Long Term Care Covid 19 Commission Mtg.

Meeting with Extendicare
on Thursday, October 8, 2020

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4 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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7 --- Held via Zoom, with all participants attending
8 remotely, on the 8th day of October, 2020,
9 9:00 a.m. to 11:00 a.m.
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12 BEFORE:
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14 The Honourable Frank N. Marrocco, Lead Commissioner
15 Angela Coke, Commissioner
16 Dr. Jack Kitts, Commissioner
17
18 PRESENTERS:
19 Dr. Michael Guerriere, President and Chief
20 Executive Officer, Extendicare
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1 PARTICIPANTS:
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3 Alison Drummond, Assistant Deputy Minister,
4 Long-Term Care Commission Secretariat
5 John Toffoletto, Senior Vice President, Chief Legal
6 Officer and Corporate Secretary, Extendicare
7 Kathryn Bradley, Director, Strategy and Performance
8 Management, Extendicare
9 Linda Plumpton, Torys LLP
10
11 ALSO PRESENT:
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13 Janet Belma, Stenographer/Transcriptionist
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1 -- Upon commencing at 9:00 a.m.
2 COMMISSIONER FRANK MARROCCO (CHAIR): Let me
3 introduce Commissioner Coke and Commissioner
4 Kitts --
5 COMMISSIONER ANGELA COKE: Good
6 morning.
7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 -- make up the Commission.
9 MICHAEL GUERRIERE: Morning.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Well, I think we're -- are you ready to go?
12 COURT REPORTER: I'm ready.
13 MICHAEL GUERRIERE: Absolutely.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay. So are we.
16 Mr. Toffoletto, good morning.
17 So let me just kind of tell you where
18 we are at. Most times when there's a commission
19 created, it's looking back at something that
20 happened, and it's trying to figure out why it
21 happened and explain to the public why it happened.
22 Our situation's a little different
23 because we're in the middle of something. The
24 pandemic is not over, and so we have -- we can't
25 really use the traditional method of investigating

1 public hearings and a report because that can take
2 a couple of years before that's played itself out,
3 and we think we should probably try to make some
4 preliminary report sooner than that.
5 So we're focused on recommendations
6 that we might make now rather than some exhaustive
7 process. We can turn our minds to that after we've
8 been able to see if we can't make some immediate
9 recommendations that might be useful.
10 So that's kind of where we're coming
11 from, and we would appreciate your observations.
12 Whatever observations you want to give us, we'll
13 appreciate, but that's something that's of
14 importance to us, and we'll be listening very
15 carefully to anything like that.
16 So that's generally where we're coming
17 from. We have a reporter. There is a transcript.
18 And we tend to ask questions as we go along, if
19 that's okay, rather than waiting and coming back,
20 so we might, from time to time, interrupt with a
21 question, and we find that's a more efficient way
22 of going about this, so if that's okay with you,
23 that's the way we will do it.
24 MICHAEL GUERRIERE: That's great.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 That's basically -- that's basically the
2 introduction, I think. Probably take a break
3 around 10:15 or so, so you might let me now around
4 that time what's convenient, and we will do that.
5 So that's -- we're ready when you are.
6 MICHAEL GUERRIERE: Okay. Very good.
7 Well, thank you. Thanks for the opportunity to
8 present. I think we're very enthusiastic about
9 sharing our observations and some of our learnings.
10 We have tried to orient our presentation to
11 understanding what we experienced and to then look
12 forward to recommendations as to how we could be
13 better prepared for the -- for the next segment of
14 the -- of the pandemic period. So that seems to be
15 consistent with what you were looking for, but
16 certainly, happy to be interrupted at any point
17 through the presentation.
18 I just want to check to make sure the
19 sound is okay? You're hearing me okay?
20 COMMISSIONER FRANK MARROCCO (CHAIR): I
21 am. I think we -- I think we all are.
22 MICHAEL GUERRIERE: Okay. Very good.
23 So, Kathryn, if you could skip to the agenda.
24 We've organized our presentation just looking at
25 the pre-pandemic period, how we were thinking about

1 this going into the process, and then some of the
2 challenges we experienced in that first wave of
3 outbreaks that we -- that we incurred, what our
4 response was, and then looking at our preparation
5 for the second wave, and then we'll end with some
6 recommendations.
7 Before moving into the -- to the body
8 of the presentation, I do want to share an
9 observation before starting that is very hard to
10 impart when you go back and kind of dissect the
11 history of our experience. And that is the
12 incredible pace of issues and change that faced our
13 organization and, I'm sure, faced other
14 organizations as we moved through this period.
15 It was a confluence of events that was
16 certainty unprecedented in my experience, and we've
17 distilled it down to a few key things, but not a
18 day went by that an unexpected issue didn't come up
19 that challenged our management team and our
20 caregiving team to deal with that.
21 And that's something that can be
22 difficult to understand as we go into, kind of,
23 looking at how things unfolded. So I'll try to
24 highlight that at various points, and the -- you
25 know, the challenge of dealing with that. I mean,

1 our observation is is that as we've dealt with this
2 pandemic, it keeps running up against the
3 constraints of the system in some way, capacity
4 constraints, whether they be lab testing or
5 staffing or hospital beds. We keep finding these
6 situations where we're coming up against capacity
7 constraints and overwhelming them, and this has
8 been, you know, the challenge as we've gone through
9 this period.
10 So the next slide, I just want to very
11 briefly talk about Extendicare as an organization.
12 We have different components to our organization.
13 Long-term care is the biggest component, but it's
14 about half of our organization. We also have a
15 very big home healthcare organization. We operate
16 in all parts of the Province of Ontario and
17 delivered 8 million hours of service across the
18 province.
19 We also have a retirement living
20 division and then a separate group that provides
21 services to other operators, various types of
22 services, back-office services, consulting
23 services, purchasing services that allow smaller
24 organizations to take advantage of our size, scale,
25 and expertise.

1 The next page details our operations in
2 Ontario in long-term care. We have 34 homes in
3 Ontario out of our total of 58 homes. We have 7
4 retirement communities in this province as well,
5 and I mentioned home health already.
6 Our contract services group provides
7 services to 43 other long-term care homes and 5
8 retirement communities in the province, and then
9 thousands of third-party residents are getting all
10 of their products and services purchased through
11 our Silver Group Purchasing partnership.
12 We've summarized here our COVID
13 experience in terms of outbreaks in our homes, and
14 you can see the total for Canada and then the
15 specific Ontario experience.
16 So in Ontario, we've had six homes that
17 have had outbreaks involving more than ten
18 residents. We've had another six that had less
19 than ten residents impacted, and then about
20 two-thirds of our homes had no resident impact.
21 Some of them had positive staff at various times,
22 but there have been no resident infections in those
23 homes.
24 You can see that the -- just by looking
25 at the percentages, that our experience outside of

1 Ontario has been a little bit less in terms of the
2 number of outbreaks. In the Western provinces
3 where we operate in Alberta, Saskatchewan, and
4 Manitoba, only 4 of our 24 homes had an outbreak,
5 but it just illustrates the fact that, you know,
6 being in communities with very low rates of
7 infection results in lower incidents of outbreaks.
8 Our policies and practices are similar
9 across the country, so that issue of what is the
10 frequency in the broader community is a major
11 driver of outbreaks in the homes.
12 So the next couple of slides, I'll talk
13 a little bit about how we were thinking about
14 preparation for the novel coronavirus. We invoked
15 our incident management system in January. Right
16 at the end of January, they started daily meetings
17 which continue to this day.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Can I just interrupt for a minute?
20 MICHAEL GUERRIERE: Yeah.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 What was the first -- how did -- what was the event
23 that, sort of, turns the light on for the first
24 time to say, we -- we should start thinking
25 about -- about this; this could affect us or

1 something of that nature? Can you help me with a
2 timeframe where that's going on?
3 MICHAEL GUERRIERE: Yeah. Kathryn,
4 maybe we'll jump ahead two slides, and then we can
5 come back.
6 So, you know, we put together a little
7 bit of a timeline --
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.
10 MICHAEL GUERRIERE: -- to give you a
11 sense. So it was right around the first case being
12 confirmed in Canada that really worried us, and, of
13 course, we were seeing news of -- of what was
14 happening in other countries, but that was really,
15 you know, a trigger for us in terms of launching
16 our internal process.
17 We started regular updates with home
18 leadership at that time and started participating
19 in, you know, provincial meetings as well that
20 were discussing the -- you know, the arrival of the
21 virus on Canadian soil.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.
24 MICHAEL GUERRIERE: Kathryn, just, can
25 we go back again.

