Long-Term Care COVID-19 Commission Mtg.

Presentation
on Wednesday, September 30, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 30th day of September, 2020, 2:00 p.m. to 4:00 p.m.

BEFORE:

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

PRESENTERS:

Matthew Anderson, President and CEO, Ontario Health;
Ashley Dent, Acting General Counsel, Ontario Health;
Jeffrey Simser, Legal Director, Agencies;
Catherine Brown, Interim Executive Lead, Health System Performance and Support, Ontario Health.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care

Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Sunil S. Mathai, Counsel, Crown Law Office Civil;
Roopa Mann, Counsel, Crown Law Office, Civil;
Tori O'Dwyer, Counsel, Legal Agencies Branch;
Janice Dhanjal, Manager, Governance and Strategy, Health Shared Services Ontario;
Louise Verity, Strategic Advisor-Office of the CEO, Ontario Health;
Miren Chauhan, Vice President Corporate Services at Health Shared Services, Ontario Health.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 2:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So I just want to thank you all for taking the time to meet with us.

This will be, I'm sure, very helpful in terms of what we have to do. It's a bit of an odd situation in this sense that normally an inquiry is called after something has happened, and the inquiry looks back and tries to figure out what happened so the public can be informed.

We've been called in the middle -- well, I'm not sure it's the middle, but we've been called in with something going on, and it kind of puts -- suspends -- it changes the rules in ways we can't completely appreciate.

Our present focus is to try to come up with some recommendations. Normally, as you can appreciate, you have an investigation, you have hearings, and then you have a report two and a half years after the inquiry was called.

We don't think that model works for us, so, you know, we're giving some serious thought to an interim report and recommendations first and then if -- look back at what happened second.

So you meeting with us, from our perspective, is very helpful and very timely. And with those introductions --

I should tell you we'll probably take a break at some point around 3 or 3:15. If you let me know when's convenient, that would be helpful.

And there's a transcript. There's a reporter here. And with that, I think I'll turn it over to Mr. Anderson.

MATTHEW ANDERSON: Wonderful.

COMMISSIONER FRANK MARROCCO (CHAIR): We're ready when you are.

MATTHEW ANDERSON: Well, thank you very much. Thank you to the Commission for inviting us all here for the discussion today. Meeting with the (indiscernible) Commission is vitally important.

The impact of COVID-19 on the residents and staff and families in the long-term care sector has been devastating, and we're keen to be here to support you and to provide our full cooperation and are pleased to provide this initial briefing.

I should state at the outset, just to disclose, that I have a personal, nonfinancial connection through extended family to Extendicare,

an operator of long-term care homes in Ontario. So should any questions arise that pertain explicitly to Extendicare, Catherine Brown will respond to those questions.

Joining me today are Catherine Brown. Catherine is our Executive Lead of our Health System Performance and Support Services at Ontario Health and has also served as our executive lead for Ontario Health in managing our COVID response.

Also with me today are Jeff Simser who is the Director of Health Agencies, Legal Branch; and Ashley Dent who is our Acting General Counsel at Ontario Health.

And Sunil, as well, who I believe you all already know.

COMMISSIONER FRANK MARROCCO (CHAIR): I should say, Mr. Anderson, before you go any further that that disclosure is more than sufficient for our purposes, and thank you for making it.

MATTHEW ANDERSON: Thank you. Our presentation consists of the following: We are going to start off with an overview of the legislative framework and accountabilities for Ontario Health and the LHINs.

As you will hear, we have multiple

corporations still within us as Ontario Health, and so we're going to walk you through that. A brief overview of Ontario Health organizational structure, and then we will focus in on Ontario Health pandemic response from our earlier involvement through to our more focussed COVID-19 work including our support of long-term care during Wave 1.

With that, I would just hand it over now to Ashley and to Jeff to take you through an overview of the Ontario Health and LHIN legislative framework and accountabilities.

ASHLEY DENT: Thank you, Matt. Good afternoon, Commissioners.

So if we can advance to the next slide, Janice.

What we're going to take you through is, for Ontario Health and the LHINs, an overview of our legislative frameworks, respectively; the government's mandate under which we operate; and then I and Jeff will take you through the legislative authorities under which we operate.

So next slide please, Janice.

So as you might be aware, Ontario Health was established in April of 2019 under the

Connecting Care Act. It is a Crown agency, and its predecessor organization you may have heard of is the Health Programs Initiative, and Section 3 of the Connecting Care Act allowed for the creation of Ontario Health to succeed that organization. And it's established as a Crown agency with a mandate to connect and coordinate Ontario's health system.

To date, as Matt said, there have been a transfer into Ontario Health of six agencies, and there is a table in the slide deck indicating what agencies transferred on December 2nd.

On December 2nd, we also had a transfer in of the non-home and community care executive functions of the 14 LHINs. And similarly, in December, five regional leads were appointed to assume the CEO leadership of those 14 LHINs, and those individuals report directly to Matt as the president and CEO of Ontario Health.

There's one agency that is yet to be transferred in, and that is the Trillium Gift of Life Network which we refer to as "TGLN."

Go to the next slide, Janice.

So as far as the governance is concerned -- so you can imagine that with the previous existence of 21 separate corporate board

and governance processes, we have actually consolidated those into one. And so what we have is the Ontario Health and the TGLN organizations that are governed by 13-member Board of Directors. And they're appointed by the Lieutenant Governor in Council, and they're accountable directly to the Minister of Health through the board share.

12 of those 13 board members are also cross-appointed again by the Lieutenant Governor in Council to each of the 14 LHINs and, again, are accountable to the Minister of Health.

So together, you have one consolidated board with accountability for the governance and oversight of Ontario Health, TGLN, and the 14 LHINs.

Supporting this governance framework is also the Minister's mandate letter, the memorandum of understanding between Ontario Health and the Minister of Health, as well as various directives such as the Agencies and Appointments Directive.

We can go to the next slide.

As I mentioned, Ontario Health is established under the Connecting Care Act, and it's actually Section 6 of this piece of legislation as well as regulation in support of the Connecting

Care Act that gives Ontario Health its legislative authority.

I'm not going to go through all of them, but I did want to highlight some that will be of relevance to the presentation that Matt and Catherine will take you through. And that has to do with efforts to actually coordinate the operational management and coordination of the health system as well as supporting and providing supply chain management services which you'll see with respect to the role that Ontario Health played in procuring and distributing PPE.

So that is the extent of the overview of the Ontario Health mandate governance and legislative authority. At this time, I'd like to turn it over to Jeff to provide his overview of the LHINs.

Jeff?

JEFFREY SIMSER: Great. Thank you, Ashley. So the Local Health System Integration Act, 2006 -- or we call it "LHSIA" sometimes -- is the legislative framework that governs those 14 LHINs or Local Health Integration Networks that Ashley referred to.

And they are separate corporate

entities, but they're integrated in a number of ways including, as Ashley pointed out, they're under the leadership now of five regional leads.

From inception, the role of the LHINs is to -- they have a responsibility for planning, funding, and integrating the health care system. And in 2017, the LHINs took on the home and community functions that were previously the responsibility of the Community Care Access Centres or CCACs.

Again, as Ashley's noted, 12 of the 13 members of each of the 14 LHIN corporations are cross-appointed. The reason it's 12, by the way, is that's a limit that's set in LHSIA. LHIN boards can only go up to 12 members.

And while each LHIN is a separate corporation, they all operate under coordinated governance framework with Ontario Health, and the LHIN boards, in turn, have then delegated certain functions to the president and CEO, Matt, who you'll hear from shortly.

And there hasn't yet been the formal transfer of some LHIN functions. But at a board level, the OH and the LHIN boards operate as if they're one. Each is largely in the same kind of

governance framework that Ashley's already described.

This next slide, the legislative authority slide, is really from Section 5 of LHSIA. But in the interest of time, I don't think I'm going to go through it in any detail at all. Although, obviously, if you have any questions, we're happy to answer them. And we'll move to the next slide.

