

# Long Term Care Covid-19 Commission Mtg.

Stabilization and Second-Wave  
on Tuesday, October 6, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom Videoconferencing, with all  
participants attending remotely, on the 6th day of  
October, 2020, 9:00 a.m. to 11:00 a.m.

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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:

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9 MINISTRY OF HEALTH AND MINISTRY OF LONG-TERM CARE:

10 Melanie Fraser, Associate Deputy Minister, Health

11 Services

12 Olha Dobush, Lead, Long-Term Care Stabilization

13 Project

14 Alison Blair, Assistant Deputy Minister of the

15 Pandemic Response Division

16

17 PARTICIPANTS:

18

19 Alison Drummond, Assistant Deputy Minister,

20 Long-Term Care Commission Secretariat

21 Ida Bianchi, Counsel, Long-Term Care Commission

22 Secretariat

23 John Callaghan, Counsel, Long-Term Care Commission

24 Secretariat

25 Lynn Mahoney, Counsel, Long-Term Care Commission

1 Secretariat  
2 Derek Lett, Policy Director, Long-Term Care  
3 Commission Secretariat  
4 Judith Parker, Ministry of the Attorney General  
5 Dawn Palin Rokosh, Director, Operations, Long-Term  
6 Care Commission Secretariat

7

8 ALSO PRESENT:

9 Eric Wagner, Counsel for Ontario  
10 Roopa Mann, Counsel for Ontario  
11 Amy Leamen, Counsel, Ministry of Health and  
12 Long-Term Care  
13 Kinsey Bowen, Counsel, Minister of Health and  
14 Long-Term Care  
15 Deana Santedicola, Stenographer/Transcriptionist

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\*\*The following is a list of documents undertaken to be produced or other items to be followed up\*\*

INDEX OF UNDERTAKINGS

The documents to be produced are noted by U/T and appear on the following pages: 31:6, 53:25, 58:25, 80:17

1 -- Upon commencing at 9:00 a.m.

2  
3 COMMISSIONER FRANK MARROCCO (CHAIR):  
4 In any event, you know, I guess  
5 basically, Ms. Fraser, the approach we have been  
6 taking is that we are in the middle of something  
7 rather than coming in after there has been an event  
8 and looking back and trying to explain it, which is  
9 typically what Commissions do.

10 So because we are in a bit of an  
11 unusual -- well, in a significantly different  
12 situation, we are behaving significantly  
13 differently. We are going to attempt to put  
14 together some interim recommendations, and then  
15 take a look back and try to figure out what  
16 happened and so on.

17 We think that is more valuable, and so  
18 we have been using this more expeditious process.  
19 The other way, there is a lengthy investigation,  
20 public hearings and then a report, and by that  
21 time, two and a half years have gone by and people  
22 can't remember why you were called into existence  
23 in the first place.

24 So that didn't seem like such a good  
25 idea to us, so with that in mind, that is what we

1 are up to. You know there is a transcript, and I  
2 think that is basically everything. We'll ask  
3 questions as we go along, if that is okay with you.

4 MELANIE FRASER: Absolutely.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 And so we are ready when you are.

7 MELANIE FRASER: Well, wonderful.

8 Thank you, Justice Marrocco, and thank you,  
9 Commissioners.

10 So I think that is a great setup for  
11 the presentation that we have here for you. The  
12 presentation includes an overview of the fall  
13 planning work that we have done, including some of  
14 the outcomes that we have already achieved, but  
15 some of the work that will continue to evolve as we  
16 respond to sort of unpredictable scenarios across  
17 the province.

18 And then towards the end of the  
19 presentation, there is a deep dive into the  
20 long-term care stabilization planning that was  
21 done, and it is well integrated into the fall plan  
22 as well.

23 So maybe just for context before we  
24 jump into the materials, in terms of the fall plan  
25 itself, this was really an effort that began, I

1 would say, early -- sorry, late in the spring as we  
2 were emerging from wave one of the pandemic and  
3 really brought together, I would say, quite a  
4 number of sectors and quite a number of different  
5 partners in the sectors to try to take all of the  
6 learnings from the first wave of COVID and look at  
7 what roles and what advice different players from  
8 across the system could provide to preparing us for  
9 the fall and a potential wave two, recognizing that  
10 none of us had a crystal ball in terms of what  
11 would be coming.

12 But the work did involve our colleagues  
13 across several different ministries, from Ontario  
14 Health, from Public Health, and as I said, numerous  
15 stakeholders and partners that we met with to  
16 ascertain their learnings, I would say, in the  
17 field and as far abroad as we could get.

18 So that is what the plan was based on,  
19 so I think the presentation will take you through  
20 the plan sort of at a high level. There are six  
21 pillars in the fall plan, and then we thought we  
22 would deep dive into each pillar and update you on  
23 where we are at and our thoughts as we go forward.

24 So with that, maybe, Alison, I'll just  
25 turn it over to you to walk through some of the



1 early slides on the data and some of those pieces.

2 ALISON BLAIR: Absolutely. Thank you  
3 very much, Mel, and good morning, everybody.

4 Thank you for having me back to present  
5 on the fall preparedness plan.

6 So I think we'll start and go through  
7 some of the context slides here, just to help set  
8 up the plan and how we have been conceptualizing  
9 how we would do that planning.

10 I think this slide is simply to say  
11 that with quick action from the government, from  
12 health sector partners and perhaps most importantly  
13 from Ontarians who listened to guidance and stayed  
14 home, we were able to flatten the curve in the  
15 first wave and avoid the worst case scenario.

16 We certainly didn't have -- there was  
17 no spring plan for COVID because it was happening  
18 to us realtime, and so we definitely learned a lot  
19 from it, and now we have been able to collect the  
20 learnings from this and put it into place to be  
21 able to avoid the worst case scenario.

22 As you will recall, back in the spring  
23 how we characterized the worst case scenario was to  
24 have an Italy-like situation where our health  
25 system would be overwhelmed and our critical care

1 beds and ventilator capacity would be exceeded and  
2 tough decisions would need to be made about who  
3 would get those resources.

4 So we are -- as part of the wave two  
5 plan, we are looking at what the scenarios could  
6 potentially be and how we plan to make sure that  
7 happens.

8 But certainly in the first wave, we  
9 were able to re-open while protecting Ontarians.  
10 But you will see in the later parts of this graph  
11 the experience that we are having now with the  
12 increase in COVID case numbers, and we are taking  
13 action accordingly based on this. You will have  
14 seen some announcements over the course of the last  
15 few weeks about reducing gathering sizes, about  
16 closures of bars and restaurants to serving alcohol  
17 at 11:00, and closures at midnight, strip clubs  
18 closing, those kinds of actions that we are in the  
19 midst of taking.

20 So that is the context for the fall  
21 planning. Of course, when we were doing the fall  
22 planning, we didn't know what numbers were ahead of  
23 us, and so we are adapting as we go, and what I'll  
24 hope to do is -- and Mel will do as well, is to  
25 show you how we have set up this plan to also allow

1 us to be responsive to surge either in different  
2 geographic places or in different parts of the  
3 public health or health system sectors to be able  
4 to address the issues as we see the ongoing  
5 epidemiology change.

6 Next slide, please.

7 So Mel mentioned this, about the  
8 lessons learned that we had from wave one. Between  
9 the Ministry and Ontario Health, we convened 46  
10 sessions with stakeholders in July, with about 300  
11 people, participants throughout the health care  
12 system and related sectors, including of course  
13 Public Health, and we got some feedback on what  
14 went well and what we could do better in the next  
15 waves.

16 So what worked well that people  
17 commented on was the leadership that the government  
18 demonstrated and the presence at all levels of  
19 government, whether it was the Premier or  
20 Ministers, the Chief Medical Officer of Health,  
21 obviously, who was doing daily and then now  
22 twice-weekly press releases or press gathering,  
23 briefings.

24 So certainly that was -- people agreed  
25 that the ability to share information throughout

1 wave one was very helpful. They appreciated the  
2 decisive and quick actions at the outset, and some  
3 of the Emergency Orders that supported work force  
4 mobilization and flexibility and people being able  
5 to make decisions at the local level was also  
6 appreciated.

7 I think also there was a general sense  
8 of the health system and Public Health and the  
9 public coming together in responding to COVID-19,  
10 so I think some partnerships that maybe wouldn't  
11 have happened when we were not in this kind of  
12 situation did come to fruition during that time.

13 The areas for improvement that they  
14 identified included a need to see a more integrated  
15 system approach, with clear goals across the  
16 settings and sectors, so what each was trying to  
17 achieve.

18 One of the comments that we had, which  
19 we have incorporated into the fall plan, is based  
20 on the information that we were getting. I think I  
21 mentioned to you that the worst case scenario that  
22 we were trying to avoid in wave one was  
23 overwhelming our critical care and our ventilator  
24 capacity.

25 There was a great deal of focus on that

1 and because we saw that as something we very much  
2 wanted to avoid, and as a result, a lot of the  
3 attention and the early resourcing related to  
4 hospital and institutional care and, I think, the  
5 community leaders, those working in the health  
6 system at the community level, wanted to make sure  
7 that we had an integrated system approach so that  
8 we are not just thinking about the institutions and  
9 where people will wind up eventually, but also how  
10 we can make sure that we are caring for people at  
11 home, which you will see as a feature in our fall  
12 plan.

13           They also asked about prioritization  
14 and proactive decision-making around expenditures,  
15 and I think that relates to what money got spent in  
16 which sectors and how do we make sure that we are  
17 being proactive about that decision-making and  
18 thoughtful.

19           And then the last was about having one  
20 source of truth, especially during wave one when we  
21 were receiving data at the same time as everyone,  
22 as the public, and needing to make sure that we had  
23 directives and policies in place and with a number  
24 of -- whether it be local Public Health Unit  
25 decision-makers, members of Ontario Health when

1 Ontario Health put out directives, and the Chief  
2 Medical Officer of Health. I think people wanted  
3 to know what was in fact the truth.

4 Sometimes what would happen is guidance  
5 would deal with subsets of one another, and I think  
6 the field found that confusing, and so what we are  
7 looking to do in the fall plan is to make sure that  
8 we are consistent and that we are aligned across  
9 the guidance.

10 I truly don't believe that there was  
11 any situation in wave one where we were at  
12 cross-purposes, but in some cases there could have  
13 been better explaining about how they relate to one  
14 another, so we are doing a better job of that now.

15 And the result through wave one is we  
16 fared well ahead of what some early expert  
17 predictions were, but wave one did reveal some gaps  
18 and points of weakness in our response, and one of  
19 those areas is of course the long-term care sector,  
20 which you are tasked with looking at, and other  
21 vulnerable populations.

22 So what we committed to as we were  
23 talking to our partners would be to build on the  
24 successes and lessons learned from wave one to make  
25 sure that we are supporting the system where they

1 are most needed in wave two.

2 If we could move to the next slide.

3 So what actions we were able to take  
4 and the early accomplishments in wave one, we'll  
5 just go over these briefly.

6 The first is about robust outbreak  
7 management with accountabilities, resources, and  
8 practiced containment protocols. So this was  
9 certainly done within outbreak situations where  
10 vulnerable people were at risk, and so  
11 understanding the role of local Public Health,  
12 understanding the responsibilities of the  
13 organization itself, whether it be a long-term care  
14 home, a retirement home, a group home, an emergency  
15 shelter, so that was something that we worked on  
16 very quickly.

17 We opened 148 assessment centres to be  
18 able to do the collection of testing specimens.  
19 The investments were made to sustain provincial  
20 testing volumes of over 25,000 per day, and at that  
21 point, more than 2.2 million tests conducted.  
22 Today, I can tell you we are not quite double that,  
23 but certainly have increased testing even more  
24 since then.

25 We have also reinforced strong public

1 health actions, and this was either through  
2 directives, Emergency Orders, advice or memos from  
3 Dr. Williams, as well as collaboration with local  
4 Medical Officers of Health and others, and  
5 obviously a -- and a communications program that  
6 also transmitted those messages as well.

7 In wave one, a health human resource  
8 matching tool was developed to help match qualified  
9 Ontarians with health care providers who needed  
10 health human resource support, and so that was  
11 definitely a success to get that up and running in  
12 wave one.

13 And the increase in case and contact  
14 management capacity is something -- including a  
15 remote work force that was pulled together of  
16 almost 2,000 staff, to be able to support case and  
17 contact management capacity.