1 Now, it was around this time that we
2 started to get concerned about the supply of PPE,
3 and it's important to understand that, you know,
4 the way we've always managed this is to depend on
5 our suppliers for the supply chain for ordering and
6 delivery of product to our homes, so we don't have
7 a supply chain and inventory system within
8 Extendicare. We've always depended on outside
9 suppliers for that.
10 So when the supply chain started to
11 fail in terms of being able to deliver PPE, we
12 activated our procurement team to establish
13 relationships with new vendors, and, of course,
14 that was a very hazardous process because buying
15 from people that we didn't know was -- you know,
16 was a very fraught process.
17 But we moved very quickly to purchase
18 everything that we could source at that time often
19 without the customer and commercial protection, so
20 there was -- there was quite a bit of money at
21 risk, and there was concern about the pricing as
22 well because pricing was typically 20 times the
23 normal price; and that certainly caused a number of
24 organizations to hesitate to -- you know, to make
25 purchases. We didn't hesitate at that time, and,

1 you know, as a result, we were able to avoid any
2 shortages through the exercise.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Is that all around the same time, the end of
5 January?
6 MICHAEL GUERRIERE: Yes, end of January
7 into February.
8 The next -- the next page then talks
9 about IPAC, and this is a key -- key element. You
10 know, we had an IPAC playbook that, of course,
11 we've used for many years for dealing with
12 outbreaks of various pathogens including, of
13 course, respiratory pathogens like influenza. And
14 that playbook was very focused on managing
15 outbreaks through symptom screening, so, you know,
16 screening of everyone coming into the home, staff,
17 visitors, suppliers, even new residents, and then
18 symptom monitoring of residents and staff multiple
19 times a day. And you'll see why that's critically
20 important in a few minutes.
21 We -- you know, we put signage in
22 place. We implemented refresher training with our
23 staff. We also implemented a mandatory 14-day
24 isolation for new admissions. So we did all of the
25 usual things that -- that we've always done in

1 terms of -- of preventing outbreaks.
2 And then we -- you know, we also
3 realized just from past experience that, you know,
4 staffing can be a challenge in the midst of an
5 outbreak, so we advised all of our homes to
6 reinforce their staffing channels in anticipation
7 of the fact that there might be some challenges.
8 We were very concerned at that time
9 that mildly symptomatic staff might still come to
10 work because they didn't want to have any
11 interruption in their income, so we put in place,
12 you know, a new policy to pay staff that were
13 self-isolating if they were coming back from travel
14 or if they were exposed to people in the community.
15 We also began efforts to restrict
16 workers from working in multiple homes. We did
17 that -- we did that in March, although we did not
18 institute that as a mandatory policy because we
19 were concerned about its potential impact on
20 staffing. The government mandate came later in
21 April.
22 And the single-site employment
23 directive, when it did come, put a lot of stress on
24 staffing and created, you know, significant
25 shortages particularly in our part-time staff.

1 But we -- you know, we felt that we
2 were putting in place, you know, the kinds of
3 approaches that we always have that have worked for
4 us in the past, and we felt that was sufficient,
5 and as we -- you know, as we progressed into the
6 period of significant outbreaks, that proved not to
7 be sufficient.
8 So if we move to the next slide --
9 COMMISSIONER JACK KITTS: Michael, can
10 I ask you a question on that?
11 MICHAEL GUERRIERE: Please.
12 COMMISSIONER JACK KITTS: So you
13 felt -- you activated your incident management
14 system early on. You felt you had the management
15 in place pre-COVID, the management you required.
16 You didn't have an issue with management in the
17 homes?
18 MICHAEL GUERRIERE: No, we didn't.
19 COMMISSIONER JACK KITTS: Okay. You
20 felt --
21 MICHAEL GUERRIERE: We did -- we did
22 have vacancies in the homes, you know, just because
23 of the chronic staff shortages.
24 COMMISSIONER JACK KITTS: Okay.
25 MICHAEL GUERRIERE: So we did have, you

1 know, a series of vacancies across our homes, but
2 they weren't out of the ordinary, and we were doing
3 everything we could to recruit at that time --
4 COMMISSIONER JACK KITTS: Okay.
5 MICHAEL GUERRIERE: -- so there wasn't
6 much that we could do differently in that regard.
7 COMMISSIONER JACK KITTS: So I guess
8 more specifically, you had the executive director
9 leadership in place pre-COVID?
10 MICHAEL GUERRIERE: Yes.
11 COMMISSIONER JACK KITTS: Okay. The
12 second is, although it cost a lot, you felt you had
13 adequate PPE supplies?
14 MICHAEL GUERRIERE: We did.
15 COMMISSIONER JACK KITTS: Okay. And
16 you have your IPAC playbook, so you felt
17 comfortable that IPAC measures and practices were
18 up to par?
19 MICHAEL GUERRIERE: Yes.
20 COMMISSIONER JACK KITTS: So the
21 biggest issue you had going in was staffing. And
22 can you just describe, was that in any particular
23 area and how concerned were you with the gap in
24 staffing?
25 MICHAEL GUERRIERE: Well, we were used

1 to dealing with the gaps that we had, and it -- you
2 know, it was a couple of FTEs per home on average.
3 You know, it wasn't -- you know, it wasn't -- it
4 wasn't a severe situation.
5 I'll say, though, that, you know,
6 looking back, and I'll detail this in a coming
7 slide, we did not anticipate all the different
8 issues that would come together to make staffing
9 such a huge problem.
10 So, you know, we thought that we had
11 this in hand. In retrospect, there were a lot of
12 things that developed just because of the speed and
13 magnitude and number of outbreaks that hit not only
14 us, but the entire sector at the same time,
15 staffing became a huge issue very, very quickly.
16 COMMISSIONER JACK KITTS: Thank you.
17 MICHAEL GUERRIERE: So the next slide
18 goes back to the timeline that we showed earlier.
19 I won't go through all of the detailed points, but
20 you can see here our first outbreak at Extendicare
21 Bayview in Toronto occurred on March 23rd. And
22 we've got our actions in purple at the bottom, and
23 on the top were the various government mandates and
24 directions that came out; and in most cases, we
25 anticipated and implemented a lot of those policies

1 a few days to a few weeks before the government
2 mandated them.
3 The one thing that we talked a lot
4 about during March was wanting to implement a
5 universal masking policy so that all of our staff
6 were wearing masks all day. But we still, at that
7 point, had not secured sufficient supplies of PPE
8 to make that sustainable just because of the huge
9 increase in volume that that would involve.
10 So we worked very hard to get that
11 supply of masks in place, and we launched on April
12 6th, universal masking in all of our homes, and
13 then it was followed a couple of days later by a
14 provincial mandate in that regard.
15 So you can see that the COVID-19 Action
16 Plan for protecting long-term care homes came on
17 April 15th, so that came three weeks after our
18 first outbreak. So, you know, we were relying on
19 our own internal policy responses, you know, in the
20 preceding time.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 How long -- can you give me some sense of how
23 quickly things are happening? Because how long
24 after -- how long did you -- did you need -- would
25 have been reasonable before there was an action --