Ontario Health and the LHINs both share a similar thing in that they're not responsible for the day-to-day monitoring of long-term care homes or for the regulatory system established under the Long-Term Care Homes Act, 2007.

But for the LHINs, there are three broad points of intersection that I think are of relevance and interest. The first is placement coordination. So the LHINs are the sole, designated placement coordinator under the Long-Term Care Homes Act.

And, practically, what that means is that LHIN employees, strictly called "care coordinators" or "replacement coordinators," are responsible for guiding people and their families, sometimes their caregivers, through the placement

application process. They manage the wait lists, and then they make admission offers to all long-term care homes.

The second area is in most long-term care homes, services are provided by the home itself, but the LHINs do have legislative authority to offer some professional therapy and some limited nursing services in a home.

The third and final role that I'm going to speak to is that LHINs provide funding to long-term care homes, and we do this through a service accountability agreement framework. It's authorized by LHSIA, and it's entered into between each LHIN and each home in each jurisdiction.

The funding for the home is largely prescribed by the Ministry of Long-Term Care, and unlike other health service providers that are covered by LHSIA, the LHINs actually don't have a number of key things that they can do statutorily. So they can't issue directives, they can't appoint investigators, and they can't appoint supervisors for long-term care homes.

So the last slide that I'm going to speak to just shows the geographic dispersement of the original 14 LHINs, and I think Matt will speak

to that a little bit in a couple of slides in terms of the five regions. And so with that, I'm going to turn it over to Matt.

COMMISSIONER FRANK MARROCCO (CHAIR): And, Mr. Anderson, before you do that --

JEFFREY SIMSER: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): -- are the mandate letters, publicly available?

U/T ASHLEY DENT: That's correct. We can also share them to you through our counsel Sunil, if that's minimal to you, Commissioner.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. That's fine. So you will give them to him, and he'll give them to us?

ASHLEY DENT: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. Unless he refuses to do that, then it won't be fine.

SUNIL MATHAI: I already got my instructions, Justice Marrocco, so I think I will be sharing them.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Anything we can do to help you, Mr. Mathai.

Carry on, please.

MATTHEW ANDERSON: Great. Thank you.

So I'm just going to take us through a little bit on Ontario Health leadership and organization, and then I'll hand it over to Catherine to talk a little bit about the early days of our time with respect to COVID.

You can go to the next slide for me, Janice. There you go.

So at Ontario Health, as you've already heard, we are an amalgam of the various agencies that have been before. We're bringing together 21 agencies into a single overall system, and you can see them all listed here. I don't think I need to go through that one too much.

If you can go to the next slide for me, please.

So just recently, in September, we moved forward with putting in place a new operating model. And just to back up a little bit, the agency, in case you missed the date -- so the agency, when the pandemic started was about one year old.

In fact, if you look at the date that Ashley put forward, the first true amalgamations occurred in December of 2019 with another agency coming on on April 1st of 2020. So we're a very

new agency from that respect.

And I joined Ontario Health in the first week of February. So just before the pandemic started. It was bad timing, I suppose. And so I joined at that time.

In the context of COVID-19, I have dual roles. I serve as Ontario Health's president and CEO. I also serve as one of the three co-chairs of the Command Table. And I believe it has already come before you, the Command Table, which was established on February the 28th by the Ministry of Health.

I served as the co-chair alongside Deputy Minister of Health Helen Angus and Chief Medical Officer of Health for Ontario Dr. David Williams. Given that you've already had a discussion on that, I wasn't going to focus on that right now in my presentation. Of course, I'm happy to talk about that in the context that there's any questions.

As we bring Ontario Health together into a single organization, what you see in front of you is the operating model that we have just approved in September. And there's a few highlights that I would pick on with respect to

that that might be helpful for you and for the Commission.

So just to orient you through the model, at the top of the page are the communities and the patients and the resident people we serve. On the second line, it's to say "here's the health providers that we work through," and I think this is --

The main thing that I wanted to get across to all of you with respect to this operating model is that Ontario Health -- we don't do -- with a few exceptions, we generally impact patient care, communities, and others through provider agencies. So we have a few exceptions where we provide direct care, but generally we work through another agency in order to provide care.

And lastly, on here, that I would just call out is that our regions are front door to our organization. And you've heard from Mr. Simser that the LHINs that have all rolled into these regions --

So the regions work most directly with the provider agencies, and the provider agencies then work with -- in the case of long-term care, they work with the long-term care residents. So

just wanted to highlight that to you as we go forward.

I think I'm going to stop there on the operating model and move you -- there's the interim and transitional regions. I think that that's a difference in background, and I'll hand it over to Catherine Brown to start us on the Ontario Health role with respect to COVID-19.

CATHERINE BROWN: Thank you, Matt. And good afternoon, Commissioners.

So early discussions with the Ministry of Health and health partners began with Ontario Health in mid-January 2020. As we learned more about the coronavirus and saw of its impacts in Wuhan, China, Ontario began to develop its own operational response to the risks that we were seeing.

Ontario Health and the Ontario Health regions and LHINs' areas have oversight of the management of Ontario's home care delivery system. Our initial focus was to ensure we were taking necessary steps to put in place screening protocols for patient care and care delivery of workers to keep both safe in that environment.

Ontario Health created travel screening

policies for guidance for our own workers and then shared those with our service delivery partners in home care to help guide their streaming of patients and workers alike.

Ontario Health, in collaboration with our regions in their LHIN home care operations also undertook PPE survey work and other preparedness planning that was instrumental in supporting the Ministry of Health in its broader health system readiness planning.

Ontario Health's screening algorithm was adopted by the Province and incorporated into their screening tool and direction for home care province-wide.

The Ministry Emergency Operation Centre, or MEOC, their guidance for home and community care providers was released on January 31st and borrowed heavily from the Ontario Health materials.

As a result of our early preparedness actions, on January 31st, Ontario Health was asked by the Ministry of Health to support the work they were undertaking on PPE stock surveys and preparedness.

Ontario Health distributed and

collected PPE survey information from a wide range of health-centered partners to provide directly to the Ministry of Health.

Ontario Health created a survey tool based on what we knew about PPE requirements at the time and distributed the survey through the health sector associations and directly to organizations to collect basic information on available PPE at the site level for all those organizations.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Brown, can I just stop you for a minute?

CATHERINE BROWN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): We tend to ask questions as we go along.

CATHERINE BROWN: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): So don't think me rude by interrupting. But did everybody respond to the surveys?

CATHERINE BROWN: That is a very good question. Given your focus is long-term care, we got good responses --

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

CATHERINE BROWN: -- from all sectors. We surveyed just, if I may, hospitals, home care

providers, long-term care homes, paramedics, community health, and family health teams at other primary care organizations. We got good response from most organizations.

For the long-term care organizations, we were asked to work through their member associations. There is a for-profit and a not-for-profit member association for the long-term care homes. The Ministry of Long-Term Care asked us to utilize those associations in the distribution and collection.

And I will say that there was not the level of response. I can get you those exact numbers, but there was not the level of response from those partners as we saw from other sectors.

And we think that that had a couple of things. If I could speculate, we believe it had to do with the two-tiered. It went through the associations, and then that wasn't as clear that it was the Ministry that was asking and that need.

And we also think, in hindsight, as the situation evolved, that there was some fear. The Ministry of Long-Term Care being the regulator and the authority for those homes, that they were afraid to say that they didn't have what they might

have or should have had. So that's speculation, but we didn't see the response that we had hoped to see from that.

Does that --

COMMISSIONER KITTS: Excuse me, can I follow up on that?

CATHERINE BROWN: Yes.

COMMISSIONER KITTS: January 23rd to February 3rd, this is Ontario Health's early role.

Does this include the Deputy Minister of Health and the Chief Medical Officer of Health? Is this the Command Table?

CATHERINE BROWN: Command Table wasn't in place at this point. This was prior to that. Because we had done the PPE survey for the home care sector, which we do have oversight on, we had created a tool in Ontario Health through Shared Services to survey those folks.

And when the Ministry learned of that, they asked us if we could modify that and send it out to all sectors. We worked with the Hospital Association to get that nailed down, and then we did the distribution.