18 The increased hospital capacity was an  
19 area that we focussed on as well, making over 5,000  
20 acute care and around 1,500 critical care beds,  
21 with an operationalization of 500 vented critical  
22 care beds and 1,000 post-acute beds. So that was a  
23 lot of capacity that was brought to the hospital  
24 sector to be able to address potential surges in  
25 wave one.



1                   And then the expansion of service  
2 capacity within Telehealth Ontario to make sure  
3 that Ontarians had a place that they could call to  
4 understand what they needed to do, whether they  
5 needed a test, where they could get that test, and  
6 that was something that we did early on in wave one  
7 as well.

8                   Next slide, please.

9                   So what we are facing this fall then is  
10 a bit different from what we were facing in winter  
11 and spring. Number one is something that of course  
12 we need to be prepared for a variety of possible  
13 scenarios throughout this fall and winter, but what  
14 we are seeing that we didn't see in the fall, of  
15 course, is that flu season is upon us and the  
16 increased demands on the health care system.

17                   We can be hopeful that we will see a  
18 suppression of both colds and flu because of the  
19 physical distancing and the facial coverings and  
20 those kinds of actions that we are taking because  
21 of COVID-19, but we still think that there will be  
22 pressures on the system due to flu.

23                   We also have a backlog of health  
24 services that were not provided when we, under  
25 directive 2, ceased the non-emergency health

1 services, and so that would mean scheduled  
2 surgeries within the hospital sector, but it also  
3 includes the kind of either procedures or  
4 immunizations or that kind of thing that can happen  
5 in primary care that didn't happen when we had gone  
6 to virtual care.

7 So as a result, based on the suspension  
8 of those scheduled surgeries, we are looking at an  
9 estimated backlog of, as you can see on the slide,  
10 187,672 surgeries, as well as diagnostic imaging  
11 scans that are also in backlog.

12 So we'll certainly look to triage that  
13 through a centralized wait list to make sure that  
14 we are managing those volumes efficiently.

15 So the backlogs didn't exist in the  
16 spring. That is something that we'll need to  
17 address, as well as overcrowding. So currently  
18 acute care bed occupancy is over 89 percent of  
19 total capacity, and that is a provincial number, so  
20 there is variation across the province with that.

21 The reduction in shared accommodations  
22 for infection prevention and control reasons has  
23 also impacted capacity both within long-term care  
24 and in hospitals, and obviously to deal with COVID,  
25 we need to make sure that we are not crowding

1 patients. So this is something that really  
2 constrains the capacity within hospitals, which  
3 were already busy before COVID, and we are looking  
4 to make sure that we live within that capacity.

5           Number 5 is similarly in long-term care  
6 homes. The Ministry of Long-Term Care policy to  
7 suspend the use of three- and four-bed rooms has an  
8 impact of eliminating available long-term care  
9 capacity bed spaces, and therefore, patients who  
10 are in hospital and are deemed alternate level of  
11 care, who are waiting for long-term care homes, are  
12 waiting longer for that, so there are more ALC  
13 patients within hospital.

14           And then finally another challenge for  
15 the fall is that the health human resources that we  
16 need to be addressing any fall surges are the same  
17 health human resources that just lived through wave  
18 one with us. We found that those areas with health  
19 human resource deficiencies, this was exacerbated  
20 in wave one, and occupational fatigue and burnout  
21 is a real thing on the frontline, and we know that  
22 we will need more personal support workers required  
23 for both home and community care and in long-term  
24 care sector to be able to address -- to address  
25 what is coming to us in the fall.

1           So those are things that we are dealing  
2 with that we weren't dealing with in the winter and  
3 spring, so the advantage of course that we have is  
4 that we have had more time to plan for the fall,  
5 but there are extra challenges.

6           This slide is an important one because  
7 it provides the scenarios that we used for planning  
8 purposes to develop the fall plan. These are  
9 scenarios -- and just to be really clear, these  
10 aren't forecasts. They aren't predictions of what  
11 happened. They aren't models, but they are  
12 planning scenarios, and these have been adapted  
13 from the Public Health Agency of Canada who put  
14 together these drawings and the scenarios.

15           And then we have worked with Ontario's  
16 Modelling Table, which reports in to the Health  
17 Command Table, to develop these scenarios and  
18 general levels of cases for Ontario to inform  
19 planning for the fall.

20           This was used to identify what we would  
21 need in place to address the scenarios and  
22 potentially to surge up to even higher levels.

23           The Public Health Agency of Canada,  
24 when they talk about number 3, the planning  
25 scenario with a fall peak, they say a

1 "reasonable" -- and I'll put that in quotes --  
2 worst case scenario for the fall peak would be two  
3 to three times the wave one peak that we  
4 experienced.

5           And if we can just go through them  
6 quickly, the first, the low planning scenario, is a  
7 slow burn where we see a smaller or no second wave  
8 of the pandemic with a few localized outbreaks that  
9 can be contained fairly quickly.

10           Number 2 is our moderate planning  
11 scenario with peaks and valleys, which could be a  
12 moderate second wave and some areas with little  
13 impact, with others with localized outbreaks and  
14 continuing infections in congregate care settings.

15           And then the high planning scenario  
16 with a fall peak, which is equivalent to what we  
17 had thought for wave one was the worst case  
18 scenario of Italy, with a large second wave that  
19 taxes the health system in areas with high  
20 population density, regional and local outbreaks  
21 that are harder to contain, and severe outbreaks in  
22 congregate care settings.

23           And to be able to plan -- to plan and  
24 to practice here, we have done table-top exercises,  
25 and some of them are still underway, to have

1 regional and provincial partners simulate or walk  
2 through scenarios to be able to strengthen their  
3 readiness for what's potentially going to happen in  
4 the fall. We'll talk more about that.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Well, we are in the fall. Is there any  
7 sense of which one of these scenarios is playing  
8 out?

9 ALISON BLAIR: I spend a lot of time  
10 with public health physicians, including the Chief  
11 Medical Officer of Health, and they all advise that  
12 we won't know about whether we are in a high fall  
13 peak or in a low one except in retrospect. I think  
14 that we have certainly talked about being in a  
15 second wave, but characterization of whether we  
16 think this would be a much higher fall peak or  
17 whether it will be something that we can manage is  
18 still very much to be determined.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 So did I understand correctly, we won't  
21 know as we are going through it which type of  
22 scenario we are encountering. We would only be  
23 able to determine that after it is over, looking  
24 back?

25 ALISON BLAIR: I think if we think

1 about where we are today, for example, in our case  
2 numbers, we are at about 500, mid 500s today, and a  
3 few days ago we were in 700. But we don't know yet  
4 if that is going to bump back up or if we are  
5 headed down a smaller peak.

6 So I think that is the difference. It  
7 won't be that we can only see once we are in the  
8 rearview mirror by six months, but when we are in  
9 it, it is very hard to tell what kind of a scenario  
10 we'll be in.

11 We take the epidemiological information  
12 like case numbers, like our transmission values,  
13 the "R naught" calculation, to be able to predict,  
14 but nobody has that crystal ball.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 So then what do you do? Do you prepare  
17 for the worst case scenario then?

18 ALISON BLAIR: What we have done  
19 through the planning for the fall is to make sure  
20 that we have the capacity to be able to implement  
21 between the low and the moderate  
22 levels...[inaudible]

23 [Court Reporter intervenes for  
24 clarification.]

25 And then being able to surge to the

1 higher levels, so that if we need to manage surges,  
2 we can do that.

3 MELANIE FRASER: It is Mel here, and I  
4 would just add to that, that when we get into our  
5 fall plan, there is also the ability to influence  
6 the height of that peak through our public health  
7 measures and prevention and rapid response.

8 So I would say it is a combination of  
9 being able to surge up to the peak that is in front  
10 of you, but then using all of the tools that are  
11 available to us to also mitigate how high that peak  
12 gets.

13 ALISON BLAIR: Thank you, Mel.

14 Next slide, please, and as if on cue,  
15 thank you, Mel, for the intro into this, that as  
16 Mel described, in terms of the levers that we have,  
17 obviously planning to be able to accommodate surges  
18 is something that we are doing, but we also  
19 recognize that in Ontarians, individual Ontarians  
20 have the ability to influence this pandemic as well  
21 as the public health measures which local Medical  
22 Officers of Health and the Chief Medical Officer of  
23 Health can inform.

24 When we look at tightening of public  
25 health measures, that is something that we have



1 done in the last couple of weeks, but as we were  
2 looking ahead to the fall, it was certainly planned  
3 that -- first of all, that we would be basing any  
4 public health measures on the same epidemiological  
5 data that was used as we were re-opening, which  
6 includes case counts and rates, the transmission  
7 rates, the R-value that I talked about earlier,  
8 public health capacity and health system capacity.  
9 These were things that we looked at as we were  
10 re-opening and very much have our eye on now as  
11 well.

12           Consultation with local Medical  
13 Officers of Health is a very important feature of  
14 how we are going about assessing and then  
15 tightening public health measures.

16           And the plan is to be as specific as we  
17 can. When we were looking at wave one, there were  
18 some very broad measures taken, and we recognize  
19 the impact of those broad measures, especially on  
20 isolation, mental health, the financial impact for  
21 individuals, that we want to make sure that as we  
22 are looking this fall, to be thinking about how  
23 targeted we can be in the public health measures  
24 that we are implementing.

25           The situations that we have outlined in

1 the table, so if we are looking at one institution  
2 or one workplace outbreak, that this would be  
3 targeted outbreak management at that individual  
4 level. If we were to see increased community  
5 transmission, first we would reinforce the  
6 preventive measures that we know work, for example,  
7 mandating facial coverings where it is not already  
8 mandated, and if we were looking at wider spread  
9 community transmission beyond certain areas, we  
10 could look to re-implement closures of businesses,  
11 services, and public spaces.

12 We also would look to do this as  
13 geographically targeted as we can. Ontarians  
14 experienced us -- the changes and the restrictions  
15 happening at a Public Health Unit level, and so we  
16 would certainly look to see whether that is  
17 possible depending on what we are seeing in the  
18 epidemiology and also the capacity for public  
19 health and health system capacity.

20 Next slide, please.

21 So now we can get into the fall plan.

22 So in a presentation that I provided to  
23 you previously, we looked at this fall preparedness  
24 strategy with six readiness objectives. Mel had  
25 spoken to you earlier about what informed the plan,

1 but I also wanted to make sure we mentioned the  
2 involvement of other Ministries in the development  
3 of this plan, notably the Ministry of Long-Term  
4 Care, but also the Ministry of Seniors and  
5 Accessibility and others who were involved, for  
6 example, the Ministry of Labour, Training and  
7 Skills Development, and the Ministry of Municipal  
8 Affairs and Housing who have also been involved in  
9 discussions on this.

10 The six readiness objectives have not  
11 changed since we last spoke about it, and the fall  
12 preparedness strategy has now been released  
13 publicly, as you will have seen.

14 Three readiness objectives related to  
15 prevention and protection and then three related to  
16 integrated health system capacity.

17 The readiness objectives that we have  
18 here are to make sure that we are covering the  
19 areas that needed preparation, and then the  
20 execution of the plan, we recognize that as we  
21 progress through the fall, based on the  
22 epidemiology, we may need to be doing any of these  
23 readiness objectives more in certain geographical  
24 areas or to focus on more of the readiness  
25 objectives more than another, just based on the

1 epidemiology that we are seeing, what outbreaks are  
2 occurring, potentially scaling up in one area more  
3 than another, so that is something that we will  
4 need to remain flexible, even within the execution  
5 and the implementation of these readiness  
6 objectives.

7           The key area of focus along the bottom,  
8 I just want to draw your attention to the  
9 importance of some of these, especially the  
10 infection prevention and control measures, to make  
11 sure that we are protecting vulnerable populations  
12 in long-term care, retirement home and other  
13 congregate settings. We talked about creating the  
14 capacity outside the hospital setting to make sure  
15 that we are accommodating the decreased capacity in  
16 long-term care and in hospital, so making sure that  
17 we are keeping people at home as much as we can.

18           And the focus on reducing the backlog  
19 of surgeries and procedures and, as we said, also  
20 primary care services as well is a key area of  
21 focus.

22           Making sure that we have enough testing  
23 capacity to support re-opening when we are able to,  
24 and to inform outbreak management and then making  
25 sure that we have the health human resources that

1 we need to address any surges.

2 The next few slides go deeper into  
3 these, and I think it is worthwhile spending -- oh,  
4 here, sorry, before we do that, the overview of  
5 investments.

6 This is all publicly available as well,  
7 but looking at 2.8 billion to make sure that the  
8 province's health and long-term care system are  
9 prepared for the immediate challenges this fall,  
10 including a second wave.

