Long Term Care Covid-19 Commission Mtg.

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

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- 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.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

MINISTRY OF HEALTH AND MINISTRY OF LONG-TERM CARE:
Melanie Fraser, Associate Deputy Minister, Health Services
Olha Dobush, Lead, Long-Term Care Stabilization Project
Alison Blair, Assistant Deputy Minister of the Pandemic Response Division

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission

Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Judith Parker, Ministry of the Attorney General
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

ALSO PRESENT:
Eric Wagner, Counsel for Ontario
Roopa Mann, Counsel for Ontario
Amy Leamen, Counsel, Ministry of Health and Long-Term Care
Kinsey Bowen, Counsel, Minister of Health and Long-Term Care
Deana Santedicola, Stenographer/Transcriptionist

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

In any event, you know, I guess basically, Ms. Fraser, the approach we have been taking is that we are in the middle of something rather than coming in after there has been an event and looking back and trying to explain it, which is typically what Commissions do.

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

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

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

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

MELANIE FRASER: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): And so we are ready when you are.

MELANIE FRASER: Well, wonderful. Thank you, Justice Marrocco, and thank you, Commissioners.

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

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

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

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

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

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

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

early slides on the data and some of those pieces.

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

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

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

There was a great deal of focus on that

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

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

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

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

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

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

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

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

are most needed in wave two.

If we could move to the next slide.

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

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

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

We have also reinforced strong public

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

ALISON BLAIR: I think if we think

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

[Court Reporter intervenes for clarification.]

And then being able to surge to the

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

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

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

ALISON BLAIR: Thank you, Mel.

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

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

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

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

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

The situations that we have outlined in

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

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

Next slide, please.

So now we can get into the fall plan.

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

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

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

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

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

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

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

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

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

we need to address any surges.

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

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

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

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

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

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

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

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

To date, we have been able to --

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Blair, sorry for interrupting. We have heard some evidence about the length of time it takes to get the test back.

ALISON BLAIR: Turnaround times.

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

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

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

So I think it is really about making

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

The guidance on who should be tested

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

ALISON BLAIR: All right.

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

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

long-term care homes.

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

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

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

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

So including that in the fall plan is

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Coke? You are on mute.

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

ALISON BLAIR: Right. Thank you,

Commissioner Coke.

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

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

COMMISSIONER ANGELA COKE: Thank you.

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

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

COMMISSIONER ANGELA COKE: I understand it is complex.

ALISON BLAIR: Uhm-hmm.

A few more things to point out about this slide.

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

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

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

The exposure notification app was

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

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

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

feeling.

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

MELANIE FRASER: Thanks.

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

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

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

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

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

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

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

So that was a significant component of getting ready.

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

And I have covered the final point there.

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

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

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

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

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

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

But the province is prepared in that regard.

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

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

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

And I will push forward to the next slide.

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

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

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

mental health and addictions programs.

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

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

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

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

build upon those.

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

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

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

COMMISSIONER ANGELA COKE: Mel?

MELANIE FRASER: Yes, certainly.

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

MELANIE FRASER: That's right.

COMMISSIONER ANGELA COKE: Do the

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

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

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

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

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

proposals on who is in their team.

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

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

COMMISSIONER ANGELA COKE: Okay.

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

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

could learn more about them as a longer term solution?

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

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

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

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

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

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

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

And then the final slide.

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

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

U/T So I think Alison mentioned earlier we

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

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

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

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

We have bursary programs. There was

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

COMMISSIONER FRANK MARROCCO (CHAIR):

If I could just interrupt you for a minute.

MELANIE FRASER: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR):

When you were talking about implementing a health work force matching portal, I think you said there were tens of thousands of employees in there. But then there is a shortage of personal support workers.

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

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

So it does include a variety of

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): But notwithstanding the tens of thousands of people that are recorded in there, there is still a critical shortage of personal support workers?

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

U/T So I think my response, after

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think it would be helpful, especially in a situation where you think our recommendation may be helpful in giving some impetus to something that you think is important. That way, you know, we obviously would have to consider it, but we would be very open to hearing what you have to say. So you might think about that.

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

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

long-term employment there.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

MELANIE FRASER: Certainly.

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

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

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

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

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

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

I think the shortages in nursing are

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): You are on mute, Jack.

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

And I think particularly in long-term

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

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

Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

-- RECESSED AT 10:19 A.M.

-- RESUMED AT 10:30 A.M.

COMMISSIONER FRANK MARROCCO (CHAIR):

We are ready when you are.

MELANIE FRASER: Commissioner Kitts, it is Mel again.

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

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

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

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

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

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

OLHA DOBUSH: Thank you very much, Mel.

And good morning, everybody, again.

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

And the efforts to respond and to

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

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

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

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

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

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

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

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

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

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

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

If we go to the next slide, please.

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

So, for example, if there is either a

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

done about it.

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

hospital.

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

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

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

MELANIE FRASER: And I see Commissioner Kitts smiling.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

MELANIE FRASER: So it would be both.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

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

COMMISSIONER FRANK MARROCCO (CHAIR): No, but that is a bed in the hospital, right, or --

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes. So is there a plan to let the hospitals run the retirement homes until this emergency period is -- until we are through with this pandemic?

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

all the partners at that community local level.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

And I think Commissioner Kitts has lots to say.

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

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

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

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

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

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

So it is really intertwined.

COMMISSIONER FRANK MARROCCO (CHAIR): Anyway, I interrupted the flow, so go ahead.

OLHA DOBUSH: Thank you. Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

dedicated training for caregivers on IPAC and PPE.

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

If we go to the --

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

OLHA DOBUSH: Yes.

COMMISSIONER JACK KITTS: Back to the HHR slide.

OLHA DOBUSH: Uhm-hmm.

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

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

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

add additional thousand new PSWs.

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

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

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

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

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

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

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

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

But majority of them have been launched already.

COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Coke? You are on mute.

COMMISSIONER ANGELA COKE: Sorry.

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

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

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

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

MELANIE FRASER: (Nodding).

COMMISSIONER ANGELA COKE: Okay.

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

actually multi-pronged.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The next slide talks about the -- sorry?

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

partnership helped to reduce the spread in the homes.

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

Depending on the individual

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay. Thank you.

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

strategy for staff.

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

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

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

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

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

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

Thank you very much.

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

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

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

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

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

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

OLHA DOBUSH: I cannot speak for both --

ALISON BLAIR: Commissioner --

OLHA DOBUSH: Oh, go ahead.

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

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

OLHA DOBUSH: Thank you, Alison.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, if there is anything further,

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

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

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

Thank you.

OLHA DOBUSH: Thank you very much.

COMMISSIONER JACK KITTS: Bye.

COMMISSIONER ANGELA COKE: Thank you.

MELANIE FRASER: Thank you very much.

COMMISSIONER JACK KITTS: Thanks.

-- Adjourned at 11:27 a.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 6th day of October, 2020.

_____

NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

WORD INDEX