COMMISSIONER KITTS: Okay. So the Command Table hasn't been set up yet? Is that --

CATHERINE BROWN: Not at that point, no.

COMMISSIONER KITTS: Okay. Thank you.

CATHERINE BROWN: Thank you. So Ontario Health -- I repeat myself, but Ontario Health worked closely with the Ontario Hospital Association to collect survey information as well on isolation rooms and ventilator availability. We provided that information as well to the Ministry of Health.

At this stage, Ontario Health was a vehicle for the Ministry to access province-wide data. Ontario Health provided the data to the Ministry of Health but was not, for example, with PPE surveys, doing any analytical work on that information. All that information was provided directly to the Ministry of Health for their analytic review.

When Ontario Health was providing support -- or when Ontario -- not Ontario Health -- was providing support for the repatriation of travellers at the Canadian Armed Forces base in Trenton, Ontario Health East Region worked locally to help marshal health and other resources to support the work at the base and then subsequently

for the set of travellers that were a repatriate in Cornwall.

On January 25th, as you know, Ontario saw its first case of coronavirus. And Ontario Health through its Toronto Region began work with our hospital partners and the Public Health unit on tracking and management of cases.

In early weeks and days, identified cases were relatively few, and tracking the cases and the case history were mapped and followed closely by Ontario Health.

Over the next several weeks, cases began to move on the Toronto area reaching into other parts of Ontario Health's regional planning and management offices.

Ontario Health immediately began holding daily meetings across all of its business areas including the regions and their clinical and other leads closely watching as the safety evolved, and the need for information and coordination efforts was growing. Through February, as the situation evolved globally, Ontario continued its planned response.

I'm going to turn it over to Mr. Anderson to take us from there on the broader

response.

Matt?

MATTHEW ANDERSON: Sorry, there was a slide in here of my shocked face as I arrived, so that's what happened between February 3rd and our next sort of discussion. We just had to take that slide out.

So just to sort of carry on from where Catherine has left off, as the case counts continued to grow through February, health system partners were seeking clarity and coordination of efforts. Many of them had begun to reach out to Ontario Health, to our regional leads, to seek information and support.

Ontario Health through its LHIN LTC placement coordination function has linkage to every long-term care home in the province, and as such, many of those early calls and questions seeking information or supplies were made through those channels and then forwarded to the Ministry Emergency Operation Centre, or MEOC, or sent to other designated response bodies.

In late February, Ontario had seen 17 confirmed cases of coronavirus, and there was growing concerns about preparedness, particularly

in a hospital sector, on what we were observing globally, for example, in Italy.

On February 27th, the Ministry of Health asked Ontario Health to lead a province-wide preparedness planning response. Over the next three days, Ontario Health created five COVID response regional planning implementation tables, what we refer to now as the "regional tables."

Each table had held its first meeting by March the 2nd. The regions were -- there's constant requests around participation as the health sector came together region by region, community by community to plan their response together.

One of the first priorities of the regional tables was to enhance surveillance by enhancing testing capacity, lab capacity, and syndromic surveillance.

I'm going to move to a couple of key elements of that early response. So moving to assessment centres. And so with our assessment centres, as case numbers and test requests grew, hospitals EDs were experiencing growing numbers of individuals presenting for testing.

Some had a rich history and were

directed by Public Health to attend for testing. Many more individuals were showing up -- just showing up for testing. The pressure on our EDs grew quickly, and the capacity to segregate those ED tests -- i.e., potential COVID-positives -- from other ED patients became problematic.

In early March, Ontario Health, at the direction of the Ministry of Health via the Command Table, took the lead in working with hospitals to establish alternative testing sites or COVID-19 assessment centres to divert the flow of potential COVID-positive patients from the emergency department to COVID testing assessment sites, designed specifically to manage the potential while freeing up the emergency departments for other urgent patient care.

Working with the Ministry of Health, Ontario Health established a Planning Assumptions and Operational Readiness Checklist for the COVID-19 assessment centres.

This checklist was developed to enable the timely design and implementation of COVID-19 assessment centres. As a requirement to open, the site had to meet the minimum requirements within the checklist to receive signoff from their

respective CEO, the local Public Health Medical Officer, and their respective Ontario Health regional lead.

Ontario Health regional leaders worked with local providers to ensure minimum requirements for were met for the assessment centres and that the modality -- whether it was walk-in, appointment, or a drive-through -- was appropriate for the target population.

Most recently, Ontario Health has continued to work with assessment centres to understand costs and has recommended a funding approach to the Ministry of Health that -- as of today, that funding allocation is pending, but we are moving forward nonetheless.

Today there are 152 assessment centres in Ontario. Assessment centres operate in a variety of models that are mostly hospital-led and including but not limited to walk-ins, appointment-based, drive-through, and mobile assessment centres.

Assessment centres currently collect specimens for COVID-19 testing in accordance to testing guidance. This means that currently we serve both symptomatic and asymptomatic visitors.

Across our broad regions, more than 2 million visits have been made to assessment centres with individuals returning more than once. To date, assessment centres have performed over 2 million COVID-19 tests.

We're going to move to our next topic, and that is with respect to Telehealth support. With respect to Telehealth, in mid-March, Telehealth Ontario was the support line where all Ontarians were directed to call to get a referral to Public Health if they were interested and needed testing.

Telehealth's existing and surge capacity ended up being overwhelmed. The process of recruiting and training nurses to augment the nursing staff at Telehealth was going to be time consuming, and the solution was needed more immediately.

Ontario Health stepped in recruiting volunteers from the OH region/LHINs who were then deployed to support increasing Telehealth's response capacity.

Ontario Health set up Telehealth training for over 420 nurses from across the province. From the time the call went out on a

Wednesday, trained LHIN staff were working in the Telehealth response line by the following Sunday. LHIN nurses contributed 52,000 hours of nursing expertise and completed 71,513 calls for Telehealth.

If we can move to the next slide.

Lab capacity. In late March, Ontario Health was asked to establish the Provincial Diagnostic Network and was tasked with rapidly enhancing provincial lab capacity to address the growing COVID-19 testing challenges.

The work focussed on scaling lab testing capacity as well as establishing a testing strategy expert panel to provide recommendations to the Chief Medical Officer of Health regarding a testing strategy and lastly to reduce the turnaround times from when a swab was performed on an individual to the time their result would be available.

Through this time, Ontario Health also took on swab supply --

Oh, you're already moving me to PPE. Just a couple more comments on lab there. Thanks, Janet.

Through this time, Ontario Health also

took on swab supply working with Public Health Ontario and others to source swabs which, at that time, were in short supply and to support the work and distribute swabs across the province to Public Health units and assessment centres eventually taking on this function across the province.

The area of testing and laboratory capacity in the COVID response is ongoing in a complex area of Ontario Health's work in the pandemic response. And for the purposes of today, I've just kept this to a short summary.

Our next topic is PPE, personal protective equipment. Throughout February, Ontario Health worked with the Ministry of Health to support plan for PPE, data collection, supply and demand processes.

As the disease evolved globally, the need for certain types of PPE, such as N95 masks, was growing. Supply was challenged, and Ontario was seeing health systems struggle to access needed equipment.

Existing supply chains were also challenged to meet the demand as global supply chain issues continued to evolve. Many small health service providers, in particular, had

limited capabilities and expertise on accessing much-needed PPE.

In March, Ontario Health engaged leading SSOs such as Plexxus and Mohawk Medbuy to support sourcing of PPE and other critical supplies and equipment. And each 50 supply chain and OH employees engaged directly to manage vendors, time lines, and procured products utilizing both conventional and nonconventional sources across the globe.

Since the creation of the task force, over 1 billion units of PPE and critical supplies have been ordered and over 200 million units received to date, and I'm staying in close working relationship with our Ministry of Health.

Ontario Health saw the need to help support distribution locally and regionally in March. Ontario Health commenced efforts to establish a regional supply chain network. This regional model was established as a means to leverage the unique features of the Ontario Health regions and their local knowledge relationships and clinical expertise.