11 So you can see the considerable dollars  
12 being spent for maintaining the strong public  
13 health measures. This includes about 1.07 billion  
14 on testing and case and contact management  
15 capacity, two big responses that we need in place  
16 for COVID.

17 But you can certainly read those at  
18 your leisure, and we can talk more about those  
19 investments if you would like.

20 The next several slides drill down into  
21 the pillars and the readiness objectives that we  
22 have here, and include -- for each of them, we can  
23 talk about the actions that have been completed to  
24 date and what the priorities and the desired  
25 outcomes are as we go forward.

1                   So for maintaining public health  
2 measures, it is no surprise that being able to  
3 test, trace and isolate cases remains a foundation  
4 of our fall preparedness plan. This has been part  
5 of our response to COVID-19 since the start, and we  
6 still need this in place to be able to keep on top  
7 of the virus and break the chains of transmission.

8                   In terms of what has been completed to  
9 date, the provincial lab network has come together  
10 since the beginning of the COVID response with  
11 capacity initially for 25,000 daily tests. You  
12 will now see that we are producing -- or processing  
13 upwards of 40,000 on a daily basis and have made  
14 investments to build up capacity to 50,000 daily  
15 tests. In fact, later this week we hope to have  
16 capacity to be able to process up to 50,000 daily.

17                   We also hope that we do not have to  
18 process 50,000 daily. That is at any given moment  
19 the maximum testing capacity. It is not something  
20 we want to be running our testing system at. And  
21 we are certainly looking to, as we see the desired  
22 outcomes, scaling up the number of COVID tests per  
23 day to be able to accommodate surges, and we have  
24 talked about being able to build that capacity to  
25 about 78,000 per day.

1 To date, we have been able to --  
2 COMMISSIONER FRANK MARROCCO (CHAIR):  
3 Ms. Blair, sorry for interrupting. We  
4 have heard some evidence about the length of time  
5 it takes to get the test back.

6 ALISON BLAIR: Turnaround times.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 So in addition to increasing the  
9 capacity for testing, is there an increase in the  
10 ability to analyze and get the result back?

11 ALISON BLAIR: I think the basic  
12 physics of this is, when we are running the system,  
13 the testing processing system, at less than its  
14 capacity, we are able to keep turnaround times low  
15 and to our target levels, and so that is why we are  
16 building up our capacity to be able to surge so  
17 that we can keep those turnaround times as low as  
18 possible.

19 For example, if we had capacity today  
20 of 50,000, and we were running it at 50,000, that  
21 can create backlogs, and we aren't able to turn it  
22 around as quickly, but if we are running at 75  
23 percent capacity, then we are able to turn those  
24 around quickly.

25 So I think it is really about making

1 sure that as the demand for testing increases, that  
2 we also have an increase in the testing capacity.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 And what is the turnaround time, the  
5 desired or the turnaround time that you realize?

6 U/T ALISON BLAIR: So the targets -- and I  
7 don't think we have those in this slide deck, but  
8 are to have 60 percent of tests done within -- or  
9 sorry, 80 percent of tests done within 48 hours,  
10 and I believe the target is 60 within 24 hours.  
11 Let me make sure that I get back to you with those  
12 targets.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 And something I have not been able to  
15 kind of keep track of, but who is responsible for  
16 testing? Who has that responsibility?

17 ALISON BLAIR: How about I talk to you  
18 about the roles for executing the testing capacity.

19 Ontario Health hosts that network and  
20 has connected that provincial lab network of over  
21 20 labs across the province, and Public Health  
22 Ontario, the Chief Microbiologist, Dr. Vanessa  
23 Allen, works with the CEO Matt Anderson at Ontario  
24 Health to run the testing area.

25 The guidance on who should be tested



1 and those decisions are with the Chief Medical  
2 Officer of Health. There is a testing expert panel  
3 that provides recommendations to the Chief Medical  
4 Officer of Health, but how those are vetted and who  
5 ought to get tested for what symptoms is a public  
6 health function that resides with the Chief Medical  
7 Officer of Health.

8 So I think those are the two sides of  
9 the coin.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Thank you.

12 ALISON BLAIR: All right.

13 COMMISSIONER JACK KITTS: Alison, can I  
14 ask a question? You know, early on in the  
15 presentation you correctly pointed out that we have  
16 got to get back to the public health measures that  
17 actually really worked in wave one, and that was  
18 staying at home as much as possible, physically  
19 distancing, wearing masks where appropriate, hand  
20 hygiene, and if I add PPE supply and training, the  
21 proper training.

22 Those are things that can really reduce  
23 the impact of COVID in the community, and we are  
24 hearing that how prevalent it is in the community  
25 is going to increase the risk dramatically for the

1 long-term care homes.

2 So in this presentation, "Maintain  
3 Public Health Measures", it is all about testing,  
4 tracing and isolating. I feel we have lost the  
5 communication to say the only thing that worked in  
6 wave one was physically distancing and stuff like  
7 that. Everything else has been we are trying.

8 So is there any way to beef up that  
9 part of it, and I would ask, where do you get  
10 support to bring that back? I know it competes  
11 with re-opening, but you can still re-open and  
12 still remind us to do the things that actually  
13 worked in wave one.

14 ALISON BLAIR: Thank you very much,  
15 Commissioner Kitts, for that comment.

16 We can talk about what is on the slide  
17 around what we are doing on health behaviour  
18 surveillance, but to address your comment directly,  
19 the Chief Medical Officer of Health throughout this  
20 fall plan has the responsibility for assessing the  
21 epidemiology, the public health capacity, and the  
22 health system capacity, and is doing so on a daily  
23 basis and bringing recommendations to government to  
24 look at this.

25 So including that in the fall plan is

1 something that we will do in order to make clear  
2 that the Chief Medical Officer of Health is  
3 supported by the Public Health Measures Table, is  
4 making recommendations on this regularly based on  
5 their assessment. That is why we have seen the  
6 public health measures.

7 In terms of the -- we certainly do know  
8 what has worked across the board, and we are also  
9 looking at, as we said on previous slides, how  
10 targeted can we be and still be effective.

11 So your answer about when do we bring  
12 back what was in wave one? I think the answer is  
13 we do so based on evidence and at the  
14 recommendation of local Medical Officers of Health  
15 and the Chief Medical Officer of Health.

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 Commissioner Coke? You are on mute.

18 COMMISSIONER ANGELA COKE: Sorry. I am  
19 just trying to understand. Is there a particular  
20 trigger that says, you know, if you meet this  
21 level, then this is what determines we have got to  
22 go back into that harder lockdown? What is the  
23 criteria for that? Is there a specific sort of  
24 threshold that you have to hit?

25 ALISON BLAIR: Right. Thank you,

1 Commissioner Coke.

2           The discussion about what are the  
3 conditions under which certain public health  
4 measures would be taken is -- the discussion is  
5 ongoing. The general conclusions have been that  
6 this is not like a recipe book where you can say,  
7 if cases go to this level per 100,000,  
8 automatically a public health measure is put in  
9 place.

10           It is going to depend on the geography,  
11 the age groups, and these are all things that the  
12 Public Health Measures Table, the Chief Medical  
13 Officer of Health locally, the local Medical  
14 Officers of Health, are also looking at, but I can  
15 tell you that it is the same indicators. They are  
16 looking at the same indicators and looking at  
17 signals from all of those on the epidemiology of  
18 the disease, public health capacity to be able to  
19 address case and contact management, for example,  
20 and what testing positivity rates are looking like  
21 and also hospitalizations and critical care.

22           COMMISSIONER ANGELA COKE: Thank you.

23           ALISON BLAIR: And I apologize if that  
24 is not a satisfactory answer from your perspective.  
25 Perhaps talking to a public health physician would

1 give you more of an opportunity to discuss what is  
2 going on right now and how decisions are made for  
3 public health.

4 COMMISSIONER ANGELA COKE: I understand  
5 it is complex.

6 ALISON BLAIR: Uhm-hmm.

7 A few more things to point out about  
8 this slide.

9 First, about case and contact  
10 management and some of the progress that we have  
11 made there.

12 One is the agreement with the federal  
13 government to do remote contact tracing staffing,  
14 and that is made much easier now that we have a new  
15 case and contact management system launched with --  
16 this is now incorrect, with 34 -- or 31 of the 34  
17 Public Health Units that we have now implemented,  
18 so that makes it much easier for a remote work  
19 force to be able to use the same information  
20 technology within a Public Health Unit so that they  
21 can input right into their system.

22 And that is something that has been  
23 implemented in all but three of the Public Health  
24 Units.

25 The exposure notification app was

1 launched at the end of July. I hope everybody on  
2 this call has it on their phones, and so that will  
3 also help with contact tracing.

4 Then I think, Commissioner Kitts, where  
5 is it on this slide about the public health  
6 measures is we have got a bullet under the "Actions  
7 Completed to Date" about government adoption of the  
8 Chief Medical Officer of Health's advice on public  
9 health measures and on regional re-openings, and  
10 that analysis continues.

11 Oh, just before you go to the next  
12 one -- I know I am taking too much time on this  
13 stuff, but the bottom right bullet about better  
14 understanding of the public's comprehension and  
15 uptake of public health measures, we recognize that  
16 there can be fatigue about these public health  
17 measures, and so the work that we are doing -- that  
18 we are initiating on health surveillance -- health  
19 behaviour surveillance will help us to understand  
20 what is being taken up well and where we have  
21 people who are not responding to these public  
22 health measures so that we can target  
23 communications or education appropriately and to be  
24 aware of the general level of what some have called  
25 COVID fatigue, and I am sure everybody here is also

1 feeling.

2 Now we can go to the next slide. Thank  
3 you.

4 Something that will be really important  
5 this -- and starting with immunizations this month  
6 about the flu campaign this year is to make sure  
7 that we are addressing as much of the flu before it  
8 even starts in terms of uptake of the flu vaccine,  
9 especially with vulnerable populations, and so we  
10 are looking to prioritize vulnerable populations  
11 for the receipt of the flu vaccine, as well as  
12 health care workers who are in contact with those  
13 vulnerable populations.

14 We want to make sure that there is high  
15 vaccine uptake and an efficient use of the vaccine  
16 doses. We are especially aware of the different  
17 kinds of flu clinics that might be successful this  
18 year with needing to physically distance, so we  
19 can't have large crowds waiting in long lines for  
20 flu vaccines.

21 So looking to make sure that this is as  
22 accessible as possible within your local pharmacy,  
23 and we also want to make sure that the public is  
24 educated and motivated to get vaccinated for the  
25 flu.

1           Again, we can hope that the flu is  
2 suppressed, as it was in Australia due to the  
3 COVID-19 measures, but we'll see what transpires in  
4 Ontario.

5           We have ordered additional flu vaccine  
6 doses through the National Bulk Purchasing Program.  
7 The national program is the only way to get the flu  
8 vaccine for Ontarians, so we are maximizing that  
9 and allocating high dose influenza vaccine for  
10 seniors to pharmacies as well this year. That is  
11 an addition.

12           And then planning that has gone on with  
13 the Ontario Pharmacists Association and the Ontario  
14 Medical Association, we can add that to what has  
15 been completed to date.

16           And making sure we are prioritizing  
17 where we allocate the flu vaccine.

18           Next slide, please.

19           Another area that we want to be doing  
20 really well at this fall is about managing  
21 outbreaks, so being able to identify -- prevent  
22 them in the first place and then identify and  
23 manage them quickly.

24           The new case and contact management  
25 system will help to identify cases associated with



1 outbreaks, and we have a number of structures in  
2 place to be able to identify and support Public  
3 Health Units in managing outbreaks.

4           The Regional Table -- sorry, the  
5 Regional Table-Top Program has been put in place  
6 between the Ministry of Health and Ontario Health.  
7 We have conducted table-top exercises to look at  
8 various scenarios that could occur within regions  
9 and to really practice how the various steps would  
10 be taken, who would be contacted first, how local  
11 Public Health would be involved, what health system  
12 partners need to be ready to do and those kinds of  
13 things, and we have practiced those for a variety  
14 of scenarios, ranging from a school outbreak to a  
15 correctional facility outbreak and other congregate  
16 settings.

17           We also have seen a pilot project that  
18 Toronto Public Health is working with the federal  
19 government on to support isolation facilities for  
20 those who are not able to self-isolate within their  
21 family homes, and Peel, I think, is now working  
22 with the federal government on the same kind of  
23 isolation facilities.

