandemics, for example. We
12 have come up with 29 evidence-informed
13 recommendations.

14 I am happy to send that because the
15 draft is pretty much done. We are just getting
16 endorsements at the moment. We are going to
17 release this in October, but I am happy to share it
18 with the Commission ahead of time.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Well, that would be very helpful, and
21 we would appreciate that.

22 DR. SAMIR SINHA: Okay, because what we
23 basically do focus on is these notions about these
24 are sort of -- we have recommendations at a
25 facility level to think about, you know,

1 aspirationally what should we do. And this goes
2 back to that notion and some of the themes we
3 talked about, that making sure folks in these
4 homes, for example, have training in geriatrics,
5 right, and know how to care for older people, have
6 training in IPAC and these sorts of things, because
7 even more recently there are some reports coming
8 out where long-term inspectors are going to homes
9 right now, including I was just reading the other
10 day in the newspaper about Orchard Villa, for
11 example, and finding out that some recently hired
12 staff have not had their IPAC training done in the
13 timely way that has been recommended and other
14 things.

15 So clearly, you know, the goal should
16 be that if these are the standards that we
17 recommend at a level of staffing, at the level of
18 the facility, if you will, in that way, you know,
19 do our pandemic plans actually have that in mind.

20 And back to Ms. Coke's point, you know,
21 the key is now we could say that this hospital
22 around the corner in Toronto, for example, or
23 wherever it is, for example, if they were to evolve
24 into an outbreak, who is their hospital resource
25 partner? You know, what is their plan to get PPE,

1 for example? Have they made sure that their staff
2 are already equipped and trained in IPAC training?

3 You know, what are those key things
4 that they need to make sure that they have done so
5 they are well prepared? Do we make sure that our
6 medical directors, for example - and I think this
7 speaks to that advice and guidance that Dr. Collins
8 and team have provided to Ontario Health around
9 medical direction and their recommendations around
10 that - have we made sure that there is a backup
11 system in place for the medical director and those
12 sorts of things?

13 Because I think right now, by having
14 that clear plan that has to be made by the home,
15 presumably now with these new relationships those
16 plans that are home-initiated can be done in
17 partnership with their partners. So for example,
18 you know, I know as a hospital, for example, what I
19 am being implicated and what my role is, or if I
20 say I don't think that is my role, I think that
21 should be the role of so and so, either way those
22 issues can be worked out and then perhaps that gets
23 signed off at a regional level, for example, in
24 that way or with the local emergency supports or
25 services group.

1 And again, you know, there might be a
2 common recommendation that that needs to be done in
3 place, because I think in Ontario, again, our
4 challenge where we don't have things organized
5 through our local health authorities where
6 everything is owned by one entity so that it is
7 really the CEO of the health authority that can
8 just say that this is how we are redeploying staff
9 and this is what we are doing and we ultimately
10 have that responsibility. For independently
11 governed homes, for example, I think probably the
12 onus is on them to create this. Probably there is
13 the onus of the government, if you will, you know,
14 the Ministry of Long-Term Care or the Retirement
15 Home Regulatory Authority saying that you need to
16 make sure that you do this, but that home has to
17 create that. It has to be set timelines.

18 And perhaps it is kind of figuring out
19 at a local level is this a plan that is developed
20 in collaboration with a local hospital resource
21 partner, the local Public Health Unit, the local
22 Office of Emergency Management, if you will, and
23 also signed off by the LHIN, for example, to make
24 sure that occurs.

25 And I don't know, for example, if

1 something like that exists for hospitals, for
2 example, or other kind of care settings in Ontario.
3 But it is not clear to me that those pandemic plans
4 that homes were creating really worked well for
5 many homes when 480 out of the 1400 that we have in
6 Ontario, retirement and nursing, ended up in
7 outbreak, 34 percent, and it is not clear kind of
8 to what extent did those plans have in place what
9 we have currently experienced and what we have
10 currently witnessed in that way.

11 COMMISSIONER ANGELA COKE: Thank you.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Thank you.

14 Anything further?

15 Well, Doctor, this has been enormously
16 helpful and a great first step for us, and on
17 behalf of all of us, I want to thank you for a very
18 thorough and very informed presentation.

19 In case you are wondering how we were
20 going to keep track of everything you said, we do
21 have a transcript which we will use for our
22 purposes, and if there is a thought of putting it
23 on the website, we'll talk to you first and give
24 you an opportunity to read it and see if there is
25 anything you want to clarify.

1 But from our point of view, we have
2 captured everything that you have said and it has
3 been great, and we really do appreciate the time
4 and how much you know about this area and thank you
5 for sharing that with us.

6 DR. SAMIR SINHA: Thank you.

7 COMMISSIONER ANGELA COKE: Thank you.

8 COMMISSIONER JACK KITTS: Thank you.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 I think what we'll do, what I would
11 like to do is for us to convene in about 10 minutes
12 or so very quickly to just reflect on what we want
13 to do here.

14 And, Doctor, I'll leave you out of
15 that. I am sure you have got other things to do.

16 So, Alison, can you set that up?

17 MR. DRUMMOND: Yes, certainly I will do
18 that.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Okay, thank you, and good morning.

21 DR. SAMIR SINHA: Okay, thank you very
22 much, everyone, thank you for your time.

23
24
25 -- Adjourned at 9:45 a.m.

1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

5 That the foregoing proceedings were
6 taken before me at the time and place therein set
7 forth;

8 That all remarks made at the time
9 were recorded stenographically by me and were
10 thereafter transcribed;

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

13
14
15
16 Dated this 2nd day of September, 2020.

17
18 

19
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22 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
23
24
25

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