The regional functions worked directly with the Central Ontario Health team and

established best practice in consistency and processes approached and outcomes between teams. The role of the regional supply chain network is to support HSPs for critical PPE explanations along with establishing regional warehousing and distribution functions.

From late April to September, regions have shifted 45 million units of PPE to 4,324 health service providers. Long-term care homes, specifically, have received 11 million units of PPE across 457 homes.

Next one, please.

COMMISSIONER KITTS: Can I just ask a question? We've heard at a number of tables from long-term care that they were under the impression or there was some early on that don't collect PPE, "leave it for the hospitals, or there's not going to be enough."

There's a lot of talk about the long-term care homes feeling there wasn't enough and what was there should go to the hospitals. Do you know -- have you heard that, and do you know where that might have come from?

MATTHEW ANDERSON: I don't know that one. Catherine, do you want to make a comment

there?

CATHERINE BROWN: Certainly. Thank you, and it's a good question, Dr. Kitts. So in the early days -- and I would ask that the follow-up be with the Minister of Health -- but there was a prioritization process as pandemic stock was very, very -- in very slim supply.

And so prioritization activities were undertaken by the Province. We were working closely to escalate requests to the Ministry Emergency Operation Centre, and my understanding is there was a prioritization exercise that was done, and different provider groups had different priority at different times.

And so I will direct you back there. I don't have that in front of me, and it wasn't a prioritization exercise that Ontario Health developed but rather responded to and implemented.

That said, we, locally, made every effort we could despite any prioritization to make sure that supplies got to where they needed to be.

COMMISSIONER KITTS: Yes. Thank you, Catherine.

CATHERINE BROWN: Thanks.

MATTHEW ANDERSON: Great. Thank you.

If I can just talk a little bit about planning and hospital capacity. So as --

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. Anderson, excuse me for interrupting. I was on mute when I was trying to --

The 457 homes -- and we've heard at different times that there's approximately 626 or 25 homes in Ontario.

Were there some homes that simply did not require personal protective equipment, or is that what that means?

MATTHEW ANDERSON: That's correct. There were homes that did not come to us or come to the central stock to look for PPE for any posted reason. Some of them had it stored. Some of them did have a good supply chain, but these are the groups that came to us.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So they may have sourced it themselves?

MATTHEW ANDERSON: Absolutely, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, okay.

MATTHEW ANDERSON: Hospital capacity planning, so the whole of Ontario began, as we were watching what was going on, in Italy, in New York

City, and elsewhere. We also turned our attention to the capacity within the hospital sector.

Work began to maximize available hospital capacity and scale up capacity in other areas to support our patients whether they be ALC patients or into other settings such as long-term care.

Ontario Health, in partnership with the Ministry of Health and hospitals province-wide, began planning and coordination efforts to address hospital capacity to free that up and to ensure there is adequate or better critical care and ICU capacity in Ontario hospitals.

Targets were expanded, and then capacity was set on the modelling and the theological curve predictions for Ontario.

In mid-January, when the efforts began, most hospitals in Ontario were at or above capacity. Hospitals were facing significant challenges with hallway medicine and capacity overall. In early March, acute care hospitals capacity sat at 95 percent or above with CCU/ICU capacity at 85 percent or above.

To assist with the capacity challenges in hospitals, the Ministry of Health issued

direction to hospitals on March the 15th providing direction to ramp down elective surgeries and other non-emergent activities in order to create capacity to care effectively for patients with COVID-19.

Hospitals quickly responded, and by the end of March hospitals, were at 70 percent acute care capacity and 75 percent CCU/ICU, eventually levelling off at approximately 65 percent of acute care beds and 75 percent of ICU/CCU capacity by mid-April.

The initial focus of planning efforts in the long-term care sector were focussed on assisting hospital expansion capacity while opening up capacity in long-term care retirement homes to enable hospitals to make available in case of an anticipated COVID surge.

And the next one, please. COVID scorecard, and I think this is sort of our last one of our general responses that Ontario Health was part of, then we'll get into -- I'll hand it over to Catherine to get into, specifically, the long-term care.

In February, as the pandemic evolved and Ontario began to mobilize its response, there was a need at the Command Table and within Ontario

Health to understand the track and progression of the pandemic and the development of the response in Ontario.

Ontario Health worked in collaboration with the Ministry of Health and Public Health Ontario to assemble what would become an essential command tool, the COVID-19 scorecard, a routine report that monitored the progression of the pandemic and the capacity of the system to respond.

On March 16th, Ontario Health took the lead to compile the first report from presentation at Command Table and continued to evolve the report over the course of the pandemic in close collaboration with the Ministry of Health and Public Health Ontario.

The scorecard was initially comprised of data from existing sources such as the integrated Public Health Information System -- that was iPHIS -- the Acute Care Enhanced Surveillance -- that was ACES -- and the Critical Care Information System, et cetera.

And it evolves to be a mix of additional existing sources such as Telehealth Ontario, and newly collected data information would be coming in from our assessment centres or a

Provincial Diagnostic Network.

Throughout Wave 1, the scorecard was compiled and presented to the Command Table three times per week and later two times per week. The reports have evolved over the last eight months to monitor the pandemic, the public health, and health system's response capacity and health system recovery.

The data continued to inform Command Table and also inform the Central Coordination Table and various other associated response tables.

I'm going to stop --

Oh, yeah, Dr. Kitts?

Oh, you're on mute, Jack.

COMMISSIONER KITTS: Thank you. The Command Table was set up before March 16th, I assume. And you said there were three co-chairs -- Ontario Health, Ministry of Health, and the Chief Medical Officer of Health.

At the Command Table, was Long-Term Care there, and what role did they play?

MATTHEW ANDERSON: So they were there. The Deputy Minister was part of the Command Table. What we did -- and I can't recall if there's a graphic in our slide somewhere.

At the Command Table there were a whole series of planning tables that were set up. Long-term care would have been one of them, primary care, et cetera, and each had a leadership model, and those folks would be part of the Command Table.

Later in its evolution, the Minister of Long-Term Care and the Minister of Health would also, on occasion, attend the Command Table.

COMMISSIONER KITTS: Thank you.

MATTHEW ANDERSON: Catherine, I think we can go over to you on the specifics around our long-term care supports.

CATHERINE BROWN: Thank you, Matt. And, Dr. Kitts, you've preempted my next comment, but I'll go through it anyway.

As the work across the regions progressed, Ontario Health recognized a need for provincial tables to support the work on preparedness planning.

One of the provincial tables OH, Ontario Health, established was an Ontario Health long-term care home retirement home table.

Meeting for the first time on March 17th, this table brought together the two long-term care associations, the Retirement Home

Association, Ontario Health, and the Ministries of Long-Term Care and Health as well as the Ministry of Seniors and Accessibility to share information, plan the response, and provide updates on work underway in the ministries and in long-term care homes.

This table was evolved into a more formal table. It did not originate under the Command Table, but it was moved to under the Command Table. The Long-Term Care Retirement Home Operations COVID-19 Action Table or "the Action Table," as it's known -- at the request of the Command Table, it was moved under them and formalized its reporting to the Command Table.

Meetings of that new table began April the 6th. The Action Table is a provincial table composed of representatives from both the long-term care sector and retirement home sector. It is co-chaired by Deputy Minister Cole in regard to retirement homes, Deputy Minister of Seniors and Accessibility; Deputy Minister Steele at the Ministry of Long-Term Care; and I am the third co-chair there from Ontario Health, obviously.

Its members consists of leadership from sector associations as well as representatives from

within those sectors. The long-term care homes are represented both by their associations and by individual representatives both for profit and not for profit as well as the Ontario Retirement Homes Association and regional representatives and then representatives from the Ministry of Long-Term Care, Seniors and Accessibility, from the Chief Medical Officer of Health's office, the Ministry of Health, Public Health Ontario, and Ontario Health.

The table is used to keep the sector abreast of updates of the government's response to COVID-19 and to engage in dialogue around policies under consideration and operational concerns. The sector also provides advice and raises questions for consideration by the ministries and Ontario Health.