24           We want to make sure that we are aware  
25 of outbreaks and of potential outbreaks, so that is

1 something that we are working on to have congregate  
2 settings assess their readiness for outbreaks and  
3 then making sure that we have the partnerships in  
4 place to both support isolation capacity and to  
5 take coordinated actions.

6 We talk here about enhanced regional  
7 IPAC supports for congregate care settings, and  
8 that includes what is being established regionally  
9 as a hub and spoke model where the regional hubs  
10 would provide the IPAC expertise and advice to  
11 congregate care settings, which would be the spokes  
12 of the hub and spoke model, to be able to advise  
13 on, conduct audits for, help preparedness planning  
14 on infection prevention and control, and then work  
15 with the spokes if there is an outbreak to make  
16 sure that we are managing that appropriately,  
17 obviously in partnership with local Public Health.

18 So I think the next slide gets into the  
19 integrated health system response, and I think I'll  
20 turn to Mel Fraser to do the next few slides.

21 MELANIE FRASER: Thanks.

22 So as you saw up front, we have sort of  
23 defined the fall plan into two kind of buckets, the  
24 first being the prevention and protection bucket of  
25 readiness objectives, and then the second being the

1 integrated capacity plan to ensure that the system  
2 has the capacity in place and to support those  
3 readiness objectives as well.

4 So the first readiness objective within  
5 this bucket of the plan is safely reducing health  
6 services backlogs. Alison covered earlier in the  
7 presentation what those backlogs look like, whether  
8 that would be in elective surgeries, whether that  
9 is in diagnostic imaging or, as she mentioned,  
10 immunizations and other services delivered in  
11 primary care.

12 So a key component of the plan is  
13 really to ensure that we can re-start those  
14 surgeries and address the backlog, even in the  
15 midst of another wave of COVID.

16 We do have detailed surveillance tools  
17 that provide us with data on the backlogs and new  
18 volumes, and we track that and monitor that very  
19 closely to ensure that we are making progress  
20 against those surgeries and procedures.

21 One of the things that most will be  
22 aware of during the early days of the pandemic, the  
23 global supply chain essentially collapsed with a  
24 significant proportion of PPE being produced  
25 actually in Wuhan, the province in China, the

1 epicentre of the epidemic and then pandemic. We  
2 saw the supply chain collapse, and a significant  
3 effort has gone into working to not only build a  
4 sustainable stockpile of PPE for the province but  
5 also to stand up domestic production across almost  
6 all of the categories of PPE that we can  
7 potentially produce here in Ontario, I would say  
8 with the exception of gloves because rubber is only  
9 made in Malaysia.

10 So that was a significant component of  
11 getting ready.

12 And also we have a somewhat fractured  
13 supply chain system in Ontario, when we think about  
14 all the different settings across which they needed  
15 PPE, as well as swabs for testing, so really  
16 building a distribution model and connecting those  
17 together and providing regional governance for  
18 those. So that is something that has been  
19 completed, and I would say it is now operating as a  
20 pretty high functioning model, especially with  
21 respect to the distribution of PPE and being able  
22 to escalate and provide resources within 24 hours  
23 when there is an urgent need.

24 And I have covered the final point  
25 there.

1                   So in terms of the desired outcomes and  
2 priorities related to this pillar, we want to  
3 reduce that backlog of procedures as quickly as  
4 possible, and you will have seen a number of  
5 announcements related to this. So we have funded  
6 some dedicated and incremental capacity to be able  
7 to perform these procedures at, you know, a higher  
8 percent of the normal volumes that would have been  
9 done in previous years.

10                   We are also looking at innovative  
11 models, including surgical smoothing and pushing  
12 forward some of those models across different  
13 areas. Commissioner Kitts will be very familiar  
14 with that type of work. Looking at centralized and  
15 regional wait list management to ensure that we are  
16 adequately using all of the capacity that exists,  
17 and that may mean moving procedures from one  
18 location or another or supporting health care  
19 workers in following the work.

20                   And then, of course, ensuring that we  
21 have our diagnostic equipment optimized and running  
22 at its full and highest potential 7 days a week and  
23 maybe in some cases 24 hours a day.

24                   The other thing that we did was, again,  
25 recognizing, you know, the global environment, and

1 we only need to look south to our partners and see  
2 the challenges they continue to face with COVID, is  
3 we have procured a provincial stockpile of critical  
4 care and ICU supplies to ensure that we never find  
5 ourselves in a position where we can't support the  
6 surgeries or the ICU capacity.

7           And we do have a significant number of  
8 ventilators also in our pandemic stockpile, so that  
9 we are prepared, as Alison described, for that  
10 worst case Italy-type scenario, although, you know,  
11 we would anticipate that there will be public  
12 health measures that would intervene before we ever  
13 saw that type of a scenario.

14           But the province is prepared in that  
15 regard.

16           And then the other thing that we have  
17 done, and I think we made significant headway  
18 through the first wave of COVID, on our digital and  
19 virtual care capabilities, and we certainly do not  
20 want to lose ground and actually want to do more.  
21 So we are increasing our capabilities.

22           And with respect to the surgical  
23 backlog, looking at opportunities to deliver more  
24 care either post-operatively or in the community  
25 through virtual care to, again, support the acute

1 care sector by having only the care that is  
2 absolutely required to happen within that sector  
3 happen there and leverage the tools that we have  
4 developed to support a higher volume.

5 And I will push forward to the next  
6 slide.

7 This is probably an important slide to  
8 spend a bit of time on.

9 So as we looked at the integrated  
10 capacity plan, we really wanted to focus on the  
11 patient and on vulnerable populations, and as  
12 Alison mentioned, you know, in our early wave there  
13 was a focus on and a concern about overwhelming the  
14 acute care capacity. In this case, we are looking  
15 at leveraging and integrating the capacity along  
16 the system and along the patient flow and ensuring  
17 that we not only have the capacity in our acute  
18 care sector, but home and community, mental health  
19 and all of the adjacent sectors, that we have the  
20 care that is needed there.

21 So in terms of some of the things that  
22 were done to date and that we are building upon, we  
23 do have virtual care programs that have been  
24 established for home and community care, trying to  
25 accelerate and build upon those, as well as the

1 mental health and addictions programs.

2 Integrating home care programs to  
3 support congregate care settings, and a lot of this  
4 builds on, you know, the transformational agenda  
5 that the Ministry and the government was on related  
6 to Ontario Health Teams and really building  
7 integrated team care around patients.

8 And so we are really looking to  
9 leverage that, and we did see those Ontario Health  
10 Teams really solidify their relationships and  
11 become a huge benefit to providing care throughout  
12 the first wave.

13 So we have announced five more teams.  
14 We have 17 more that are in the process of  
15 completing their full application, but again,  
16 really looking at a system approach to providing  
17 care as opposed to a sector-by-sector approach.

18 And as I mentioned, the virtual  
19 services, we have done things like creating  
20 temporary payment codes for physicians, on-boarding  
21 more physicians on to OTN, funding virtual care  
22 solutions at the regional level, and providing more  
23 guidance to physicians to help support the  
24 procurement of virtual care technology. Again, we  
25 don't want to lose gains and want to continue to



1 build upon those.

2 So in terms of our desired outcomes, we  
3 do want to see more capacity in the community to  
4 reduce the reliance on the acute care sector, and,  
5 you know, some of this relates to the next pillar,  
6 which is health human resources, and I'll talk a  
7 bit more about that later.

8 So looking at, you know, our ability to  
9 create higher intensity bundles of service in the  
10 community just to support some of those more  
11 fragile and complex patients in their home where  
12 they are safer, creating a suite of cross-sectoral  
13 mental health and addiction supports, not only  
14 targeted at a variety of sectors but also at our  
15 work force and supporting them throughout.

16 And I think I have covered off the  
17 enhanced home and community care capacity.

18 COMMISSIONER ANGELA COKE: Mel?

19 MELANIE FRASER: Yes, certainly.

20 COMMISSIONER ANGELA COKE: Sorry, just  
21 a question. You had mentioned before the Ontario  
22 Health Teams and more of them coming on stream; is  
23 that right?

24 MELANIE FRASER: That's right.

25 COMMISSIONER ANGELA COKE: Do the

1 people encompassed in that, does that include the  
2 long-term care homes?

3 MELANIE FRASER: So they are all  
4 slightly unique, but certainly there are Ontario  
5 Health Teams that also include long-term care. It  
6 is really a collection of providers from across the  
7 sector who have agreed to provide integrated care  
8 for a geography of patients.

9 Because they are in their early days in  
10 terms of their development, most of our Ontario  
11 Health Teams have sort of specified an early  
12 population within which they are going to focus on,  
13 and many of them would have complex elderly  
14 patients, for instance, in that population, those  
15 who might be on a wait list to go to long-term care  
16 or need a variety of supports from different  
17 sectors.

18 COMMISSIONER ANGELA COKE: Okay. So  
19 the design of who is included and not is up to  
20 them?

21 MELANIE FRASER: So because, I would  
22 say, we are very early in our journey in Ontario  
23 Health Teams, we have been -- and this is really  
24 being co-designed with the sector, I would say --  
25 we are allowing teams to come together with their

1 proposals on who is in their team.

2 But the intention is that, you know, as  
3 we move forward, there is a specific geography of  
4 people that these Ontario Health Teams will be  
5 responsible for serving, and so as they mature,  
6 they would include all of the suites of services  
7 that those populations require, and they will be  
8 funded for that population's clinical outcomes as a  
9 whole and as an entity.

10 But this is a multi-year journey, and I  
11 think what we have seen through the first wave of  
12 the pandemic is that it really helped to solidify  
13 the relationships with those teams, and the  
14 relationships between those teams then helped  
15 provide better care to some of those patient groups  
16 by really integrating the care around the patient  
17 as opposed to a suite of hand-offs from one sector  
18 to another.

19 COMMISSIONER ANGELA COKE: Okay.

20 COMMISSIONER JACK KITTS: Mel, it is  
21 Jack. You know I support the Ontario Health Team  
22 concept and appreciate that.

23 Who at the Ministry -- or who would you  
24 suggest give the Commission a primer on what  
25 Ontario Health Teams are meant to be so that we

1 could learn more about them as a longer term  
2 solution?

3 MELANIE FRASER: Sure. So that would  
4 be one of my programs, so I would be happy to come  
5 back with one of my ADMs and give you a deep dive  
6 on that, for sure.

7 And I think it is an opportunity to  
8 look at in terms of the future of the health system  
9 and how these things intersect.

10 COMMISSIONER JACK KITTS: Okay. Thank  
11 you.

12 MELANIE FRASER: So the second bullet  
13 on the page where we mention having contingency  
14 planning to deal with surges in acute and critical  
15 care, so we -- as part of our fall plan, we did,  
16 you know, reflect back on, you know, what we saw  
17 through the first wave. We looked at the evidence  
18 and advice on what could potentially happen in a  
19 second wave, and our plans have the capability to  
20 surge up and flex up to provide support in areas in  
21 need.

22 Maybe a good example to talk about is  
23 Ottawa today, and our plan contemplated a number  
24 of, you know, low, medium, high scenarios, as  
25 Alison went through, and we have capacity plans

1 then to support each of those that we can flex up  
2 to proactively as we watch and monitor the data.

3 And so, for instance, in Ottawa some of  
4 that capacity will be coming online shortly as it  
5 was approved through the plan.

6 We talked a lot about the digital plan,  
7 and maybe an important point, that it is digital  
8 first where it is clinically appropriate. So we  
9 have made investments to provide care for patients,  
10 low-acuity patients, to prevent them from having to  
11 come to emergency departments and to provide more  
12 care in the community, but again, that is where it  
13 is appropriate, and we are trying to reserve our  
14 acute care capacity for those higher and more  
15 vulnerable higher-acuity patients.

16 And then the final point here is really  
17 ensuring that our clinical supplies and equipment,  
18 our PPE, that we have a reliable inventory to  
19 support all of the sectors that may need it, and  
20 there has been a significant amount of work done  
21 there, in partnership with our colleagues at the  
22 Ministry of Government Services.

23 And you know, just we have made  
24 tremendous headway in terms of where we have come  
25 relative to the constraints on the global supply

1 chain. That may be another briefing you might like  
2 at another time for the Commission. It really is a  
3 fascinating story of where we started from and how  
4 we have arrived at where we are today.

5 And then the final slide.

6 So I have referred to this pillar as  
7 being the backbone of the strategy. Really our  
8 health human resources are the backbone of the  
9 health system, and so this is a critical pillar in  
10 terms of being able to recruit and retain the  
11 health human resources that we need for the various  
12 scenarios and the capacity that we have planned,  
13 being able to train them, being able to support  
14 them, whether that is through mental health  
15 supports and in their working conditions and also  
16 looking at family and caregivers as an important  
17 part of the capacity that the system has and  
18 ensuring that we are thinking about patients and  
19 residents as the centre of the plan.