1 an action plan? I'm trying to get a sense of how
2 quickly things are happening.
3 MICHAEL GUERRIERE: Yeah. Well,
4 that first -- just to give you an example, that
5 first outbreak was on March 23rd in Bayview.
6 Within four weeks of that date, we had an
7 additional 11 homes go into outbreak, so we were
8 experiencing a new outbreak every couple of days,
9 again, at the same time that we were dealing with
10 staffing challenges, changing policies, the
11 challenges with procuring PPE through that period,
12 and myriad other things that were happening as well
13 internally and externally that, you know, made it a
14 very -- a very challenging environment for
15 management teams to have to think about, you know,
16 of the 25 issues that are on the table, what are
17 the 5 we're going to -- you know, we're going to
18 focus on today to be able to, you know, not be
19 overwhelmed by the number of issues that were --
20 that were coming at management during that time.
21 One of the things that our incident
22 management team was dealing with on, literally, on
23 a daily basis was trying to distill all of the
24 conflicting instructions that were coming from the
25 Ministry of Long-Term Care from Ontario Health and

1 its five regions from all of the different Public
2 Health units across the province. We were just
3 inundated with directions, advice, guidelines. The
4 document flow was intense. So a lot of that
5 group's focus was in distilling all of that
6 information and having a consistent set of standard
7 operating procedures and directions that would --
8 that would go to our homes.
9 And then those -- you know, those
10 standards would change on -- you know, probably
11 every -- I'd say, twice a week, probably, we were
12 updating those standards. So things like what PPE
13 should be used in what situations, the whole
14 concept of symptoms and what's the definition of a
15 COVID -- a COVID case, policies around testing were
16 changing constantly. So the rapid-fire nature of
17 those changes and then us having to reeducate our
18 staff, communicate that to management teams, and
19 kind of deal with that flow at the same time that
20 we were dealing with new outbreaks happening on
21 a -- you know, every couple of days during this
22 period of time, I've never experienced anything
23 like it in my life.
24 So if I may, I'd go on to trying to
25 share some of the key learnings in those early days

1 that have shaped our, kind of, second wave
2 preparation planning and have shaped the
3 recommendations we're leaving with you today.
4 So the first was the understanding
5 about the degree of asymptomatic spread of the
6 virus. You know, as I mentioned earlier, our whole
7 IPAC strategy was focused on symptoms and using
8 symptoms for guiding, cohorting, and isolation of
9 staff.
10 And in those early days, when we had
11 those first -- you know, those first outbreaks,
12 typically, we would be limited by Public Health to
13 only five tests in the homes, so they would swab
14 several of the residents who were symptomatic, and
15 then once COVID was confirmed, we stopped testing,
16 and everything was managed on a -- on a symptomatic
17 basis which is always the way we've done things.
18 But we know now -- I mean, there's
19 reports now that have been published that are, you
20 know, suggesting 15 to 30% of all transmission is
21 from asymptomatic or presymptomatic people, and
22 that would be in keeping with our experience,
23 because when we started testing all the residents
24 and all the staff in a home, we were surprised at
25 how many people came back positive, but we thought

1 we might be having a -- you know, an outbreak that
2 involved 5 or 10 people, we would get 30 positive
3 coming back, 40 positive coming back; and so what
4 was clear is that the virus was actually
5 circulating in the home long before we even
6 recognized that it was there. So we shifted our
7 entire approach to one of comprehensive testing in
8 the home and using testing to screen all of our
9 staff on a regular basis.
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 I'm just trying to understand. Testing was limited
12 to five -- how did that -- how did that start out?
13 It's limited to five people?
14 MICHAEL GUERRIERE: Yeah, they --
15 Public Health would send five swabs. We would swab
16 five symptomatic people. We would wait for the
17 results to come back, and if it diagnosed COVID,
18 then we knew that we had a COVID outbreak in the
19 home, and the assumption was is that anybody with
20 symptoms in the home probably had symptoms because
21 of COVID, and we would cohort people on that basis.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 When would the results come back?
24 MICHAEL GUERRIERE: Results were slow
25 in those early days. I would say, you know, it was

1 variable. Some parts of the province, it was, you
2 know, 24 to 48 hours. Other parts of the province,
3 we were seeing 7, 8-day delays in getting the
4 results back.
5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 So in that 7 or 8-day, you tested somebody, and
7 now, what do you do with them in the 7 or 8 days or
8 the 48 hours while you're waiting for the test to
9 come back?
10 MICHAEL GUERRIERE: Well, we would
11 cohort people based on symptoms, and we would
12 assume that it was a COVID outbreak until proven
13 otherwise.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay.
16 MICHAEL GUERRIERE: And, you know, the
17 challenge there, if you start moving people around
18 in a home based on whether they're symptomatic or
19 not, we now know in retrospect, we were moving
20 people around who were COVID positive who we didn't
21 know because they were asymptomatic or
22 presymptomatic or atypically symptomatic.
23 I mean, that's the other thing that
24 happened. If you go back and look at the direction
25 that came from Public Health, the description of

1 COVID symptoms was evolving regularly through this
2 whole period; so, you know, we found that in many
3 of our residents who are over 85 and have a variety
4 of different chronic diseases, we wouldn't
5 necessarily see respiratory symptoms; we wouldn't
6 necessarily see fever, but we might see
7 hypotension; we might see confusion; we might see
8 enteric symptoms. So there were a variety of
9 different ways that this virus would manifest that
10 really made it extremely difficult to use symptoms
11 to be able to manage and isolate people, so that
12 was one key learning.
13 The next page talks about older homes.
14 The difference in the performance of, you know,
15 what are described as C-bed homes compared to newer
16 homes was absolutely stark. I mean, to start, IPAC
17 is always challenging in long-term care. There's a
18 whole series of things that make it difficult. The
19 nature of the expertise in the home is somewhat
20 limited.
21 Two-thirds of our residents are living
22 with dementia, and so that cognitive impairment
23 results in a high incidence of people who wander or
24 have behaviours that are very difficult to manage.
25 And then a lot of our residents have very

1 significant physical needs which require physical
2 intervention on the part of the caregivers that
3 makes any kind of distancing with the caregivers
4 very, very difficult. It's a very physical
5 business.
6 But what we also know now, having
7 looked at our -- you know, our data after the first
8 wave, is that older homes with shared rooms are a
9 major challenge in terms of IPAC, and it's not just
10 the shared rooms. Those old homes have very, very
11 limited space.
12 So the overall square footage of the
13 home is about half on a per-resident basis of what
14 the newer homes have. And then, of course, design
15 elements in some of the older homes that have
16 carpet and other things make cleaning and infection
17 control much more difficult.
18 So that difference, you know,
19 certainly, in our experience, all of the outbreaks
20 of any significance, all of the outbreaks that
21 involved any loss of life were in the older homes.
22 And then the third item was the
23 staffing item, and I talked about this a little
24 bit, but, you know, in addition to staff becoming
25 ill and, therefore, being sidelined by the virus

1 itself, there were a number of other things that
2 proved very difficult. We talked about the
3 single-site employment directive. We lost
4 significant staff before that -- you know, even
5 before there was an outbreak. The extensive
6 self-isolation requirements after travel or after
7 contact with people that were travelling, and then
8 the nature of the pandemic's impact on society
9 meant that a lot of people had childcare issues,
10 and there's probably a synergistic effect with the
11 Canada Emergency Relief Benefit. So we lost
12 hundreds of staff during that initial period of
13 time.
14 And, you know, we had always relied on
15 agencies to help fill shifts, to help address
16 absenteeism; but, of course, they were the same
17 agencies that other homes were relying on as well.
18 So the number of outbreaks that occurred over that
19 period of time across the entire sector meant that
20 the agencies were overwhelmed, and they just
21 couldn't provide the services that they used to
22 provide.
23 And then in outbreak situations, added
24 to all of those issues, was the fear factor. And
25 the uncertain nature of the virus and certainly in

1 those early days, the speed of spread really scared
2 people. There were perceptions of PPE insecurity.
3 Fortunately, we never ran short of PPE, but there
4 was so much talk about it in the press. People
5 were concerned about it. The lack of availability
6 of lab tests to monitor the spread, and then when
7 news of deaths among healthcare workers came, that
8 really contributed to the anxiety.
9 We were very fortunate not to lose any
10 of our staff, but there -- you know, that news from
11 other operators was very corrosive to confidence in
12 our homes.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 What was -- just help me with -- you couldn't use
15 private labs at this stage? Or how -- you were
16 saying here the lab tests were not available. Were
17 those public labs? Or was that all labs?
18 MICHAEL GUERRIERE: We've approached
19 private labs a few times and so far have not been
20 able to purchase any capacity directly from the
21 private labs. We've been told that their entire
22 capacity is -- you know, is taken up with the
23 volumes coming from Public Health.
24 COMMISSIONER FRANK MARROCCO (CHAIR): I
25 see.