The secretariat support is provided by Ontario Health, and this table continues to meet and has been instrumental in increasing information sharing and flow amongst the parties.

The first significant outbreak in long-term care homes was identified on March 20th. It was an outbreak declared in the Pinecrest long-term care home in Bobcaygeon. This was a small home with 65 beds.

Ontario Health East Region was contacted by the home the next day, on March 21st, seeking PPE and assistance with finding staff to work for the home. By this point, many staff were off sick already COVID positive or as a contact of COVID.

The Ontario East Region sourced home care organizations for staff and provided necessary PPE. There was minimal success with staffing based on growing concerns that Ontario Health was seeing.

We raised with the Ministry of Long-Term Care a request to take all necessary steps to stabilize the home. Resulting in the Ministry responding with a contract for another home operator to manage the home to help bring the situation under control.

In Ontario Health Central Region, around the same time, we began to hear similar concerns about homes in that area. We learned of an outbreak at Camilla Care in Mississauga and reached out to them to see what we could do to support the home in caring for their residents.

It is difficult to pinpoint the exact moment or the home that opened the Ontario Health response as the number of homes in outbreak began

to grow quickly. At the end of March, March 22nd, there were 12 homes in outbreak. Two weeks later, April 5th, there were 100 homes in outbreak, and a week later, 127.

Our presence in communities through the long-term care placement function and the growing presence of the Ontario Health regional COVID response tables and our hospital partnerships placed Ontario Health in a position to help homes in need across the province.

The slide you're looking at gives you several examples of the kinds of pieces of work that we undertook, and I'll talk to some of them now.

By early April, the regions had put in place response teams, typically long-term care response teams, typically involving the local Public Health unit, a hospital partner in the community, and Ontario Health.

These teams worked together to support ongoing outbreak response in communities across Ontario. The teams varied based on the local circumstance, the partners' availability, those participating, the capacity of the partners to respond, and, of course, the needs of the home.

By mid-April, there were widespread outbreaks in long-term care homes across Ontario with the highest concentrations in Toronto, Ottawa, Peel, and the 905.

In Toronto, they deployed mobile testing teams in the home to help with swabbing of staff and residents as was happening in many parts of the province. It wasn't exclusive to Toronto.

The OH project lead for that team, who was coordinating testing in four homes, flagged that she was hearing from testing teams on site their concerns about the use of PPE and the infection prevention and control measures that were in place in these homes raising concerns for them about the impacts they may have on resident health, and, of course, disease management.

Ontario Health Toronto pulled together an urgent meeting of their local hospital CEOs to develop a plan to respond resulting in the assignment of all long-term care homes to a hospital partner in their area. There are 36 homes in the Toronto Ontario Health Region.

Each hospital agreed to reach out and offer support to their assigned homes. Ontario Health liaised with those hospitals to get that

work underway.

The plan for the assigned hospital was to confirm connection and then provide an initial assessment on that call. Hospitals worked with their long-term care partners to review IPAC, infection prevention and control measures; PPE supply; testing; as well staffing needs and then began to mobilize the response between the hospital, the long-term care home, Toronto Public Health, and Ontario Health.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Brown, if I can --

CATHERINE BROWN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- just ask you, having established the connection for purposes of the emergency between the long-term care home and the hospital, is that connection still in effect?

CATHERINE BROWN: Yes, it is, and it's a very good question. The hospital relationships varied across the province depending on the outbreak situation in the home and the level of need of the home.

Across the province today, all hospitals have an assignment to long-term care

homes. Some of those are notional. I say that in that the home and the hospital know each other, but they may not lean on each other because the home may be stable and not need that kind of response.

In other areas, hospitals are heavily supporting long-term care homes. And in, of course, those areas of highest outbreak, we see extraordinary relationships between the hospitals and long-term care homes and ongoing supports, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): So is the view that that was a successful deployment of -- or a successful initiative?

CATHERINE BROWN: Yes, absolutely. And I think one of the things that has shifted from then until now, at the time that hospitals were deployed in the spring, as Mr. Anderson mentioned, their capacity was quite open, and they had kept staff on in anticipation of a surge in the hospital.

So they had both staff and resource to be able to deploy easily to the homes. That is not the case today. Although those relationships are still in place and hospitals are still providing extraordinary support, they are often at or above capacity, again, and there is a human resource

piece, which I will speak more about later, but I'm happy to answer your question at this time.

COMMISSIONER FRANK MARROCCO (CHAIR): There are a couple of questions, Ms. Brown, before you go on.

Commissioner Coke?

COMMISSIONER COKE: I'm just wondering in terms of, you know, efforts to encourage further integration, is there any thought to sort of formalizing those relationships?

CATHERINE BROWN: Certainly when we talk to our hospital CEO partners, they often talk about a more formal, ongoing relationship. And one of the areas, in particular, is around medical leadership and expertise.

One of the things we saw in homes was just that lack of ability to assess patient need to put in place the necessary infection prevention and control measures.

One of the greatest places of support and success for homes that were struggling was that extra lift from hospitals with that expertise that they have in those two areas and an ongoing relationship with that level of medical expertise.

There are physicians that provide

support to long-term care homes, but they have a different level of expertise than those from the hospital that are going and doing infection prevention and control.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Commissioner Kitts?

COMMISSIONER KITTS: Yeah. I just want to see if I understood correctly.

So did you say that all long-term care homes have an affiliation now with a local hospital that's not formal but is a working relationship; is that true?

CATHERINE BROWN: It's slightly -- it's a good -- I didn't clarify that, so thank you for that.

It's slightly less than -- in some areas, we may know that we've assigned a hospital to a home so that were there to be a need, we can deploy them. They, for the most part, have had contact with the hospitals but not in all cases.

So in parts of northern Ontario where homes are more remote, the hospital may not have already been deployed. But in most areas, certainly in the south -- the 905, Central, and Eastern Ontario -- there has been contact if not an

ongoing relationship.

And certainly in the Ottawa area, for example, we see a heavy reliance on the hospitals in Central, Peel, Markham, that area, a very heavy reliance and, of course, in Toronto.

COMMISSIONER KITTS: Right. So I guess, as you said, the reliance on the hospital was easier when there was so much capacity and lots of resources.

Given the reopening and the stresses on the hospitals now, I'm trying to figure -- are you aware of which are the highest-risk long-term care homes for Wave 2, and are they partnered already with a hospital to take more of a preventive stance than a "come in to clean up" stance?

I'm trying to figure out if that's the relationship and how that works.

CATHERINE BROWN: That's a great question. Yes. So over the summer, we were asked by Matt and the two Deputy Ministers of Health of Long-Term Care to undertake Ontario Health to a preparedness checklist that was provided by the Ministry of Long-Term Care.

We took that checklist because it was a basic kind of yes/no checklist. "Do you have PPE?

Do you have adequate health and human resources?"

We elaborated on that. We fanned that out to all long-term care homes and then asked them to respond. Some of our regions -- not the North, necessarily, because of their geography -- but certainly in Central and Toronto and predominantly East and West as well, they also tried, where possible, to put boots on the ground to go into homes and take a look and see what their preparedness was.

We have some capacity challenges ourself to do all of that, but certainly the homes that were at highest risk from Wave 1, we had eyes in those homes. And so we've submitted those responses back to the Ministry of Long-Term Care, and we continue to rely on those preparedness assessments and our own experience of those homes.

I should say that Ontario Health, through the LHIN function, has a strong workforce that has been utilized heavily to do a lot of this work with the homes. It is not solely the hospitals. We work very closely with the hospitals, but we extend their capacity and help them as they go into those homes. And often, we go in first, and then we call on the hospital to give

us some extra support for IPAC or other needs such as that to help with that kind of deeper assessment where we see it's necessary.

So in answer to your question, that work took place over the summer, and we're relying on it heavily now, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you compel these -- the home and the hospital, can you compel the relationship?

CATHERINE BROWN: That is an excellent question. So Ontario Health on its own has no ability to compel anybody to do anything in this regard. We rely heavily on our hospital partners to follow our lead and work with us focus on that.