20 So we have -- you will have seen a  
21 suite of announcements recently, and this is a  
22 culmination of a significant amount of work that  
23 has been done over the course of the spring and  
24 summer.

25 U/T So I think Alison mentioned earlier we

1 have a health work force matching portal. We are  
2 making some upgrades to that tool, but please don't  
3 quote me on the number. I can get you the number.  
4 But literally we have tens of thousands of  
5 individuals and their health care professionals,  
6 and it is a tool that employers can go into to help  
7 identify and find matches for vacancies and gaps  
8 that they have in their capacity.

9 We recognize that, as Alison pointed  
10 out earlier, again, that there is a significant  
11 deficiency of personal support workers in the  
12 system. This was the case prior to the pandemic,  
13 and the pandemic really exacerbated the situation.

14 So we have taken a number of direct  
15 actions to address that. We have accelerated  
16 training programs to try to -- that should say  
17 "training", not "raining", to help to escalate the  
18 number of PSWs that are being graduated.

19 We have a return to service program,  
20 which is designed to help with retention, so PSWs  
21 who are graduating and choose to go into a  
22 long-term care home or a home and community care  
23 organization that is in need will receive a bonus  
24 for a particular length of service.

25 We have bursary programs. There was

1 pandemic pay, and we have recently announced a wage  
2 enhancement for PSWs working in both home and  
3 community care, long-term care and hospitals, and  
4 this is to recognize, you know, the ongoing  
5 challenges, as I said, that pre-dated the pandemic  
6 with recruitment and retention of that workforce.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 If I could just interrupt you for a  
9 minute.

10 MELANIE FRASER: Sure.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 When you were talking about  
13 implementing a health work force matching portal, I  
14 think you said there were tens of thousands of  
15 employees in there. But then there is a shortage  
16 of personal support workers.

17 So are the people in the portal in  
18 there in other capacities than personal support  
19 workers?

20 MELANIE FRASER: So it really was a  
21 tool that was launched to capture a voluntary work  
22 force and not volunteers as in being unpaid, but  
23 people who would volunteer to be deployed to a  
24 setting in need.

25 So it does include a variety of



1 different professionals. They could be retired,  
2 they could be active, a variety of different skill  
3 sets in regions all across the province.

4 So it becomes one opportunity for  
5 organizations who are in need of employees to go  
6 into the tool and determine if they can find an  
7 employee with the right skills match to make a job  
8 offer to.

9 Some of the upgrades that we are making  
10 to the system is to be able to get a better sense  
11 of reporting and how many of those matches actually  
12 turn into true employment and get a better sense of  
13 whether that tool is working.

14 And I would just say that is only one  
15 tool in the arsenal, and that is why we have quite  
16 a multifaceted workforce plan here, which is  
17 targeted at PSWs, nurses, and a variety of  
18 different tactics, I would call them, to not only  
19 augment the supply, to help with retention, to help  
20 with placement in areas of need, and to address,  
21 you know, ongoing concerns with wages relative to  
22 other sectors.

23 So it is one tool, and we are  
24 augmenting it as we speak to be able to get better  
25 data from it in terms of the matching.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 But notwithstanding the tens of  
3 thousands of people that are recorded in there,  
4 there is still a critical shortage of personal  
5 support workers?

6 MELANIE FRASER: For sure, and maybe I  
7 can just give you an example.

8 So when the tool was launched, an  
9 individual might have said, you know, I was  
10 formerly a nurse. I might be interested in  
11 volunteering. So their information is gathered and  
12 held in that portal.

13 A home may go in and -- let's say a  
14 long-term care home. An employer went into the  
15 portal. They may offer that individual a position,  
16 and the individual may say, Well, I have changed my  
17 mind. I am actually not interested in going to  
18 that home.

19 So it is a completely voluntary tool.  
20 We have made matches, but it is not seen as the  
21 sole solution to generating a sufficient work force  
22 to mitigate all the gaps in the system, and  
23 particularly related to PSWs where we know we have  
24 our most pressing gaps.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1           Looking at what we are doing, is there  
2 a recommendation that occurs to you that we could  
3 make that would help address the shortage of  
4 personal support workers?

5           You can think about it and get back to  
6 me. You don't have to answer in ten seconds or  
7 less. You know, it is not like Jeopardy or  
8 whatever it is.

9           MELANIE FRASER: I think what I would  
10 recommend, Commissioner Marrocco, is that perhaps  
11 we come back with our full PSW strategy. There are  
12 so many components of our plan that we are looking  
13 at, and there is a real complexity to the work here  
14 and the number of issues that relate to some of the  
15 long-standing recruitment and retention issues  
16 related to personal support workers, so perhaps a  
17 deep dive on that.

18           And again, it is another one of my  
19 ADMs, Michael Hillmer, that leads that strategy,  
20 and we could brief you on it. And the strategy is  
21 reflective of both -- you know, of all of the  
22 health sector. It is not -- you know, we are very  
23 cognizant of not pulling from one area to benefit  
24 another.

25 U/T           So I think my response, after

1 reflecting for a minute, would be to come back and  
2 do a bit of a deep dive, and then there may very  
3 well be some recommendations that the Commission  
4 might want to make in that regard.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Well, I think it would be helpful,  
7 especially in a situation where you think our  
8 recommendation may be helpful in giving some  
9 impetus to something that you think is important.  
10 That way, you know, we obviously would have to  
11 consider it, but we would be very open to hearing  
12 what you have to say. So you might think about  
13 that.

14 MELANIE FRASER: Yes, I appreciate  
15 that. Thank you.

16 And I think the other thing, a number  
17 of these tactics, as I have described them as, are  
18 new, and we really want to evaluate their  
19 effectiveness in doing what they are intended to do  
20 as well in terms of, for instance, the Return to  
21 Service Program, and the Return of Service Program,  
22 does that incentive, you know, stabilize a PSW in a  
23 particular home and help get them through, you  
24 know, the initial six months of working in a new  
25 environment and help to improve the prospects for

1 long-term employment there.

2 So I think there are a lot of these new  
3 initiatives that we also need to evaluate and  
4 understand, and should they work, there is  
5 certainly an opportunity to scale them up, and if  
6 not, there is certainly an opportunity to, I think,  
7 modify them as we move forward to ensure that they  
8 are delivering their intended benefit.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 What I would normally do, Ms. Fraser,  
11 is take a ten-minute break around now. If there is  
12 a point in your presentation that's convenient for  
13 me to do that, if you would let me know, then we'll  
14 take the break.

15 MELANIE FRASER: Certainly. I will  
16 cover two more bullets and then I might recommend  
17 we take a short break, and then Olha Dobush could  
18 pick up with the stabilization plan component of  
19 the deck.

20 COMMISSIONER JACK KITTS: Mel, just  
21 before you do, could I follow up on Commissioner  
22 Marrocco's questions.

23 MELANIE FRASER: Certainly.

24 COMMISSIONER JACK KITTS: To me, the  
25 biggest things that stand out as huge barriers for

1 us going into the second wave is physical capacity,  
2 beds, and health human resources capacity, people.

3 Has Michael Hillmer or anyone done the  
4 review to see what is the magnitude of the gap  
5 between sufficient PSWs and where we are now, and  
6 similarly with how many beds we need and where we  
7 are now, so that we can get some -- get our arms  
8 around what the magnitude of that challenge is?

9 MELANIE FRASER: Certainly, we do  
10 review the data regularly and with the help of the  
11 modelling team that supports Ontario.

12 We look at the capacity that is  
13 required relative to their modelling and then we  
14 benchmark the capacity we have against that, as  
15 well as our current occupancy rates, and look at  
16 where we need to be in our plan in terms of  
17 activating high, medium, low scenarios.

18 In terms of the health care, health  
19 human resource support to augment that capacity, I  
20 think we noted that earlier in the summer, when we  
21 were doing our planning, we felt like we were  
22 potentially 6,000 PSWs short of what would be  
23 required across both long-term care and home and  
24 community care.

25 I think the shortages in nursing are

1 less sort of -- what is the word I'm looking for --  
2 regular across the province but are more particular  
3 to certain types of nurses, surgical nurses, and  
4 particular areas.

5 So some of our strategies to address  
6 nursing you can see there. We are looking at 800  
7 more nurses being required in targeted areas of  
8 need, so we do have the data, and certainly we  
9 could come back and give you a deeper dive on that.

10 And it is something that, as I said, we  
11 are updating regularly. As, you know, the curve  
12 and the model adjust the line on what we think we  
13 need, we have to also then adjust our response to  
14 move up towards that line.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 You are on mute, Jack.

17 COMMISSIONER JACK KITTS: Sorry. Would  
18 the capacity of beds be literally the number of  
19 ALCs in hospital?

20 MELANIE FRASER: So when we are looking  
21 at capacity, we are tracking the acute care  
22 occupancy rate. We are looking at ALC and why they  
23 are ALC, which ones are on hold to go to LTC.

24 We have kind of taken a very specific,  
25 looking at regional -- looking at these things

1 regionally so we can understand what long-term care  
2 occupancy is available, what complex continuing  
3 care beds are available, what the acute care  
4 capacity is, what the hallway health care rates  
5 are, what the ALC rates are, and what they are  
6 waiting for.

7 We also look at the home and community  
8 care referrals and see whether they are up to 100  
9 percent and whether there is any opportunity to  
10 mitigate by managing more individuals in the  
11 community with intensive supports.

12 So it is a combination of all of those  
13 things relative to the demand that we are seeing.

14 COMMISSIONER JACK KITTS: Okay. Thank  
15 you.

16 MELANIE FRASER: And so maybe just to  
17 wrap up this slide, I would say, you know, one of  
18 the final points here is -- and this is probably a  
19 good segue into Olha's presentation, is in addition  
20 to looking at all of these health human resource  
21 requirements to support the plan, the engagement of  
22 patients' families and caregivers is really an  
23 important part of the fall plan, and a recognition  
24 that excellence in care requires their engagement.

25 And I think particularly in long-term



1 care, where we saw, unfortunately, a significant  
2 amount of isolation because of the number of  
3 outbreaks during wave one.

4 So with that, I will pause and turn it  
5 back over to you, Commissioners.

6 Thank you.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 All right. Well, then we will take ten  
9 minutes.

10 -- RECESSED AT 10:19 A.M.

11 -- RESUMED AT 10:30 A.M.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 We are ready when you are.

14 MELANIE FRASER: Commissioner Kitts, it  
15 is Mel again.

16 Just before we turn it over to Olha, I  
17 just wanted to clarify some of my comments about  
18 the acute care capacity in the beds.

19 So in terms of the fall preparedness  
20 plan, you may recall that during wave one we added  
21 a significant amount of capacity into the hospital  
22 system in preparation for that worst case scenario  
23 that at the time the modelers were predicting the  
24 Italy scenario, and fortunately we never reached  
25 that capacity level.

1                   So we have maintained all of that  
2 capacity, and the capacity that we have included  
3 here in terms of the fall plan is really intended  
4 to not only be able to have that capacity available  
5 in the acute care sector to manage the second wave,  
6 but also to maintain the ability to continue to  
7 perform the surgeries and reduce the backlog.

8                   So I just wanted to make that point of  
9 clarification, that this is incremental in addition  
10 to capacity that has been maintained before,  
11 including all the alternate health facilities and  
12 things that were stood up quite quickly in wave  
13 one.

14                   COMMISSIONER JACK KITTS: Thank you,  
15 Mel, that is appreciated.

16                   MELANIE FRASER: Okay, Olha, I will  
17 pass it off to you then.

18                   OLHA DOBUSH: Thank you very much, Mel.  
19 And good morning, everybody, again.

20                   So if we go to the next slide, in terms  
21 of the context, Commissioners, you will be very  
22 well aware that the COVID-19 pandemic has created  
23 unprecedented challenges in the health system, and  
24 in particular in the long-term care system.

25                   And the efforts to respond and to

1 manage the outbreaks in long-term care homes  
2 required a collaboration and mobilization across a  
3 number of partners, including various Ministries,  
4 such as Ministry of Long-Term Care, Ministry of  
5 Health and others, and health care sector partners  
6 to support the response and management on the  
7 ground.

8           These efforts have been generating the  
9 positive results and progress that we have seen  
10 over the summer months, and building on these  
11 learnings, it was important for the Ministry to  
12 make sure that we sustained the gains achieved and  
13 build the capacity in the sector to effectively  
14 prevent and respond to the outbreaks.