1 MICHAEL GUERRIERE: But that --
2 honestly, that came over the summer. I mean, in
3 this -- in these early days, this was all happening
4 so fast that we didn't even -- we didn't even
5 approach the lab, so this is -- you know, this is
6 the time period in April and May. And as I'll show
7 you in an upcoming chart, we launched our own
8 process for collecting swabs from our staff and
9 from our residents in June. We had to get support
10 from Public Health, and we got that at the
11 beginning of June.
12 So prior to that, we hadn't really --
13 we hadn't really pursued this, but I don't think
14 there would have been the capacity to do that at
15 that time anyway.
16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 So you're doing -- does this -- did that -- do I
18 understand that to mean you're going to do --
19 you're doing our own, then?
20 MICHAEL GUERRIERE: Well, today we're
21 doing our own swabs, but we still rely on the -- on
22 Ontario Health and the Public Health lab system to
23 conduct all the tests.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay.

1 MICHAEL GUERRIERE: We haven't been
2 able to -- you know, to access any other -- any
3 other volume. My understanding is that the private
4 lab capacity is all taken up by Public Health.
5 So those were the three things that I
6 think surprised us that came out of our analysis.
7 There were other things. I mean, the -- certainly,
8 there were a host of other issues that the Ontario
9 Long-Term Care Association and others have shared
10 with you, but these are the three things that we
11 felt were critical and have dominated our thinking
12 as we try to insulate ourselves from the risk of
13 the pandemic going forward.
14 So this next chart is just showing you
15 the timeline of outbreaks in our Ontario homes over
16 the seven months of the pandemic period. So you
17 can see the first outbreak was at Bayview in March
18 and then quickly followed by a series of other
19 outbreaks. And you can see superimposed the dates
20 that we implemented various policies that we think
21 were critical in tamping down the outbreak
22 frequency, so the universal masks, single site,
23 comprehensive testing of residents and staff, and
24 then you can see that we had, you know, a lot of
25 smaller outbreaks that were contained. The more

1 rose-coloured dots are outbreaks that involved only
2 staff, so no residents were involved.
3 And during that time in May, we
4 advocated to begin regular testing of staff which
5 we implemented across our organization starting
6 June 1st, so we're testing all of our staff on a
7 weekly basis.
8 You can see that with those strategies,
9 we had no new outbreaks of any significance for a
10 four-month period, and then, at the end of August,
11 we went into outbreak at West End Villa in Ottawa,
12 and, in fact, all of our five homes in Ottawa went
13 into outbreak in September.
14 So we can certainly talk about the --
15 you know, the anatomy of those outbreaks, but in
16 our view, you know, there's a couple of key
17 causative issues. One, of course, is the increased
18 prevalence of the disease, again, as the second
19 wave came on in the Ottawa area.
20 The second is the -- is the fact that
21 lab capacity in Ottawa has been more constrained
22 compared to the rest of the province. So I
23 mentioned earlier that we launched weekly staff
24 testing across the province. That's everywhere in
25 the province except Ottawa where we've only been

1 able to do bi-weekly testing at the request of the
2 Public Health lab there just because capacity
3 wasn't able to keep up with a higher volume.
4 So, of course, that testing on a
5 bi-weekly basis means that, you know, when we --
6 when we get a case that's positive of the staff,
7 we're not necessarily removing it from the -- from
8 the home in a timely way because we may be
9 detecting it quite a few days later.
10 The other element that's occurred as
11 the -- as the prevalence has increased in the
12 community, so has demand for lab testing, and our
13 response time slowed down. So over the summer
14 months, we were seeing turnaround times across the
15 province typically of about two days.
16 But as we've come into September, the
17 turnaround times for lab results at our homes in
18 outbreak has typically been a week or more, and
19 that makes it incredibly difficult just going back
20 to what I was describing in terms of cohorting.
21 When we're getting test results, we're finding out
22 who was positive a week ago, we really had
23 significant difficulty being able to -- being able
24 to proactively manage the outbreak and cohort
25 properly.

1 Typically in cohorting, you know, we
2 divide the home into red zones and green zones and
3 label those parts of the home so that everybody
4 knows, you know, what are the COVID-positive and
5 the COVID-negative parts of the home. Because we
6 had such extended periods where we didn't have the
7 test results, we created a yellow zone as well of
8 people with pending results that we were waiting
9 for, and that made things very difficult, and you
10 can see that, you know, our efforts to contain it
11 in the home, you know, were -- we managed to
12 contain it largely to a single floor, which -- you
13 know, which was good, but you can see that a large
14 number of staff and residents were affected there.
15 So that -- you know, that was a very disappointing
16 outcome from our perspective.
17 So the next slide just details some of
18 our responses to the staffing challenges that we've
19 seen. You know, one of the first things on the
20 list is regular testing, weekly testing to maintain
21 a safe work environment for the staff, and to keep
22 fear under control is critical.
23 We applied premium wage rates in
24 outbreak homes paying everyone time and a half even
25 for regular shifts. We put up people in hotels if

1 they felt that they need to be isolated from their
2 families. We've overstaffed all of our homes going
3 into the second wave. We centralized recruiting as
4 a major change for us because recruiting up until
5 the pandemic period was done home by home. We've
6 created a centralized group to do that.
7 We have taken advantage of the fact
8 that we have a Home Healthcare Division, and we
9 solicited 1,600 of our homecare staff to try to get
10 them to come to work in long-term care.
11 Interestingly, we had a yield on that
12 solicitation of less than 1%, so getting people to
13 come to work in a COVID-positive environment is a
14 very difficult thing to do.
15 We've continued to nurture our
16 relationships with agencies, and I've talked about
17 what we've done in terms of paid leave and single
18 sites.
19 So we've really left no stone unturned
20 in trying to deal with this. I think we've had,
21 you know, some -- you know, some positive impact on
22 this, but the supply of staff across the province
23 continues to be a problem.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Why the attractiveness for part-time staff from the

1 staff's perspective, from the home's perspective?
2 Can you help me with that at all?
3 MICHAEL GUERRIERE: Yeah. So, I mean,
4 a big challenge in staffing and long-term care, of
5 course, is that we're a 7-by-24 operation. So
6 we've got a staff across those seven days, and
7 we've got to meet the collective bargaining
8 agreement that says that staff will only work one
9 weekend in two.
10 And so when you -- when you take those
11 two -- those two challenges, you end up having to
12 have a mix of full-time and part-time staff.
13 Our costs for full-time and part-time
14 staff are exactly the same, and our -- our
15 part-time staff do have benefits, and for those
16 benefits that are different from full-time staff,
17 they get pay in lieu of benefits, so there's no
18 advantage to us in terms of having part-time or
19 full-time. We would prefer to have more full-time
20 staff.
21 To that end, we've recently negotiated
22 with a couple of our unions a different -- a
23 different shift structure to allow a special shift
24 of full-time staff who work every weekend. We
25 think there's a -- there's a subset of staff that