Where we have a home that is in -- is resistant -- so I'm going to just speak to something later in my presentation.

What we learned through Wave 1, one of the weaknesses we saw was a capacity of leadership to actually respond to the advice they were given and move forward with implementing that, and that was often around their ability to manage in a crisis, staff being off. They were off sick. They just did not have that ability to respond in the moment.

And so hospitals went in hard, if I could say, to help them with that. They took staff in. They took IPAC in.

Where we saw, in some homes, a resistance or an inability to implement the advice of the hospital, we spoke to the Ministry of Long-Term Care about using one of their tools, which is a Ministry management order, to deploy hospitals -- order hospitals, and homes -- sorry, order homes to let hospitals manage them.

So as I mentioned a moment ago with Bobcaygeon, typically that's an order ability that the Ministry of Long-Term Care has in its toolkit, but they use other providers to go in and help support a home. That wasn't an option here, and they needed a different tool.

They put an emergency order in place -- and I'm sorry, I don't have the date for that -- that changed the criteria for the management orders and allowed this management of the homes.

And that has been a game changer for some of those tough homes where the leadership capacity was the weakest, and that is what allows us to your question about what's the leverage to say to the home "We're going to take over now and

get you back on your feet." That has been the lever.

For the most part, we've used that ten or so times. For the most part, homes have responded well to the support from hospitals and, overall, have responded well to the collaboration.

I don't know, Matt, did you want to comment there?

MATTHEW ANDERSON: No, I think you nailed it there, Catherine. And just -- there is a -- you know, we always do it through a cooperation model at first. There are a couple of tools that have been created.

But, you know, going back to the comments from both Jeff Simser and Ashley Dent, we don't have any legislation or anything along those lines that enable us to do this. This is just something we've been asked to do, and in most instances, that's all that's required. But as Catherine pointed out, in a few instances, we needed some additional tools to help.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. It occurred to me that some homes might not want to admit that they are really unable to deal with the problem. And so they would, perhaps,

falsely maintain their -- that they don't need my assistance. That's where my question was coming from.

So you ask the Ministry of Long-Term Care to issue a management order, and then the Ministry applies whatever criteria it has to apply to try to see if it can arrive at the decision that issued the order, and then you rely on the order.

Now, does that take a long time, or is it relatively quick?

CATHERINE BROWN: Another excellent question. So they --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, you didn't need to sound surprised.

CATHERINE BROWN: No, I'm sorry, I didn't at all. So the tool -- so they changed the criteria. The previous criteria prior to COVID was a series of noncompliance incidents which doesn't apply in this circumstance.

So they changed the criteria through an emergency order that allowed it to be a quicker deployment. However, it is called an "order." It is nonnegotiable that the Ministry is issuing it, but there is a contractual negotiation that takes a couple of days and sometimes longer.

So the hospital legal folks look at it. The home's legal folks look at it. Everybody has to agree to those terms and conditions.

So in the spring, when we use those, there was a little bit more time, and I'll speak to that in more detail in a couple minutes.

But what we're seeing now, recently, in Ottawa, we had a couple of homes go into outbreak, and the management order -- the hospitals are typically the ones that say to us at Ontario Health "We need your help with the Ministry to get the orders in place because we now need to manage the home. We've tried persuasion. We've tried with them. Now we need it."

So we asked the Ministry, and it was -- the Medical Officer of Health for Ottawa was very concerned that the process was taking too long, the negotiation and the cycle time. And so she issued an order under her authority, Section 29(2) under the Health Protection and Promotion Act which essentially an order.

It is immediate. It goes into effect immediately, and so we have used that twice now in Ottawa. And what it does is it gets the hospital in there immediately, and then the Ministry follows

on that with the contractual piece of the management order, and then Public Health pulls back.

Today in Toronto, the Toronto Public Health will be taking the same approach issuing a Public Health order, Section 29(2) again on a home in Toronto that has been in outbreak for a week or so.

And the work on the management order is taking too long, and so Public Health has issued the order today, and then, again, Ministry will conclude it with their work.

COMMISSIONER FRANK MARROCCO (CHAIR): And so the local Medical Officer of Health, if I've got the title right, has the authority, then, to virtually, immediately issue the order and put you in -- put the hospital or whoever into the home, and then they can carry on with whatever negotiation they want to carry on with, but somebody's managing?

MATTHEW ANDERSON: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

CATHERINE BROWN: And I should also emphasize, Commissioner, that the hospital is still

working with the home prior and through this whole process regardless of whether the order has been issued or not. So in all of the examples I've given, the hospital is actively working with the home while the legal tools get put in place to support the...

MATTHEW ANDERSON: Yeah. I was just going to add, if I may, just that -- what Catherine said on that last point, these don't emerge all of a sudden, and so we're working towards this.

We have hospitals -- and likewise, for the Ministry of Long-Term Care, right, it's not like they suddenly -- they are asked by Ontario Health. They see this sort of path going through as well through their planning table, so people are aware that we're headed down a particular path.

Obviously if we can stop that path from happening, that's great. And as Catherine has said, in about 10 or 11 instances, we just weren't able to, and we needed to do orders.

COMMISSIONER KITTS: Can I ask, does the order compel the hospital to go in and the long-term care home to accept them?

Because there could be a scenario where the hospital doesn't feel they have the ability,

and the long-term care needs them.

So I know long-term care gives the order to the long-term care home, but does the Public Health order compel the local hospital to work with the long-term care home as well? Do they both get the order?

CATHERINE BROWN: Yes. That is true. The order is actually -- we call it a "friendly order" or they have been thus far. The hospital is compelled to go in by the order, but they are already well on side and in agreement that that tool would be useful to do it. So it's a friendly order, and it compels both parties, yes.

COMMISSIONER KITTS: Do you think -- and I'm just throwing this out there -- given we're, I guess, into Wave 2, do you think that the -- I don't want to use the word "order," but do you think that hospitals and long-term care homes or local ones should already be joined at the hip ready for Wave 2 as opposed to getting an order to go in after the fact?

CATHERINE BROWN: That's a tough question. They are working very closely together for the most part, and I will say, by way of example -- I don't even want to say this out loud.

I will not quit -- but we're seeing in some of the areas in Central Region where those partnerships have continued, and those hospitals are already working together -- Trillium, Humber Regional.

They were heavily into it with those homes in Wave 1. They stayed connected. We're seeing that continue.

So we don't feel that there's a need for orders in most of those areas, and there may be homes that pop up where hospitals haven't previously been involved in the same way, and we're not seeing that piece.

But I don't think there's a need at this point. I don't -- Matt, if you wanted to offer to compel hospitals to do it. They're already working very competently to their fullest extent to the point where their capacity is also stretched so...

MATTHEW ANDERSON: I would -- maybe --

COMMISSIONER FRANK MARROCCO (CHAIR): No, sorry.

MATTHEW ANDERSON: Two very quick comments to supplement what Catherine has said.

One is that your local hospital, in many ways -- you know, you can choose to help out

while a person is in the home, or you can wait until they show up in your emergency department.

So there's an incentive right built into that system that says "Yeah, let's do this."

And then, Dr. Kitts, directly to your question, in particular -- everything that Catherine said, I echo. And in particular, when we were speaking about areas like IPAC, or infection prevention and control, and medical coverage or medical support, those two areas in particular to -- I would add to Catherine's comments in terms of the recent activity to the home, the interest from the hospital, and how they are working together.

COMMISSIONER FRANK MARROCCO (CHAIR): But just to come back, so the local Medical Officer of Health can order it, period?

CATHERINE BROWN: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): And that puts them together?

MATTHEW ANDERSON: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): So if there's reluctance on either side, all you need is a local Medical Officer of Health who is prepared to exercise the authority they have?

CATHERINE BROWN: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Does that ever become a problem where the local Medical Officer of Health doesn't want to make -- doesn't want to use their -- doesn't want to use their authorities or is reluctant?

CATHERINE BROWN: It has not been a problem on the orders to this point.

Sorry, Matt, you were going to say something?