15           And with that in mind, with this  
16 objective, the Ministry, in partnership with the  
17 Ministry of Health, has undertaken the fall  
18 preparedness planning or what we also call  
19 stabilization planning for the long-term sector.

20           The actions coming out or the actions  
21 that formed that stabilization and preparedness  
22 plan were announced last week as part of the  
23 COVID-19 long-term care preparedness plan, and what  
24 I would like to add is that these actions very much  
25 build on lessons learned from the emergency

1 pandemic response in wave one. And certainly as  
2 the long-term care sector is part of the broader  
3 health system, it is positioned within the broader  
4 health system fall preparedness plan that my  
5 colleagues have walked through earlier this  
6 morning, as well as it aligns with longer term  
7 transformation and modernization agenda.

8           If we go to the next slide, it provides  
9 the visual that the different streams of work that  
10 are currently being undertaken with respect of the  
11 long-term care sector.

12           And it is fair to say that some of the  
13 long-standing systemic issues facing the long-term  
14 care sector have been amplified and brought sharply  
15 into focus by COVID-19.

16           And I'll speak a little bit more about  
17 some of these systemic issues. However, the work  
18 in the Ministry is very much cognizant of those  
19 systemic issues, and hence the modernization agenda  
20 is looking at building and addressing some of these  
21 issues and long-standing matters longer term.

22           Emergency response, unfortunately the  
23 outbreaks have been happening, and they continue to  
24 happen, so it is important to recognize that as we  
25 are looking to prepare for the fall and stabilize

1 the system, we are also managing the outbreaks in  
2 the sector and working very closely with the homes  
3 as well as with partners at the local and community  
4 level to make sure that that response is quick and  
5 effective.

6 These different streams of work, they  
7 are very much aligned, although they do achieve and  
8 focus on different objectives.

9 If we go to the next slide, please.

10 So the overall approach to developing  
11 the fall preparedness and stabilization plan for  
12 the long-term care sector looked very much to learn  
13 from what has happened on the ground during the  
14 wave one, as well as how can we learn and sustain  
15 what worked well, what are the gaps that need to be  
16 addressed in this immediate short term to make sure  
17 that the sector has the capacity and is better  
18 prepared for the future waves.

19 In terms of the approach that we have  
20 taken, we have looked at any evidence that has been  
21 emerging through the response to wave one, as well  
22 as any studies and inquiries and reports that have  
23 come out that would provide the recommendations or  
24 provide some of these insights and these additional  
25 learnings.

1                   We have also undertaken targeted  
2 engagement sessions, so similarly to my colleagues  
3 from the Ministry of Health, the Ministry of  
4 Long-Term Care has also engaged with the sector,  
5 with experts, with partners such as hospitals and  
6 Ontario Health regions to understand what immediate  
7 solutions and interventions are needed to stabilize  
8 the sector, as well as to ensure better  
9 preparedness and what is feasible in a short period  
10 of time.

11                   So as this slide positions, that some  
12 of the systemic challenges that, you know, very  
13 much have been here pre-pandemic, and we are aware  
14 of the high occupancy rates, the staffing  
15 shortages, and we talked a little bit about that  
16 earlier, aging infrastructure, as well as  
17 increasing complexity of resident care.

18                   So these systemic challenges have been  
19 amplified by COVID and the response to COVID during  
20 the first wave.

21                   Some of the additional things that we  
22 have seen and learned through this response is  
23 acknowledging the relationship between the  
24 community infection rate and home outbreaks.  
25 Infection in staff and visitors preceded residents'

1 infection, and as the Commissioners will see later  
2 in my presentation, some of the interventions about  
3 the surveillance and testing very much would  
4 respond to this learning.

5 The structural characteristics,  
6 particularly for the older c-d type homes with more  
7 than two beds in a room, challenged outbreak  
8 prevention and containment.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Can you just help me with this. How  
11 does -- what affects the high occupancy? How do  
12 you address the high occupancy rate? There is not  
13 a lot of time. You have to have temporary  
14 facilities, I guess. Is that how you do it? Or  
15 how do you do it?

16 OLHA DOBUSH: Thank you very much,  
17 Justice Marrocco, for your question.

18 So in terms of the immediate response,  
19 so further to the advice and guidance from the  
20 Chief Medical Officer of Health and the directive  
21 of the Chief Medical Officer of Health -- it is  
22 directive number 3. So as the immediate response,  
23 the admissions and re-admissions to rooms with more  
24 than two occupants have been restricted.

25 So, for example, if there is either a

1 new resident being admitted into the home or  
2 somebody returning from the hospital, so they would  
3 not be placed in the room that has more than one  
4 additional resident.

5 So some of these immediate measures  
6 have contributed to that additional physical  
7 isolation of residents, to help with prevention.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 But that, you know, exaggerates or  
10 makes it worse, right, in terms of occupancy rates.  
11 What can be done about that in the short term,  
12 because that is what we are in. You know, in the  
13 long term there is many things that, I guess, you  
14 can do, but what do you do in the short term?

15 One of the other things that is  
16 involved with this that we heard is that there are  
17 approximately 5,000 people -- 5,000 beds in  
18 hospitals with people in them that should be, in a  
19 perfect world, in a long-term care facility, which  
20 of course, you know, overcrowds the hospital on the  
21 one hand. I mean, it is obvious, it overcrowds the  
22 hospital.

23 So, I mean, the shortage exists, and I  
24 take it continues to exist, and there is nothing  
25 that can really be done about it or that has been



1 done about it.

2 MELANIE FRASER: Olha, perhaps I'll  
3 jump in to help you with this one.

4 So thank you for the question,  
5 Commissioner, and I think this was to my earlier  
6 point about the incremental capacity that was built  
7 and is being built in other parts of the health  
8 system because it is about patient flow.

9 So with reduced occupancy and reduced  
10 capacity available in the long-term care sector,  
11 part of our plan did include the creation of more  
12 what we call AHFs or alternate health facilities,  
13 so more space in the acute care sector to manage  
14 those complex patients that are intended to go to  
15 long-term care where there isn't currently  
16 capacity.

17 We have also done things like leased  
18 retirement homes and staffed them with the hospital  
19 to create additional capacity to manage, again,  
20 those complex patients in a safe setting while  
21 recognizing that there is depreciated capacity in  
22 the long-term care homes.

23 And then finally, I would say the high  
24 intensity home care bundles which are really about  
25 creating a significantly higher level of staffing

1 on a daily basis to care for residents in their  
2 homes with, you know, an integrated suite of health  
3 care professionals around them to provide them  
4 almost long-term care like support but in their  
5 home settings.

6 So as we looked at the fall plan, and  
7 we looked at those challenges up front, we  
8 recognized that other parts of the system would  
9 have to create the capacity while the long-term  
10 care homes stabilized and were able to, on a medium  
11 or longer-term basis, create the additional  
12 capacity to manage the volumes of individuals  
13 requiring long-term care.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Is the idea to make sure that the  
16 people who are moved into the facilities you have  
17 created or you were explaining to me, to make sure  
18 that those are the people that are in the hospitals  
19 that get in there?

20 Because I guess if you can move  
21 somebody from a hospital who doesn't belong in the  
22 hospital to a long-term care facility, you create  
23 the space in the hospital that wasn't there before,  
24 and it is less expensive care in the -- not less  
25 care, but less expensive care because it is not a

1 hospital.

2 Is there a plan to make sure that those  
3 are the people that fill the additional beds that  
4 you are creating?

5 MELANIE FRASER: So I will answer first  
6 by saying I'm not a clinician.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Okay. All right.

9 MELANIE FRASER: And I see Commissioner  
10 Kitts smiling.

11 Certainly the hospital capacity that is  
12 created is created for different intents and  
13 purposes. So, you know, we have stood up acute  
14 care capacity. There is capacity that is probably  
15 more akin to an ALC-type patient. Those are those  
16 patients that require an alternate level of care  
17 than traditional acute care.

18 And the hospitals are actually running  
19 and managing this added capacity, so they will  
20 stand up the capacity in an alternate health care  
21 facility and staff it appropriate to the level of  
22 care that is required.

23 But I think you are quite correct to  
24 say that a lot of those additional beds that are  
25 being stood up are designed to provide care for

1 that level of acuity of patient that would  
2 otherwise be in a long-term care home.

3 And then that does help to free up  
4 acute care capacity and medicine beds in the  
5 hospitals that is more needed for a different level  
6 of acuity patient.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 So do I understand you correctly that  
9 the Ministry is relying on the hospitals to  
10 manage -- in this emergency period is relying on  
11 the hospitals to manage the flow of people from the  
12 hospitals to the long-term care facilities, or did  
13 I misunderstand?

14 MELANIE FRASER: So it would be both.

15 So we have individuals, residents, who  
16 come from the community who are destined to go to  
17 long-term care, and we have individuals who go to  
18 hospital and are destined for long-term care.

19 So in both cases we have built capacity  
20 to be able to serve those patients either in the  
21 hospital or in the community until capacity can be  
22 made available within the long-term care home, and  
23 there is patient and resident preference in this.  
24 But certainly if there was an ALC patient destined  
25 for long-term care in a hospital, the hospital

1 would find the most appropriate bed for them within  
2 their care setting, based on clinicians' advice and  
3 also conversations with the family.

4 And there is a wait list that exists  
5 for long-term care. Patients and residents have  
6 choices in where they want to go, and that system  
7 is being maintained.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 So who decides? I am just having a  
10 little trouble with understanding who the  
11 decision-maker is. We have a bed. We have a  
12 person in a hospital who doesn't need to be there,  
13 and we have a person in the community who needs it.

14 Who decides who goes? Like is there a  
15 decision-maker?

16 MELANIE FRASER: Into the long-term  
17 care bed or into the --

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Yes, if you create an additional bed,  
20 and you have two people, two possible candidates  
21 for the bed, one in the hospital and one in the  
22 community, who decides who goes?

23 MELANIE FRASER: So if you are speaking  
24 to the long-term care bed, I'll leave it to Olha to  
25 respond to that question.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 All right.

3 MELANIE FRASER: But with respect to  
4 that hospital bed, if it is being managed and run  
5 by the hospital, it would be the hospital that  
6 would determine the placement of the patient within  
7 a bed that is under their management.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 No, but that is a bed in the hospital,  
10 right, or --

11 MELANIE FRASER: Or a retirement home  
12 that they are running, yes.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Yes. So is there a plan to let the  
15 hospitals run the retirement homes until this  
16 emergency period is -- until we are through with  
17 this pandemic?

18 MELANIE FRASER: So I'll just give you  
19 a really crystal clear example, just so that it is  
20 clear.

21 So we'll take hospital A as part of our  
22 capacity plan. We understood that hospital A may  
23 start to see pressures because of an inability to  
24 admit patients to long-term care because of the  
25 outbreaks and the capacity issues there.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2                   Right.

3                   MELANIE FRASER: So we have funded that  
4 hospital to go and lease a retirement home or  
5 several floors in a retirement home. Effectively  
6 they run it as an arm or a ward of their hospital,  
7 and so they will make decisions about which of  
8 their patients are most suitable for those beds  
9 based on their acuity and other clinical decisions,  
10 at which point that patient actually enters a  
11 long-term care home. There is another process for  
12 that. So as a bed becomes available in a long-term  
13 care home, Olha can describe to you the process by  
14 which they would take somebody from either the  
15 community or from that bed being run by the  
16 hospital.

17                   COMMISSIONER FRANK MARROCCO (CHAIR):  
18                   So let me understand this just so far.  
19 If you have a long-term care facility that you have  
20 asked the hospital to administer, then the hospital  
21 can move patients out of the hospital into the  
22 long-term care bed? No? Yes or no?

23                   MELANIE FRASER: No, I don't think that  
24 is how it works. What I am speaking about is  
25 alternate health facilities that hospitals have

1 stood up to manage their alternative level of care  
2 capacity and that are planned to support those  
3 patients while they are waiting for a discharge and  
4 a referral to a long-term care centre.

5 We do have long-term care homes that  
6 are being supported and managed by hospitals, but  
7 there is a process for long-term care admissions,  
8 and maybe if Olha explains that, then it will make  
9 it a little clearer about how people access first  
10 available beds in long-term care facilities.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Thank you.