1 would be willing to do that. This is something
2 we've just been working on over the summer. We've
3 created a hundred positions of full-time positions
4 that are combinations of part-time positions that
5 have been brought together. And so we're quite
6 excited about the prospects of being able to shift
7 to -- to more of a full-time situation. But
8 that's a work in progress.
9 COMMISSIONER ANGELA COKE: Now, just --
10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Commissioner Coke.
12 COMMISSIONER ANGELA COKE: I just
13 wanted to ask you about your challenges with
14 staffing, is this equally with nurses as it is with
15 PSWs?
16 MICHAEL GUERRIERE: Yes, although, it's
17 different in different geographic regions of the
18 province. So in some parts of the province,
19 registered staff is a big challenge. You know,
20 particularly more rural communities, we have more
21 challenges with registered staff, but, you know,
22 when you look at it on average across the whole
23 system, we have challenges with both.
24 So with that, I'll just highlight our
25 preparations for the second wave and the way we're

1 thinking about this. I won't -- you know, I won't
2 highlight every item here because we've talked
3 about a number of them already, but there's a
4 couple that are new. So just looking at number 5,
5 you know, we've created now a COVID-response team
6 of experienced IPAC professionals and leaders who
7 have been working in long-term care outbreak
8 settings.
9 And that, you know, we deployed this
10 with West End Villa. We were able to bring a team
11 from Toronto into our Ottawa home to support the
12 leadership and supplement the leadership in
13 managing the outbreak. So that -- that's a new
14 capability that we're continuing to build.
15 We're certainly spending time with our
16 medical directors, haven't talked about that too
17 much, but I know you've heard from others on
18 this -- on this point. The majority of our medical
19 directors have been outstanding through this
20 process, have been very present in the homes, have
21 been very supportive of the homes and the staff.
22 But we have had, in, you know, a small
23 minority of cases, situations where the physicians
24 have not been willing to go into a COVID-positive
25 environment, which has been a challenge; so, you

1 know, we're proactively working with all our
2 medical directors to make sure that we have
3 physicians in each home who are prepared to
4 continue to come into the home in the case of an
5 outbreak. And we've also, just this week,
6 recruited a chief medical officer which is a new
7 position for our organization to better coordinate
8 our medical resources.
9 The item here about number 7,
10 strengthening connections with hospitals, we've had
11 some extraordinary help from hospitals through this
12 process, but we have also experienced some
13 situations where, you know, hospitals, if we don't
14 have relationships that sort of pre-exist, an
15 outbreak, it can take time to make a connection and
16 to get assistance, and that can be -- that can be
17 very problematic when days and hours count.
18 So in our preparations, we're making
19 sure that we have relationships with the IPAC
20 leaders in the local hospitals that are -- the
21 person responsible for IPAC in each home is already
22 introduced to the people in the hospital, that they
23 know who to call, that we share with the hospital
24 our second wave preparations and that, you know,
25 they have an opportunity to give us advice and help

1 us to prepare. Number eight --
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 There's a question.
4 Commissioner Kitts.
5 COMMISSIONER JACK KITTS: Just a
6 question on the hospitals, Michael. There are
7 other partners in the system like Public Health,
8 Home and Community Care and others. How essential
9 are they in also doing what the hospitals are able
10 to do or -- or is it too -- is the strengthening of
11 the hospitals far more important than other
12 partners in the system? What's more efficient and
13 more likely to happen for Wave 2?
14 MICHAEL GUERRIERE: Well, I would say
15 that, by in large, the hospitals have been the most
16 helpful to us, that -- you know, that they have the
17 expertise that we need and the resources that we
18 need in these situations.
19 That said, there have been a couple of
20 situations where the linz (phonetic) have had
21 clinical people in administrative roles who have
22 been willing to come into homes to help at the
23 bedside and to help clinically. And obviously,
24 that has been really appreciated by our teams when
25 that's happened.

1 They've also been helpful in making
2 connections to hospital people; so, for instance,
3 at West End Villa, you know, a few weeks ago when
4 the -- just in the early days of the outbreak
5 there, we had a resident with significant cognitive
6 impairment who was really a challenge to keep
7 isolated in their room. Like, just, you know, they
8 became quite violent if we tried to, you know, kind
9 of constrain them to their room. And, obviously,
10 the wandering is, you know, incredibly dangerous.
11 So, you know, the Ontario Health Region
12 people were very helpful in connecting us with the
13 Royal Ottawa -- a Royal Ottawa team to do a virtual
14 consult to help us with, sort of, a chemical
15 restraint strategy that worked very well. So just
16 an example of you don't know who to go to, and
17 they -- you know, they can be -- they can be quite
18 helpful in those circumstances.
19 COMMISSIONER JACK KITTS: Okay. Thank
20 you.
21 MICHAEL GUERRIERE: So this next item
22 on communications, you know, deserves a moment. I
23 think as we look back on our first wave outbreaks
24 and the intensity of those days as those outbreaks
25 were occurring and as we were challenged finding

1 staff and dealing with test results and daily calls
2 with Public Health, et cetera, we did not put
3 enough priority on communications with families. I
4 think that's -- you know, that's one area where,
5 looking back, you know, I wish that we had done
6 more.
7 But, you know, what we've done over the
8 summer is initiated Zoom town-hall meetings with
9 all of our families of all of our homes making sure
10 that the families understand what our preparations
11 are, understand who the leadership of the homes are
12 so they, you know, develop some confidence in the
13 leadership, and then we establish a pattern so that
14 when a home does go into outbreak, we're able to
15 trigger that communications playbook, keep the
16 families informed right from day 1, and make sure
17 that we don't end up, you know, with questions from
18 the family or a feeling that they have nowhere to
19 turn in -- you know, in a time of real concern.
20 We've also instituted team Zoom calls
21 with our staff which have been very helpful, and
22 some of the hospital staff, in particular,
23 infectious disease specialists, have been
24 incredibly helpful in advising our staff and giving
25 them confidence that we're doing the right thing.

1 They've heard a lot of things in the press about,
2 you know, what PPE should be used that's not
3 consistent with what the Public Health has been
4 advising the sector, so it's very helpful when they
5 have an infectious disease expert explaining to
6 them what best practice looks like.
7 And then the last point on this slide,
8 just to make the obvious point that, you know,
9 influenza and the confluence of COVID and influenza
10 is something that can be quite challenging, so our
11 vaccination program for staff and residents is at
12 the highest priority, and we regard that as being
13 part of our second wave preparation. So that's --
14 that outlines what we're doing.
15 So before I go to our recommendations,
16 I do want to just take a moment to summarize our
17 thoughts on the anatomy of the really large
18 outbreaks that we've seen.
19 Our observation is that the most severe
20 outbreaks result from a number of things coming
21 together and that, you know, the convergence of
22 those things creating a really significant
23 outbreak, and it comes down to five factors.
24 The first one, of course, is that the
25 virus has to come from somewhere; so high rates of

1 transmission in the community surrounding the home
2 obviously increases the likelihood that a staff
3 member will bring it into the home or perhaps a
4 visitor, you know, particularly, you know, that
5 asymptomatic transmission being a challenge.
6 Then lack of access to sufficient
7 testing or delays in getting results, we've talked
8 about that quite a bit.
9 Delays in getting access to outside
10 help, so whether that's, you know, IPAC expertise,
11 medical oversight or in situations where there are
12 significant staffing shortages, getting
13 supplementary direct care staff and cleaning staff
14 can be critical.
15 The third item there is a large
16 proportion of the staff lost, so, you know, whether
17 that be through infections or fear or the other
18 factors that we've talked about, clearly, it
19 becomes very difficult to continue with IPAC
20 protocols in an environment where the
21 staff-to-resident ratio is -- you know, is
22 significantly less than normal. That leads to IPAC
23 protocol breakdowns and, you know, deficiencies in
24 care.
25 And then finally, the older home, so