MATTHEW ANDERSON: I was just going to say that yes and no in that obviously everybody is trying to find -- when we're in these type of situations, everybody is trying to find a coordinated response.

In the instances where we have had Public Health do it in the -- I know of three. In the first one, it was the emergency order that you just heard didn't exist at the time, and so the Public Health units --

And this would have been with Orchard Villa, and so that would have been done -- because there wasn't that mechanism.

And then the others -- I mean, Catherine can speak to you more succinctly than I,

but I do think it's more of an instance of where it's a feeling of "Let's get moving and get this done while the parties are negotiating a more sustainable model which is the Minister's order."

CATHERINE BROWN: Anything -- sorry, we've seen through Wave 1 the swift response. Giving management a longer time to respond is not in anybody's interest in (indiscernible) care.

We need to make decisive action and say "This leadership is not responding as we need them to." We can always pull back on the order. I will say, though -- and I don't want to put words in Dr. Etches' mouth, but Dr. Etches is the Ottawa Medical Officer of Health for that region.

In contemplation of the orders for the homes in Ottawa, she did -- she was concerned that it was typically beyond what she would order. She would order things that were in the realm of Public Health activities -- testing, IPAC changes -- but she couldn't typically order management changes.

And so because the precedent had been set by Durham Public Health months earlier and because the process of management ordered through the Ministry was taking longer than she felt was advantageous to the residents and the care in that

home, she took that measure.

So to your point, was the reluctance in the scope of it? Yes, because she felt it was outside, but she did not have any reluctance to proceed to ensure that there was a timely solution of that home and for those homes.

COMMISSIONER FRANK MARROCCO (CHAIR): And I guess there's no -- I guess a directive or something would be helpful in over --

Would it be something like that to overcome that, or is it well established now that these sorts of orders could be made?

CATHERINE BROWN: I think it's well established at this point.

MATTHEW ANDERSON: Yeah. And if I may, I think that that sort of goes full circle to Dr. Kitts' question at the beginning.

How do we establish and maintain these relationships so you never get yourself into this spot where -- or you can avoid as much as possible getting yourself into this spot of a management order and a full take-over of the long-term care home by maintaining the relationships particularly on IPAC, medical coverage, et cetera.

Can you just avoid all of that and

keep -- which is the best of all worlds. That means you're keeping the resident healthy. You've got a channel. You can escalate quickly if you're a long-term care home and you need some help. And the hospital, you know, can put a little bit of energy into it.

But it's now to the point of distraction and having to turn off hospital activities to support the long-term care homes. So that's the desired state, but we have some work to do on that.

COMMISSIONER FRANK MARROCCO (CHAIR): I don't mean, Ms. Brown, to take away from the presentation that you're making.

But when you say -- well, what do we need to do to establish that? Because as someone who's not familiar with health services, it seems quite logical to me because if somebody gets sick in a long-term care home, you phone an ambulance, for example. They take the person to the hospital.

They don't say "I don't know what hospital to take the person to." If I'm going to -- I'm going to -- so since we know the hospitals that must be connected to the long-term care -- must be within reach --

MATTHEW ANDERSON: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- wouldn't it be a good idea to establish those relationships as part of everybody's way of doing things?

CATHERINE BROWN: Yeah.

MATTHEW ANDERSON: So my answer to that would be yes, and my answer to that would be we've got to find the mechanisms to be able to do that and go on further.

And I know for Dr. Kitts, he knows more about this than me. But, you know, when I look at it, even in a non-pandemic situation, the number of times that we're transferring a person from a long-term care home into an emergency department oftentimes because they are palliative, and they are in the final stages of that, and they are dying, and now we're going to have them die in an emergency room instead of in their bed in their room --

The number of times that happens, the number of times that they were sending people from long-term care over to an emergency room because they have the flu -- and there's nothing, in particular, that the hospital's going to be able to

to do for them. And, in fact, the resident gets worse by being in that emergency room, and this is all well documented. There's nothing magical about what Matt is saying here.

Establishing these relationships and thinking through "how do we make it so that we are in a more proactive mode and encouraging" --

If we can figure out the model correctly, you know, it would encourage things like having portable lab, portable ultrasound, portable x-ray in these homes or easy to get to these homes where a clinician can get the diagnostics that they need without moving the -- the basic diagnostics that they need without moving the resident.

These are all things that we could be doing to -- even whether we're in a pandemic or not in a pandemic -- make things a whole lot better for our residents in long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): And the hospital would coordinate the access to those services?

MATTHEW ANDERSON: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Should be a lot easier for the hospital to do that. Is there --

I'm sorry, Ms. Brown. We'll give you more time.

CATHERINE BROWN: It's okay.

COMMISSIONER FRANK MARROCCO (CHAIR): We've sort of distracted. But is there any reason that's been offered for why that's not a good idea that needs to be addressed or dealt with?

Or is it just something that just didn't happen and didn't become obvious until the pandemic made it obvious?

MATTHEW ANDERSON: Yeah. I mean, my own perspective -- and Catherine and I have never had a chance to talk about this because, you know, as I mentioned at the top, three weeks into my job, we were in the pandemic. So Catherine and I have never a chance to reflect together on some of these things.

I mean, from my perspective, it's one of those things that's been challenging to get it to the top of the list of things that need to get addressed. I suspect that there is many elements of accountability agreements and legislation.

I imagine there's all kinds of mechanisms that all have to be thought through in order to do something along these lines. I have no

particular perspective on if it's a for-profit home or a not-for-profit home. Does that have any bearing on how you would set up how these relationships and so on?

To my mind those are all things that can be thought through if the will is there to make this kind of a connection.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. Just make it a condition and a license.

CATHERINE BROWN: Right. Exactly. If I could just build on Mr. Anderson's point that, in my previous life, I worked at the Ministry of Health and oversaw the long-term care group which was a branch at that point, not a Ministry.

And there is -- you know, it's different than hospitals. We own the hospitals from a public sector perspective in relation to being able to direct them easily. These are, as Mr. Anderson described, for-profit and not-for-profit entities.

Some of them are very large organizations, so it's finding the tools and the levers to be able to make those conditions, whether part of the license or otherwise, come to life. And I think it's critical, absolutely, as

Mr. Anderson just said.

COMMISSIONER FRANK MARROCCO (CHAIR): I was going to take a break. We're going to take a break.

CATHERINE BROWN: I saw both Matt and Dr. Kitts' eyes go off on that, but you know what I mean.

COMMISSIONER FRANK MARROCCO (CHAIR): I was going to take a break. Is now a good time, Ms. Brown?

CATHERINE BROWN: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Ten minutes.

CATHERINE BROWN: Sure.

-- RECESS AT 3:14 P.M. --

-- RESUMING AT 3:29 P.M. --

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry, everybody. I got detained. Anyway, back.

I guess, Ms. Brown, we're ready when you are.

CATHERINE BROWN: I'm trying to get off mute there. Thank you, Justice Marrocco. I will take it from here.

So moving from the partnerships of hospitals and the work that we were doing there, as

the situation in the long-term care homes was evolving, the need to track and capture data on the homes and the risk and response became essential.

Around this time, which would have been sort of early April, mid-April, the Ministry of Health and the Ministry of Long-Term Care procured shared a calibrated list of all long-term care homes rated red, yellow, or green, which I think you've heard about the red, yellow, green trackers.

Based on their history, this chart was put together, as I understand it from the two Ministries, based on the home's history with the Public Health unit or with the Ministry of Long-Term Care.

Those lists were combined to form one list where homes had been rated red, yellow, and green. That list was then distributed out to Ontario Health, and a process was established for Ontario Health to undertake its use and its own knowledge of what was happening on the ground combined with the input of the local Public Health units and the Ministry of Long-Term Care compliance reports as well as the work we were doing with hospitals to track the ongoing outbreaks and, more importantly, to track the response.

This tracker -- the red, yellow, green, tracker -- was updated seven days a week from the time it was initiated right through June with frequency reduced to several times a week over the summer, and we're now back at seven days a week over the last, I think, week or so.

The Ontario Health regions gather the data daily to capture both the ongoing outbreak status but also to capture the response underway including IPAC assessments, PPE, health human resource risks, et cetera.