13 OLHA DOBUSH: Thank you very much, Mel,  
14 and thank you very much, Commissioner.

15 What I would add here, I think to your  
16 question, is in terms of coordination of this  
17 process, and to my understanding -- although I am  
18 not a direct lead on this file, but to my  
19 understanding and observation that Ontario Health  
20 Regions are playing a key role in working closely  
21 with the hospital as well as with the long-term  
22 care home and, as Mel has rightfully pointed out,  
23 looking also in terms of the wishes and the  
24 preferences of the resident and the family members,  
25 and they are coordinating the process together with



1 all the partners at that community local level.

2 So I would add further to that, the  
3 role is also with the Ontario Health Regions.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 It just seems like there is so many  
6 people engaged in the decision-making here that it  
7 is hard to pin it on somebody so that you can find  
8 out who -- let me come at it another way.

9 How many additional spaces have been  
10 created since March? And you may not be the right  
11 person to ask, and if you are not, then just say  
12 so. I don't expect you to be an authority on  
13 everything that it occurs to me to ask you.

14 But is there a number? Like how many  
15 beds, additional beds, have been created? Do you  
16 know?

17 U/T MELANIE FRASER: Yes, so I am the  
18 person, and I should know the number offhand, but I  
19 can certainly get you the number of additional beds  
20 that have been created and are in the process of  
21 being created. It is, you know, more beds come  
22 online each day.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 But basically what you are telling me  
25 is, as you create an additional bed, the

1 traditional process for assigning a person to that  
2 bed is continuing?

3 MELANIE FRASER: Yes. So my  
4 understanding -- and again, I am not the expert on  
5 this, but this is traditionally coordinated by the  
6 LHINs in terms of the wait list for long-term care.  
7 There is a number of criteria that go into the wait  
8 lists. People can be designated in crisis and that  
9 tends to put them at the top of the wait list, but  
10 that is the role of Ontario Health and the Regions  
11 and the LHINs that are nested underneath them that  
12 make those decisions.

13 So the creation of the added capacity  
14 in the hospital isn't directly related to that  
15 process. It is in response to our recognition that  
16 there is a reduced level of capacity in the system  
17 writ large, particularly in long-term care, and  
18 wanting to ensure that we have appropriate care and  
19 facilities available for those that need that  
20 higher level of care outside of the community.

21 And I think Commissioner Kitts has lots  
22 to say.

23 COMMISSIONER JACK KITTS: That is  
24 exactly it. I think what we are talking about is  
25 two different scenarios.

1                   So under normal circumstances, without  
2 a COVID pandemic, hospitals say that the patient is  
3 no longer needed to be in a hospital, and it is the  
4 LHINs, the Community Care Access Centre group, who  
5 come in and decide where that patient can go, and  
6 they arrange for that to happen, and they have got  
7 to be aware of a lot of competing concerns; you  
8 know, people in the community that need the bed,  
9 other hospitals, other areas.

10                   So that process works, and it is really  
11 a care supporter who decides when and where that  
12 patient will go.

13                   Because we are full capacity in both  
14 long-term care and hospitals, Ontario Health said,  
15 if you can find alternative -- what did you call  
16 them, Mel, alternative health facilities, we will  
17 support you moving patients into them, but because  
18 they are not into long-term care homes, they are  
19 into empty buildings, like old retirement homes or  
20 things like that, then the hospital has to provide  
21 the staff to look after them. It is less skilled  
22 staff and less staff, but still the hospital has to  
23 provide those.

24                   So the health human resources and the  
25 physical capacity are intricately entwined, because

1 if the hospital doesn't have the staff to look  
2 after them in the new space, it is not going to  
3 work either.

4 So it is really intertwined.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Anyway, I interrupted the flow, so go  
7 ahead.

8 OLHA DOBUSH: Thank you. Thank you  
9 very much.

10 In terms of the other learnings was the  
11 importance of the infection prevention and control  
12 and both preventing as well as rapidly containing  
13 the outbreak, and as well as with staff retention.  
14 This is something that we have heard quite overtly.

15 And also the importance of the risk  
16 assessment of homes, and just-in-time surveillance  
17 is imperative for early intervention and  
18 identification of those positive cases.

19 And as my colleagues, as well as  
20 actually Commissioner Kitts has already mentioned,  
21 that heavy reliance on the health system and other  
22 partnerships for additional staffing capacity,  
23 infection prevention and control and expertise and  
24 that emergency response was also one of the key  
25 learnings.

1                   And the need and the importance of  
2 reliable and clinical care and leadership quality  
3 in homes has also been identified as one of those  
4 key learnings.

5                   So if you go to the next slide, because  
6 very much in response to the learnings that I have  
7 just outlined and what you have heard from the  
8 sector, as well as other partners, the  
9 stabilization and the preparedness plan, a key  
10 focus was on prevention and bolstering the capacity  
11 of the sector to be able to do better in the future  
12 waves of pandemic while ensuring the health and  
13 safety and well-being of both residents and staff.

14                   And in direct response to these  
15 learnings that I have just mentioned, the key  
16 strategic priorities for the long-term care  
17 preparedness plan focussed on strengthening the  
18 workforce and particularly through the increasing  
19 supply of personal support workers as well as  
20 registered professionals, as well as reunited  
21 families, and including the recognized role of the  
22 caregivers and reliable levels of clinical care.

23                   The next priority was about enhancing  
24 infection prevention and control to ensure that  
25 homes and the residents and staff feel safer.

1           It also included the sustainable supply  
2 and training on the protective personal equipment  
3 use, as well as the IPAC, infection prevention and  
4 control practices, and a home's physical  
5 infrastructure and occupancy levels that would  
6 support these effective IPAC practices.

7           Other goals and priorities were to  
8 sustain the partnerships that have already been  
9 built through the first wave and making sure that  
10 we improve and enhance those partnerships at the  
11 community, regional and local level.

12           And that also includes the effective  
13 and financially sustainable prevention and  
14 containment in homes themselves, as well as the  
15 effective partnership and surveillance at the  
16 community and local level.

17           And the fourth one is the overall  
18 enhancement in the risk assessment of homes, as  
19 well as the ongoing surveillance, to be able to  
20 prevent and manage outbreaks as well as a testing  
21 strategy that ensures early identification of COVID  
22 cases.

23           The next number of slides go -- if you  
24 go to the next one, they go into the action plan,  
25 so how would we ensure that these objectives in

1 these priority areas and expected outcomes are  
2 delivered on. So the next number of slides, they  
3 talk about strengthening the work force, enhancing  
4 IPAC, partnerships, and surveillance and risk  
5 assessment.

6 They go into the next level of detail  
7 about the actions that are not just planned, but  
8 many of them have either been launched or are  
9 currently actively being rolled out with the sector  
10 and in the communities.

11 So Mel had already mentioned about  
12 strengthening the workforce and the work that the  
13 Ministry of Long-Term Care is doing in partnership  
14 with the Ministry of Health, and here we have  
15 included a number of very specific interventions  
16 with one particular goal of retaining and  
17 increasing the supply of PSWs and registered staff  
18 in the homes.

19 We are also recognizing that to ensure  
20 that there is the capacity or ability for that  
21 surge capacity to exist, some of the additional  
22 immediate interventions and actions have been  
23 taken.

24 For example, such as the temporary wage  
25 increase that has been announced recently. We

1 already mentioned about the continued work and  
2 access to the Health Workforce Matching Portal, as  
3 well as extending the staffing flexibility in  
4 long-term care through the Reopening Ontario Act,  
5 so that flexibility that allows homes -- or allowed  
6 a home in the first wave to hire personal aide  
7 workers as well as the flexibility to assign staff  
8 where there is most need has continued.

9           One of the significant actions and  
10 priorities for the strengthening of the workforce  
11 is the recognition of the role of the caregivers,  
12 and over the course of the summer and even as  
13 recent as yesterday and I learned last week, the  
14 government has been revising the visitors policy to  
15 ensure that visitors are allowed in homes to see  
16 their loved ones, as well as recognizing the role  
17 of the essential visitor and essential caregiver.

18           And the most recent change that was  
19 announced is going to be effective -- was announced  
20 last week and is going to be effective on October  
21 7th is going to also provide that the resident can  
22 identify up to two members as caregivers.

23           Another area that we have strengthened  
24 in terms of the visiting policy is also making sure  
25 that we provide the access and connect to the



1 dedicated training for caregivers on IPAC and PPE.

2 So these are the number of actions  
3 that, you know, are very much in response to  
4 bolstering that capacity in the area of HR and  
5 staffing in the sector, with the recognition that  
6 LTC is very much part of the broader health system.

7 If we go to the --

8 COMMISSIONER JACK KITTS: Olha, can I  
9 ask a question? It is Dr. Kitts.

10 OLHA DOBUSH: Yes.

11 COMMISSIONER JACK KITTS: Back to the  
12 HHR slide.

13 OLHA DOBUSH: Uhm-hmm.

14 COMMISSIONER JACK KITTS: Has somebody  
15 done the math and determined how many workers are  
16 going to be created in what length of time?

17 OLHA DOBUSH: Yes, some of these -- the  
18 question is yes and, you know, perhaps, as Mel had  
19 identified earlier about, you know, looking or  
20 bringing back a more comprehensive health HR  
21 strategy, we can, you know, sort of look at  
22 additional information here.

23 What we have identified, so some of  
24 these specific interventions -- so, for example,  
25 the PSW Return of Service Program is estimated to

1 add additional thousand new PSWs.

2 The Fast Track Program is looking to  
3 train an additional 220 students.

4 The PSW Supportive Care Program is  
5 looking to train an additional 160 new supportive  
6 care workers, as well as the nursing. So on the  
7 registered staff, the Nursing Care Graduate  
8 Guarantee is providing the incentives and  
9 investment for 600 nurses.

10 And then the Attending Nurse  
11 Practitioner is looking to add an additional 15 new  
12 Nurse Practitioners.

13 So some of these initiatives have been  
14 estimated to add that additional capacity and  
15 supply.

16 COMMISSIONER JACK KITTS: Okay. This  
17 would be then a best-case scenario, if it worked  
18 out. And do you know the timelines for these? Is  
19 this going to happen in the next few weeks, months,  
20 whatever?

21 OLHA DOBUSH: Thank you very much,  
22 Commissioner, for your question.

23 The majority of these initiatives have  
24 already been launched and actually they have been  
25 rolling out since September.

1 I believe there was one or two here  
2 that are imminently set to be launched from the  
3 implementation perspective in terms of the funding  
4 and the agreements, so the team is just putting  
5 final touches.

6 But majority of them have been launched  
7 already.

8 COMMISSIONER JACK KITTS: Thank you.

9 MELANIE FRASER: Maybe I can just add  
10 to that, Olha.

11 We do have specific targets and a  
12 calendarization for when we anticipate each of  
13 these various initiatives to add incremental staff,  
14 and they range from, I would say, November through  
15 to January.

16 We also have the health human resources  
17 portal as one of the intervening tools, and we are  
18 also looking at other opportunities to build an  
19 additional pool of staff to support both long-term  
20 care and home and community care and others in the  
21 intervening period.

22 But certainly we can bring back --  
23 these are metrics that we monitor and track almost  
24 daily.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Commissioner Coke? You are on mute.

2 COMMISSIONER ANGELA COKE: Sorry.

3 Previously, you had mentioned that they  
4 were 6,000 PSWs short. Was that short in long-term  
5 care or short in the broader system?

6 MELANIE FRASER: So that estimate was  
7 developed towards the end of wave one, and the  
8 6,000 was an estimate related specifically to  
9 long-term care and home and community care, and it  
10 is estimated to be split almost 50/50 between the  
11 two.

12 However, as we see, you know, more  
13 people in the community and less in long-term care  
14 and vice versa, you know, those numbers, that  
15 ratio, can move a little bit.

16 COMMISSIONER ANGELA COKE: Okay. But  
17 the numbers we see here is to cut into the --  
18 whether it is 3,000 or whatever?

19 MELANIE FRASER: (Nodding).

20 COMMISSIONER ANGELA COKE: Okay.

21 OLHA DOBUSH: If you go to the next  
22 slide, another priority where we have learned a lot  
23 and are putting a very targeted effort is in  
24 strengthening the infection prevention and control  
25 efforts, and the programs and investments here are

1 actually multi-pronged.

2           Some of them, as Alison has earlier  
3 mentioned, is in partnership with the Ministry of  
4 Health that is leading the development of the hubs  
5 and spoke model where those hubs of expertise in  
6 the community would be available for access by  
7 congregate settings was the primary -- of course,  
8 priority and focus on the long-term care sector.