1 you know, the -- that environment where people are
2 sharing rooms where there's no room for donning and
3 doffing; there's no staging for staff, makes it
4 very difficult to mount an IPAC effort on a
5 sustained basis for weeks on end.
6 So in our experience, all of these five
7 things have to be there to get -- to get one of the
8 larger outbreaks.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 What can you do about a lack of access to
11 sufficient testing? And the reason I ask the
12 question is that if -- if you have public labs that
13 are engaged, and if Public Health has really
14 appropriated the capacity of the private labs, then
15 how do you -- do you have a thought on how you
16 could make that more efficient or you can expand
17 testing?
18 MICHAEL GUERRIERE: Well, the next
19 slide is our first recommendation. It's just on
20 that point.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Well, you know what I was thinking, and I was going
23 to -- I was going to -- if the recommendations are
24 important, and I was thinking maybe I would take a
25 break before so that when we come back, we can kind

1 of, concentrate on the -- so I'll hold the
2 question, and I don't want to -- I don't want to
3 take you out of the rhythm of what you're doing.
4 If you're going to get to it, that's just fine.
5 MICHAEL GUERRIERE: Well, I'm also
6 happy to conclude on this first recommendation, so
7 perhaps it --
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Sure.
10 MICHAEL GUERRIERE: -- it resonates in
11 your minds during the break because it is -- it is
12 probably, in our view, the easiest and biggest
13 immediate improvement that we can make in the
14 circumstances for long-term care.
15 And, you know, our proposal -- and I've
16 certainly made this proposal in writing to the
17 Province a couple of weeks ago, is that we believe
18 that long-term care tests should get priority of
19 place, that we should be putting in place a policy
20 of 24-hour turnarounds for long-term care. And,
21 you know, I fully recognize that there is a real
22 challenge in meeting the demand for lab tests in
23 the province. I understand that.
24 But the fact is is that we know that
25 long-term care is the key vulnerable population

1 that determines the mortality rate that we as a
2 society sustain from this virus.
3 And to me, making the decision that any
4 long-term care swabs that come into the lab go to
5 the front of the line is something that's very
6 doable, that labs are very used to providing that
7 kind of priority to an intensive care unit or to --
8 you know, to the Emergency Department that we
9 should be doing the same thing for long-term care
10 recognizing the vulnerability of that population
11 and recognizing that keeping the virus out is the
12 best way to minimize the morbidity and mortality
13 that we've been seeing.
14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 All right. Well, why don't we -- with that
16 resonating, why don't we break for ten. You know,
17 you just, sort of, turn off the camera and the
18 sound, but don't log out because we want to make
19 sure you can get back in, so...
20 MICHAEL GUERRIERE: Okay. Sure.
21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 All right. Good. Ten minutes, then. Thanks.
23 (BREAK)
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Did you want to wait for anybody?

1 MICHAEL GUERRIERE: No. I think
2 they're probably back even though they haven't come
3 on the screen.
4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Oh, they're hiding. Okay. Go ahead.
6 MICHAEL GUERRIERE: No. I think we're
7 good to start.
8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 All right.
10 MICHAEL GUERRIERE: So I left you with
11 the 24-hour turnaround guarantee. There's a couple
12 of other points on testing that I'd like to also
13 highlight. We talked about testing all long-term
14 care staff weekly. We really believe that that
15 should be the standard across the province. We're
16 doing it weekly everywhere but in Ottawa, and we
17 have five homes in outbreak across the province and
18 all of them are in Ottawa.
19 So, you know, we're quite concerned
20 about that and feel that a weekly cadence on the
21 testing would be, you know, much better insurance.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 If I can just interrupt for a minute, but it's the
24 turn around time, isn't it?
25 MICHAEL GUERRIERE: Well, both. I

1 think the turnaround time but also just the
2 capacity to be able to do it weekly. We're only
3 doing it bi-weekly in Ottawa because of the
4 capacity constraint. And it has been suggested to
5 us a couple of times in the last two weeks that we
6 should cut back our frequency of testing to
7 bi-weekly just because of the challenge across the
8 province in -- in meeting the supply-demand issue
9 that exists in lab tests right now.
10 We haven't agreed to that. We don't
11 think that's the right thing to do, and, in fact,
12 we believe that as the prevalence in the community
13 increases, we should be putting more effort into
14 preventing the virus from getting into long-term
15 care, not less. So it's priority of place in terms
16 of turnaround, but it's also just access to the
17 volume necessary to do this testing weekly.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 It would seem to me, and I guess you're saying the
20 same thing, that cutting back in the testing is
21 contrary to what really seems to be fundamental to
22 your strategy for containing it. That would be --
23 MICHAEL GUERRIERE: Yes.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 That would be counterproductive completely.

1 MICHAEL GUERRIERE: That would be our
2 view. That would be our view, yeah.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Yeah.
5 Dr. Kitts.
6 COMMISSIONER JACK KITTS: Just a point
7 of clarification. Like, are you -- are you saying
8 that in every home in Ontario that you own apart
9 from Ottawa, you are doing weekly testing and
10 you're getting a 24-hour turnaround?
11 MICHAEL GUERRIERE: We're not getting
12 24 hours at the moment, Jack. I think we're
13 getting, you know, more typically 48 or even a
14 little bit longer than that, but it's been pretty
15 good.
16 COMMISSIONER JACK KITTS: Okay.
17 That's amazing results.
18 MICHAEL GUERRIERE: Yeah. Our staff
19 have formed some relationships with the people in
20 the lab supply chain that I think are helping with
21 that, but -- you know, but my view is is that it
22 should be -- you know, it should be a policy on a
23 policy basis for the province that all long-term
24 care homes should have that priority.
25 The other element is that as a

1 point-of-care testing becomes available, as antigen
2 testing becomes available, we've already put our
3 hand up to be first in line in that regard. We
4 would be delighted to pilot that. We would
5 delighted -- be delighted to invest in that. We
6 think that that could be a game-changer for the
7 sector as it becomes available.
8 And, you know, particularly as we're
9 getting this, you know, surge in case volume in the
10 community, we're quite anxious about it, and we
11 think that, you know, these outbreaks we're dealing
12 with in Ottawa are proof-points that we have a lot
13 to be worried about.
14 The next area of recommendations is in
15 regards to staff. And, you know, the staff issue
16 is challenging to navigate because it's
17 complicated. There's a lot of -- a lot of issues.
18 But fortunately, the province commissioned a
19 staffing study in response to the Gillese Inquiry
20 that was published on July 31st. We believe it's
21 an excellent analysis. It's very accurate, and
22 that it correctly lays out a roadmap to improving
23 staffing both in the short term and long term for
24 long-term care.
25 So, you know, we're endorsing that. We

1 don't think we have a lot to add other than to
2 suggest some priorities in terms of some of the
3 recommendations that are in that document.
4 We think our first priority from a
5 long-term care perspective is to increase the
6 supply of PSWs in the province, and the volume that
7 we need to add is quite, quite significant.
8 So we feel that the only way to do it
9 and to do it quickly and to have an immediate
10 impact would be a preceptorship-style program in
11 partnership with colleges and the -- and the
12 provider community.
13 We think we can increase supply of
14 workers very quickly and that it's important that
15 we provide a both practical and more, you know,
16 classroom didactic style combination of programming
17 to provide a longer-term pass to PSW credentials
18 and even to, you know, registered staff
19 credentials. We're doing this now in our homecare
20 operation very, very successfully, and we think
21 that this is something that we should be scaling up
22 to the province for long-term care.
23 The second priority, in our view, is to
24 add additional funding for more hours of care. We
25 put it as a second priority because if we did this