9           We are also introducing -- we are  
10 realizing and introducing additional measures  
11 specifically for homes themselves; for example,  
12 additional investment in IPAC staffing, 20 million  
13 will be dedicated to new and additional personnel,  
14 100 percent dedicated to IPAC in long-term care  
15 homes, and 10 million for training of existing and  
16 new personnel specifically dedicated to IPAC.

17           We have also heard that some homes,  
18 particularly those with the older design and older  
19 infrastructure, may have some of the physical  
20 characteristics that are actually preventing and  
21 prohibiting effective IPAC practices in those  
22 homes, and with that in mind, the government is  
23 investing over 60 million for minor capital repairs  
24 and renovations that would enable a home to  
25 practice proper IPAC procedures and protocols.

1           The government is providing access up  
2 to an 8-week supply of personal protective  
3 equipment to all long-term care homes, as well as  
4 we have launched, in partnership with the Ministry  
5 of Health and Public Health Ontario, dedicated and  
6 role-tailored IPAC training and that training has  
7 already been available to the sector since  
8 September.

9           We talked a little bit about the  
10 occupancy levels, and so additional investments to  
11 make sure that homes continue their sustainability  
12 operationally, particularly with these additional  
13 restrictions on admissions and re-admissions, so  
14 the investment has been earmarked of 40 million to  
15 support homes with these reduced occupancy levels.

16           I would like to mention a little bit  
17 about the extending prevention and containment  
18 fund, because one of the key eligible expenses  
19 under this fund is to support with the emergency  
20 staffing, so realizing, you know, a lot of  
21 discussion has happened to date and during our  
22 planning work about the importance of building that  
23 supply of staffing.

24           We do realize and appreciate that in  
25 some of these instances, in some of these programs,

1 it will take a little bit of time to make sure that  
2 that supply as estimated is available.

3 So through the extension of the  
4 prevention and containment fund where one of the  
5 eligible expenses is emergency staffing, we are  
6 ensuring that homes can rely on that additional  
7 funding for any surge capacity as they would  
8 require.

9 So the funding is 405 million until the  
10 end of the fiscal year, which translates to about  
11 45 million a year.

12 If we go to the additional slides,  
13 appreciating the time, perhaps maybe I'll just  
14 touch a little bit on the improving the  
15 partnerships, and then the surveillance.

16 So from the partnerships perspective,  
17 there has been, as I mentioned, heavy reliance on  
18 the hospitals as well as other community partners  
19 in supporting homes to respond to this pandemic,  
20 and what we have -- over the course of the summer,  
21 the Ministry has asked long-term care homes in  
22 collaboration with Ontario Health Regions and other  
23 partners in the community to complete assessment  
24 exercises to identify the gaps and inform their own  
25 preparedness actions, realizing and appreciating

1 that response to the emergency is needed at  
2 multiple levels, provincially, locally, as well as  
3 at the home level. And hence these preparedness  
4 assessment and planning exercises allowed the homes  
5 to look at their own level of preparedness and  
6 identify gaps, as well as plan for any mitigating  
7 plans.

8 It also has informed the provincial  
9 actions. Through some of these assessments, what  
10 we have seen is that the results informed regional  
11 and provincial actions to address gaps and to help  
12 facilitate planning and preparedness at the home,  
13 regional, and provincial level.

14 We have also heard that it did  
15 strengthen and further helped solidify those  
16 partnerships with Ontario Health Regions, Public  
17 Health Units, hospitals and other community  
18 organizations at that local and community level.

19 Homes have also been encouraged to join  
20 and be active partners in these local and regional  
21 planning tables and take an active role.

22 We talked a little bit about the  
23 innovative approaches to looking at how we can  
24 support and provide some of the innovative and  
25 alternative approaches to allowing people to stay



1 in their homes if they wished to longer, and one of  
2 the new programs that will be rolling out is  
3 investing in the Community Paramedicine Program  
4 through the skills of community paramedics and  
5 working with municipal partners.

6 And of course, you know, for those  
7 homes that are most at risk and have difficulty and  
8 require critical and immediate attention in terms  
9 of -- to help with their response and contain the  
10 outbreak, continuing to facilitate temporary  
11 management partnership between Ontario hospitals  
12 and long-term care homes to help the homes manage  
13 resident care in response to COVID.

14 And so far, since May, the Ministry,  
15 together with other partners, have facilitated  
16 about 13 of these either Voluntary Management  
17 Contracts or Mandatory Management Orders.

18 The next slide talks about the --  
19 sorry?

20 COMMISSIONER JACK KITTS: Can I just  
21 ask about the facilitate temporary management  
22 partnerships. So that -- what you are referring to  
23 are the 13 hospitals that required either a  
24 Mandatory or Voluntary Management Order, and I  
25 understand that the hospital and the long-term care

1 partnership helped to reduce the spread in the  
2 homes.

3           Instead of a reactive reaction in  
4 facilitating the partnerships between hospitals and  
5 long-term care, have you considered a proactive  
6 approach, particularly with hospitals and long-term  
7 care homes that you -- I believe you know which  
8 ones are at higher risk for spread in the next wave  
9 than others. So has there been much discussion  
10 about that proactively?

11           OLHA DOBUSH: Thank you very much,  
12 Commissioner Kitts, for your question, and the  
13 answer to your earlier question is yes, those are  
14 referring to the Voluntary Management Contracts and  
15 Mandatory Management Orders.

16           Your second part of the question is a  
17 great segue into the next slide where we talk about  
18 the proactive risk assessment and surveillance, and  
19 in fact, as I mentioned earlier, we have learned  
20 quite a great deal as well as in terms of the data  
21 and the ability to see which homes have -- like  
22 what are some of the risk factors that may be used  
23 to forecast and to support homes proactively.

24           And with that, a surveillance system  
25 supported by sustained data collection to monitor

1 and detect outbreaks is currently in place, and we  
2 have also -- because over the past number of weeks  
3 we have seen a surge in the number of outbreaks and  
4 cases in the long-term care homes.

5 So what the Ministry has done is  
6 re-activated the incident management structure to  
7 do just that, to proactively monitor the homes that  
8 are in outbreak, as well as those that may  
9 potentially be at the higher risk.

10 And this has been done very much in  
11 partnership with not just the Ministry of Long-Term  
12 Care, the Ministry of Health, as well as Ontario  
13 Health, and Ontario Health Regions, Public Health,  
14 and the Chief Medical Officer of Health.

15 So a number of partners, very much both  
16 at the local, as well as at the Ministry level, are  
17 looking at the data, looking at the insight  
18 regularly to ensure that the action is taken both  
19 in a proactive way as well as urgently in the  
20 response.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Let me interrupt for a moment. This  
23 incident management structure or table, does it  
24 have the power to make an order about how the  
25 incident is to be managed?

1                   OLHA DOBUSH: Thank you very much,  
2 Commissioner, for your question.

3                   So the incident management structure is  
4 within the setting of the Ministry and the roles of  
5 the individual players or participants in it.

6                   So the actual structure itself does not  
7 have the order-making powers. However, the  
8 individuals that are part of this structure by  
9 virtue of their roles and responsibilities have  
10 authority to make decisions and to direct action  
11 and response.

12                   COMMISSIONER FRANK MARROCCO (CHAIR):

13                   So does the table ask them to make an  
14 order, or do they just sit there listening and  
15 hearing and then decide they should make an order?  
16 How does it work?

17                   OLHA DOBUSH: So, for example, to use,  
18 you know, a very specific -- well, one of the  
19 examples. So, for example, if there is a home that  
20 is at the higher risk or is considered at the  
21 higher risk, as part of the monitoring, some of the  
22 key data elements are collected; for example, is  
23 this about IPAC? Is there an issue with the PPE?  
24 Is there an issue with the staffing?

25                   Depending on the individual

1     circumstance of that particular home at risk, then  
2     the action or the response or the call to action  
3     would be orchestrated accordingly.

4             So, for example, if the home is in need  
5     of additional PPE, then a direction would come from  
6     the table to make sure that the people who have the  
7     ability and -- the authority and ability to  
8     expedite or address that are engaged and are doing  
9     so.

10            So similarly, if there is, for example,  
11     a lack of IPAC expertise, so through that  
12     partnership at the local level, through the Ontario  
13     Health Region, as well as the hospital that may be  
14     attached to a particular home or is considered a  
15     partner to a particular home, then the conversation  
16     happens whether that IPAC expertise could be  
17     dispatched and deployed to a home immediately to  
18     facilitate that additional response and action.

19            And that is reported back whether there  
20     is any additional escalation or directed action is  
21     required.

22                    COMMISSIONER FRANK MARROCCO (CHAIR):

23                    Okay. Thank you.

24                    OLHA DOBUSH: And last, but not least,  
25     the point on this one is a continuing testing

1 strategy for staff.

2 The expected outcomes here are very  
3 much what the Commissioner's questions were about  
4 the increased visibility into homes at risk as well  
5 as homes in outbreak, strong partnerships to enable  
6 that care and coordinated action to prevent and  
7 manage outbreaks at the provincial, but also more  
8 importantly at the local and community level, and  
9 then continuing to implement that surveillance and  
10 testing strategy for residents and staff.

11 I believe the next slides talk about  
12 the timeline. I wouldn't put too much time -- or  
13 spend too much time here, given that I already  
14 mentioned that we are very much in the midst of  
15 implementation, with the majority of these actions  
16 being already announced or actively underway or  
17 imminently to be rolled out.

18 I have also included -- because I have  
19 stressed quite a lot in terms of the partnerships  
20 and the importance of others to both inform the  
21 stabilization plan and then that stabilization and  
22 preparedness action.

23 As part of the appendix, I have  
24 included for your reference sort of the Governance  
25 and Partnerships Tables that the Ministry has

1 established at various levels to make sure that we  
2 hear the voice of the caregivers, that we do engage  
3 with partners, such as hospitals and Ontario  
4 Health, as well as Public Health.

5           So very much a comprehensive  
6 participation from everybody in the health system  
7 and broader to make sure that our plan and our  
8 efforts are well informed, and then there is an  
9 oversight and, you know, fire under the feet to  
10 make sure that these things are implemented  
11 prudently, and we are responsive to any new  
12 learnings as we are seeing every day.

13           Thank you very much.

14           COMMISSIONER JACK KITTS: Thank you.  
15 Could I just ask a question about the  
16 decision-making. In the left-hand side said, when  
17 you say "Minister", that is Minister of Long-Term  
18 Care?

19           OLHA DOBUSH: That's correct, or  
20 whoever Minister -- it is recognizing the  
21 ministerial authority for decision-making.

22           COMMISSIONER JACK KITTS: Does Ministry  
23 of Health have one like this too?

24           OLHA DOBUSH: In terms of the  
25 different -- I think Ministry of Health has a

1 number of other Partnership Tables, so this is --  
2 yes, the side with the provincial, regional and  
3 local level, that speaks primarily to the Long-Term  
4 Care Tables that are being led by the Ministry of  
5 Long-Term Care.

6 COMMISSIONER JACK KITTS: Yes. So this  
7 is a long-term care chart. Presumably Ministry of  
8 Health and Ontario Health would have their own  
9 charts as well? Is that how it is?

10 OLHA DOBUSH: I cannot speak for  
11 both --

12 ALISON BLAIR: Commissioner --

13 OLHA DOBUSH: Oh, go ahead.

14 ALISON BLAIR: Commissioner, as part of  
15 the discussion that we had -- now it feels like a  
16 long time ago when we had our first session, we had  
17 the governance discussion with the Health Command  
18 Table and the various tables.

19 In fact, all of these tables are also  
20 in that chart, and the material that we had  
21 provided to you about which committees roll up into  
22 which is included in that.

23 OLHA DOBUSH: Thank you, Alison.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Well, if there is anything further,



1 then I guess we would hear it. If not, thank you  
2 very much for the presentation, and thank you very  
3 much for offering to get back to us with some  
4 additional information which will also be very  
5 helpful to us.

6 And I was quite serious about the  
7 suggestions for recommendations that we might make.  
8 We would be happy to consider them, and we will if  
9 you make them.

10 So with that, thank you very much, and  
11 I guess you'll be hearing from us again.

12 Thank you.

13 OLHA DOBUSH: Thank you very much.

14 COMMISSIONER JACK KITTS: Bye.

15 COMMISSIONER ANGELA COKE: Thank you.

16 MELANIE FRASER: Thank you very much.

17 COMMISSIONER JACK KITTS: Thanks.

18

19

20 -- Adjourned at 11:27 a.m.

21

22

23

24

25

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 6th day of October, 2020.

17  
18 

19  
20  
21 \_\_\_\_\_  
22 NEESONS, A VERITEXT COMPANY

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

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