1 first without addressing the supply issues, we
2 would just create more vacancies in the sector, so
3 we need the supply, but then I think additional
4 funding for more hours of care is important. It's
5 all highlighted in the study.
6 But the two points that I make here is,
7 one, that workload is a major driver of turnover in
8 the sector. We know that there's a lot of people
9 who are trained at PSWs that aren't working as
10 PSWs. This is a very physical, very exhausting
11 profession and made more so by staff-to-resident
12 ratios that we think are suboptimal.
13 There's also an issue with resiliency.
14 So, you know, if we're fully staffed in our homes
15 today, you know, we can meet resident needs, but
16 any challenge that comes up that's out of the
17 ordinary, whether it be an outbreak or the acuity
18 of the residents or something that triggers an
19 increase in absenteeism, the home is really
20 stressed to be able to deal with that.
21 And then the third item that, you know,
22 in terms of priority would be funds for higher
23 salaries which would certainly assist with
24 attracting and retaining caregivers in the sector.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 There's a question.
2 Commissioner Kitts.
3 COMMISSIONER JACK KITTS: Michael, can
4 I just -- we've heard that a lot of PSWs have
5 either left the system over this, or they're out
6 there, and it's very difficult to recruit them
7 back. And you've listed five points here as to how
8 you will try and recruit them back and also attract
9 new PSWs.
10 We also understand that a big part of
11 this may be the environment and culture in the
12 long-term care homes particularly with the PSWs not
13 feeling valued or respected. Is that an issue, and
14 are you able to address that?
15 MICHAEL GUERRIERE: Yeah, I think it is
16 an issue. But, you know, I would say that some of
17 the things that are on the page here are some of
18 the drivers of that, you know, not feeling valued.
19 It's very difficult to have a
20 fulfilling, you know, care relationship with
21 residents when you don't have time to do the job
22 that you want to do. And I think that's a big -- a
23 big issue for -- you know, for this group. They're
24 asked to do extraordinary things in very short
25 periods of time, and they're scrambling to do it.

1 And, you know, I think that's, you know, a key
2 aspect of job satisfaction. It's an exhausting
3 job. It can be incredibly rewarding, and there's
4 certainly -- you know, there's certainly a strong
5 culture of caring among that group.
6 I have to say that through this
7 pandemic, I've spent some time with people who are
8 willing to go to extraordinary levels for the
9 residents that they've developed strong
10 relationships with.
11 I mean, the everyday heroism that has
12 manifest through this pandemic has really been
13 extraordinary. It's -- you know, as a personal
14 experience, you know, spending time with people
15 like that, it really has been inspiring. It's
16 something that I'll carry with me forever.
17 So -- you know, so that's there, but I
18 think if they're not given the time to do the job
19 that they want to do, I think it makes it very
20 difficult, you know, to retain people over a long
21 period of time.
22 COMMISSIONER JACK KITTS: Okay. Thank
23 you.
24 MICHAEL GUERRIERE: If we move to the
25 next item, it relates to relationships and

1 integration with the rest of the health system. So
2 I'm talking about hospitals in particular, but I'm
3 also thinking about primary care and home care and
4 other parts of the health system.
5 But in terms of immediate needs, you
6 know, talked about the importance of having help
7 for a home especially in the early days of an
8 outbreak. So I've tried to be precise here in
9 suggesting that, you know, we need regional IPAC
10 teams that are prepared to go into homes that are
11 available for deployment on a 24-to-48-hour basis.
12 It has to be -- you know, it has to be quite fast;
13 and in my view, the trigger should be more than
14 five positive resident cases.
15 The second point is the IPAC leads in
16 each home and creating those relationships -- I
17 referred to this earlier -- with the IPAC team and
18 the local hospital. You know, a great example of
19 this is what the Scarborough Health Network has
20 been doing with homes in Scarborough. We --
21 they've invited our IPAC leads from the homes to
22 actually go into the hospital and spend a couple of
23 weeks with the IPAC team in the hospital, so as a,
24 you know, kind of a training opportunity, but they
25 also get to know each other. They learn to trust

1 each other. Though know -- they're on a first-name
2 basis. They have their phone numbers, and so
3 creating that relationship so that, you know,
4 somebody can pick up the phone and say, you know
5 what? I'm worried about this. You know, what do
6 you think? Can you give me some advice? Could you
7 drop by and, you know, have a look at this
8 situation?
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Who -- excuse me. Let me just interrupt for a
11 minute. Who should drive that? You know, it's one
12 thing to say that these should be established, the
13 passive voice, but who -- how do you see that being
14 led, I guess, is the word I'm looking for?
15 MICHAEL GUERRIERE: Yeah. Well, a
16 couple of thoughts on that: So in our case, you
17 know, just because we're -- we are a network of
18 homes, you know, we've been reaching out to the
19 hospitals directly in proposing this, so, you know,
20 we've got those resources to be able to do that.
21 I think with, you know, individual
22 homes, that can be a little bit harder, and so
23 there may need to be some facilitation of that.
24 I think the Scarborough Health
25 Network's model is one to look at. I think they've

1 set up an amazing structure for supporting -- I
2 think there's 19 long-term care homes in their
3 catchment area, and they've created a structure and
4 a management team within their hospital for that
5 outreach to connect with all those long-term care
6 homes. So they've -- you know, they've set that
7 up.
8 So, you know, I think that the hospital
9 is a great place to house that. It's not the only
10 option for sure, but I think the Scarborough Health
11 Network would be a good place to look at that.
12 The other possibility -- and I've put
13 here as the fifth point is, you know, the Ontario
14 long-term care clinicians have suggested a regional
15 chief medical officer for long-term care which we
16 endorse. We think that's a great idea, so it could
17 be under the auspices of that CMO to facilitate
18 those relationships.
19 So I think there's a couple of models
20 that might work, and maybe it should be a bit
21 different in different parts of the province.
22 The other thing that I've put here as a
23 separate bullet point is partnerships between the
24 homes and local hospital networks for clinical
25 matters in support of residents. And that's really

1 relationships, you know, primarily on a medical
2 level. And, you know, I think there's a lot of
3 research now that demonstrates that more can be
4 done in the long-term care setting in terms of
5 preventing people from having to be moved to the
6 Emergency Department which is definitely a
7 suboptimal place for, you know, managing seniors.
8 And then there's been -- you know,
9 there's been use of temporary management contracts
10 for long-term care homes and having hospitals step
11 in in a management role. We think there is a role
12 for that. We think the time to invoke that is when
13 there are leadership gaps for whatever reason or
14 some capability gap that needs to be addressed in
15 order to protect residents.
16 So, you know, our view is, you know,
17 very fast response with an IPAC team, and then if
18 there are other deficiencies that are not being
19 addressed, then we move to a management contract
20 quite quickly. I think that's one of the things
21 we've learned is that the earlier that that
22 happens, the more quickly the outbreak comes under
23 control.
24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Do you think it would be feasible if the order that

1 they do that came first and then let them negotiate
2 a management contract with the order having been
3 made?
4 MICHAEL GUERRIERE: Well, I can only
5 speak to this in our -- you know, in our situation.
6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Right.
8 MICHAEL GUERRIERE: The order was
9 incidental. So the verbal intention and agreement
10 and connection between our organization and the
11 hospital to put a management contract in place has
12 happened even before the order was issued from
13 Public Health.
14 So, you know, that may not be the case
15 everywhere, but, you know, I -- you know, I don't
16 know that -- that the order is as important as, you
17 know, just making a contact between the
18 organizations at the right level.
19 I think in some cases perhaps -- and
20 I'm speculating here -- that the order may be what
21 precipitates the contact, you know, between the
22 organizations to initiate the discussion about the
23 management contract. But, you know, that hasn't
24 been our particular experience.
25 And then the final point which, you

1 know, in a -- in a -- you know, from the
2 perspective of trying to address the challenges in
3 the midst of a pandemic may seem a bit strange,
4 but, you know, the older homes are a primary driver
5 of the challenges that we're facing with these
6 outbreaks. I think the statistics very, very
7 clearly indicate that.
8 And, you know, our observation would be
9 that there's been very little progress on replacing
10 those old homes over the last 15 years or so. And
11 part of the reason for that is that replacing these
12 homes takes a long time, right? There's a long
13 lead time to getting these construction projects
14 done, and so it never seems to get to the top of
15 the priority list because it takes too long to make
16 any difference.
17 I mean, by the time, you know, new
18 homes come online, hopefully, the pandemic will be
19 largely behind us, so there's a temptation to, you
20 know, not -- kind of discount this from a -- from a
21 pandemic perspective.
22 But, you know, in our view, it would be
23 a real tragedy if we get to, you know, the end of
24 this decade and we still have C-beds in operation.
25 Now, the province has done a lot of

1 work on a new program to replace the C-bed homes.
2 And, in fact, the province had done that work prior
3 to the pandemic. It was -- it was well done in --
4 in conjunction with Infrastructure Ontario and was
5 certainly done in consultation with the long-term
6 care sector.
7 But the program that's been announced
8 will replace about a third of the C-beds in
9 operation by 2025. So our strong recommendation is
10 that that program needs to be expanded to make sure
11 that we have all the C-beds homes out of operation
12 in the next ten years.
13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Can you --
15 MICHAEL GUERRIERE: It seems like a
16 long time, but if we don't start now, we're going
17 to still be talking about C-beds in 2030.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 How long does it take to go from the -- to work
20 through the process to replace a bed?
21 MICHAEL GUERRIERE: So I'll separate
22 that into two parts. So when it comes to the
23 tendering and construction phase of one of these
24 homes, we're about to start replacement of one of
25 our homes under the new program in Sudbury in --

1 you know, in the next few weeks, and it will be,
2 you know, a two-year period from contracting to
3 actually having people move in.
4 There's probably ways to shorten that
5 using modular construction techniques and different
6 things, but largely, you know, you're looking at an
7 18-month to two-year process around the
8 construction.
9 Now, then there's the question of how
10 long does it take to go through the approval
11 process to get to the point of being able to start
12 construction? And in our experience, that has also
13 been two years.
14 So, you know, getting the bed
15 allocations and then going through all of the
16 design approvals, financial approvals, et cetera,
17 there's a whole sequence of steps that one has to
18 go through before getting approval to actually
19 start construction.
20 So now, that's an area that I know that
21 the government is working on and the Minister has
22 certainly talked about ways of shortening that
23 process. So I know they've got that on their
24 radar, and they're working on that.
25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Do you have a sense of why it would take two years
2 to get an approval?
3 MICHAEL GUERRIERE: Well, yeah, I think
4 the -- now, again, this is -- this is my
5 particular, you know, perspective on it, which may
6 not reflect intent in the past, but much of the
7 long-term care sector is organized around
8 individual homes. So the whole approval process
9 and licensing process really is done on a home --
10 on a home-by-home basis.
11 So in the case of Extendicare, for
12 instance, we have 22 applications for construction
13 projects in front of the government today. So
14 every one of those is -- goes through the approval
15 process separately. And when you think about the
16 fact that we have, you know, a standard layout and
17 a standard design that we build over and over
18 again, or you think about the fact that we're, you
19 know, a publicly traded corporation, so all of our
20 financial information is available publicly, we
21 still have to go through the financial approval
22 step. We still have to go through, with each
23 project, approval of our designs, making sure they
24 meet -- that they meet all of the specifications.
25 So, you know, we think there's an

1 opportunity to take a more portfolio approach and
2 in some ways think about a pre-approval kind of
3 step that as long as the design is staying to these
4 parameters, that some of these steps could be --
5 you know, could be skipped over.
6 So part of it is just -- you know, just
7 the way that the system is oriented to think about
8 each home individually as opposed to a program of
9 building that could be looked at, you know, as a --
10 as a single portfolio.
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 So notwithstanding the fact that you're publicly
13 traded and your financial information is publicly
14 available and there's a regulator, namely, the
15 Securities Commission, do you have to, then,
16 duplicate that financial -- do you have to provide
17 a different variation on that financial information
18 as part of these applications?
19 MICHAEL GUERRIERE: Yeah. We provide a
20 financial brief as one of the steps for every one
21 of the homes.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.
24 MICHAEL GUERRIERE: Largely the same
25 each time. Now, there's, you know, financials for

1 each individual home, but, you know, again, I
2 think -- you know, the funding -- the funding
3 structure for long-term care is standard across the
4 province. So it's not like the finances are looked
5 at each time and then the funding model is then
6 designed around those local finances. It's done
7 using a single formula for -- you know, for the
8 whole province.
9 So, you know, given that our
10 organization, you know, bears the operating risk --
11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 M-hm.
13 MICHAEL GUERRIERE: -- it's a little
14 bit hard to understand why we would be doing
15 something different for every home as opposed to
16 doing one financial analysis for the entire
17 portfolio.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Well, and I don't know the -- what's the advantage
20 of looking -- or what's the professed advantage of
21 looking at the finances of a particular home when
22 you're dealing with a provider that has 22 homes?
23 It would seem to me -- I don't know,
24 and I'm asking; I'm not saying -- that the overall
25 financial picture is what would be important,

1 not -- not the peculiarities of a particular home
2 somewhere in the empire.
3 MICHAEL GUERRIERE: M-hm. Well, and --
4 so -- yes, so I would agree with that. But I think
5 that, you know, the steps that have been laid out,
6 you know, make a lot of sense for, let's say, an
7 organization that's intending to build a long-term
8 care home for the first time.
9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 M-hm.
11 MICHAEL GUERRIERE: Right? So you
12 can -- you can see where all of the steps make
13 sense in what circumstances. I think the overlay
14 that needs to be there is which of these steps need
15 to be applied in this particular circumstance so
16 that there's some -- you know, there's some
17 streamlining of the process where -- you know,
18 where warranted.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Yeah. We're on a fast track --
21 MICHAEL GUERRIERE: Yeah.
22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 -- for a proven provider.
24 MICHAEL GUERRIERE: Yeah. So I think
25 that's the last bullet that -- you know, that we

1 have here.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Well, if -- unless there are questions -- there
4 don't appear to be; we were asking them as we went
5 along. Thank you very much. It's extremely
6 helpful in terms of the suggested recommendations,
7 gives us something to think about.
8 And we may come back because there's --
9 there may be more long-term issues that we could
10 productively report on, and we may want to discuss
11 some ideas that we have about shorter-term
12 recommendations as we get a clearer idea of what
13 they might be.
14 But this has been very informative. I
15 speak for myself, and I can speak for all three of
16 us.
17 COMMISSIONER ANGELA COKE: Yes.
18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 And thank you very much for the time and effort
20 that went into this. We'll try to do it justice
21 when we're working through the recommendations.
22 MICHAEL GUERRIERE: Well, thank you.
23 And, you know, if I can -- if I can just, kind of,
24 add a personal note that I think would be just
25 important to impart, you know, the -- I think it

1 has to be said that, you know, the enormity of the
2 tragedy that has -- this pandemic has represented
3 for our residents and their families is enormous.
4 It's been on a scale that, again, I've never
5 experienced in my career.
6 The anguish of separation, the anguish
7 of just not knowing, the -- you know, the impact
8 has been huge. And also on our staff, you know,
9 the number of times that I've had, you know, very,
10 very emotional meetings with our staff on the front
11 lines who are, you know, bearing the brunt of this,
12 worried that, you know, that they've let our
13 residents down, it's just been a heartbreaking
14 experience for us.
15 So all I can say is we have a lot -- a
16 lot riding on your work, and absolutely anything we
17 can do to help in that process, we -- we're here,
18 and we'd be very happy to assist in any way we can.
19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Thank you for that. And I guess we'll sign off for
21 now.
22 MICHAEL GUERRIERE: Okay. Thank you.
23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Thank you very much.
25 MICHAEL GUERRIERE: Thank you for your

1 time.
2 COURT REPORTER: Thank you.
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Thank you.
5 COMMISSIONER JACK KITTS: Thanks,
6 Michael.
7 -- Adjourned at 11:00 a.m.
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1 REPORTER'S CERTIFICATE
2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:
5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;
9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;
13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.
16
17 Dated this 9th day of October, 2020.
18
19
20 Janet Belma.
21
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25 CHARTERED SHORTHAND REPORTER

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