These tracking reports still in use today are used to understand the local response and to capture the risk, as I have mentioned. As more homes were remaining in outbreak for sustained periods of time an OH regional response teams became more active in the delivery of response in homes, similarities began to emerge for those homes that went into outbreak and struggled to restabilize.

We saw three similarities in homes of this nature: First was a loss of health human resources to support care and to support one another through the crisis; secondly was an inability to provide the necessary infection

prevention and control measures such as cohorting of residents, donning and doffing, PPE usage, and other actions to minimize spread; and lastly -- and we feel that these three were a combination in most homes where it was problematic -- was a lack of the necessary leadership, as I mentioned earlier, to provide the essential guidance and crisis support to stabilize the home.

These three factors were present in varying degrees in all homes that struggled to manage and contain outbreaks. The shortage of staff in homes owing to sickness, COVID isolation, and sometimes fear left homes struggling to fill shifts to provide essential caring.

Leadership was often working around the clock with very few hands on deck, and hereto we saw many leaders at home sick with COVID leaving homes very short of critical leadership in a time of need.

The ability to undertake cohorting and other infection prevention and control practices like deep cleaning, PPE training, and response were challenging when staff levels were precariously low and the priorities were feeding, medication management, and other essential care requirements.

I'm going to talk a little bit now about health human resources. As I mentioned a moment ago, the shortage of staff was a growing problem. Staff shortages in the long-term care existed prior to COVID.

Longstanding personal support worker shortages in the province coupled with the impact of COVID outbreaks was a growing problem for the sector.

As immediate response to the initial outbreaks in long-term care, on March 23rd, Ontario Health launched an online registration page through our HealthForceOntario arm for health professionals to sign up, if they were able, to address emerging health workforce gaps.

Key priorities for that outreach included respiratory therapists, medical laboratory technicians, physicians, nurses, and personal support workers. Within 24 hours, over 5,000 professionals had registered.

On March 27th, in an effort to broaden the outreach to find support, particularly for Pinecrest in Bobcaygeon, we sent out an urgent e-blast to all personal support workers and nurse volunteers in the vicinity of that area from what

we had gather in the previous outreach.

Ontario Health also reached out through the home care delivery system that the LHINs support as a first effort. Home care organizations were not easily able to respond, owing to a number of factors that were impacting their human resource capacity.

Home care provider organization advised us that fear of working in a COVID-positive environment was a significant barrier. As well, we were told by employers in the home health care sector that when CERB came into effect in mid-March, the benefit value was comparable or greater than what some personal support workers were able to earn in home care, and so we understood from those employers that they, too, began to have a critical shortage of health human resources particularly personal support workers.

The shortage of PSWs in Ontario, as I mentioned, has been challenging for years, and it has now become critical with the pandemic ongoing.

In mid-April, the province implemented an emergency order that restricted long-term care employees from working in more than one location. This order, though essential to prevent spread

between homes, further exacerbated the PSW shortage for long-term care homes.

Many workers working two jobs, because of the wage for that workforce, had to pick one employer, and so that meant some homes were left short-staffed beyond what they were previously.

From the very first days of outbreaks in the long-term care, not only did Ontario Health support with outreach to available health care professionals, we deployed our own staff. Both clinical and nonclinical staff put their hands up to work directly in homes by providing personal support services, nursing services, admin support, support of decanting residents, meal delivery, and housekeeping, to name a few.

As of mid-August, OH staff had provided over 17,000 hours of support inside long-term care homes. With many homes in difficult outbreaks, we saw immediately that those in greatest need had the least ability to utilize tools that were being put in place to help them such as the Ministry of Health's Health Matching Portal and other tools.

By late April, with the matching portal which had been launched a few weeks earlier that was launched in early April, over 100 long-term

care homes were in outbreak, many experiencing severe human resource challenges and administrative challenges affecting their ability to do their own hiring and recruitment.

Ontario Health undertook to help the homes in need retrieve the resources from the portal. With rampant needs emerging in long-term care in the GTA, am urgent e-blast was sent out to over 2,000 nurses and personal support workers to create a mini resume to confirm their availability to be rapidly sent into COVID-19-positive long-term care homes.

And a temporary job application, for lack of a better description -- SurveyMonkey tool was created by Ontario Health to begin receiving volunteer applications for urgent positions in long-term care.

On April 21st, the first batches were received. 783 volunteers who were willing to work in COVID-19-positive environments had been then -- were sort of pored through and then sent out to the regions for matching to those long-term care homes in need. That SurveyMonkey was then built into the administrative health portal to allow us to be able to more easily select out candidates that were

available and willing to work in homes.

Through all of the mechanisms, Ontario Health trained and coordinated 53 screeners province-wide to go through thousands of resumes and contact individuals to screen them for appropriate placement in long-term care homes. They then referred those candidates to the regional human resource leads to match with the portal.

If you want to go to the next slide, Janice. I'll --

COMMISSIONER COKE: Catherine?

CATHERINE BROWN: Yes, Angela.

COMMISSIONER COKE: I'll just ask a question. It's obviously a big portion of that portal. Is that continuing now?

CATHERINE BROWN: Yes, it is.

COMMISSIONER COKE: To the same extent?

CATHERINE BROWN: We're about to ramp it up again. One of the weaknesses of the tool, it has people putting their names forward. We then -- you know, the screening and matching and the human resource on our end to go through that -- people who put their names forward, then when we talk to them -- there may be age restrictions; they don't want to work in a COVID-positive home; they're not

currently qualified; they have to be recredentialed.

There were many screening factors that we had to go through. And also people who wanted to be personal support workers but hadn't been trained that, kind of thing.

So yes, the portal continues, and the screening efforts continue to this day, and we're about to undertake some new work in that because the push continues to try and find resources. I do think --

COMMISSIONER COKE: Okay.

CATHERINE BROWN: Sorry, yes. Go ahead.

COMMISSIONER COKE: No. Just inquiring, too, was this the source of where people were getting the foreign trained professionals as well?

CATHERINE BROWN: We worked through the foreign trained professional piece. One of the things we found was that homes struggled with onboarding. Often the foreign trained professionals were at a higher level of certification than what the homes needed, and they had trouble kind of sinking in to say "I know you

were a nurse, but we need you as a PSW," and so there were some challenges there.

But yes, we do continue to look at foreign trained professionals as an approach. We're also looking at how we can better ready them for deployment to long-term care homes because, again, onboarding staff when you're in crisis is not a priority.

So how do we get them ready on this side of the fence, for lack of a better description, when we're not sure the environment they're going into?

COMMISSIONER COKE: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): Would some form of -- you know, you have people who want to gain access to the health professions or -- to use that word.

If you could create an entry point and then allow people to move through the system on the -- you know, there would be continuing education and so on.

I mean, would that make it more attractive? Has anybody considered that sort of thing?

So the person would work. They would

also get some education. They would be tested, and then you might move from a probationary personal support worker to a personal support worker to whatever the next -- I don't know. I don't want to get the nurses engaged in this.

But you can see where it would lead to as long as you could meet certain established requirements.

CATHERINE BROWN: It's a good suggestion and one that -- the Province of Quebec undertook an exercise in the spring as they were coming out of Wave 1 in June and July.

They worked with their colleges to recruit unemployed folks, lots of unemployed folks. You know, waitresses and waiters and things like that.

And they set up a program with their colleges which was, I think, part of what you're saying. Looked at how the education was paid for, helped to augment that so that out-of-work folks could get trained, and then they were deployed on a placement basis. So they did a three-week placement, I believe, after a rapid training course of three or four weeks. And then if, at the end of that process, people felt they were ready to go,

then they could be deployed or they were given a job guarantee.

So we're looking at those mechanisms in the province, particularly, through -- their levers are looking at how they can be setting up those types of programs just to --

COMMISSIONER FRANK MARROCCO (CHAIR): See, I wouldn't that you -- if you do it as a placement, you don't get enough time out of them.

But if you incorporated working in a long-term care facility as part of the educational requirements -- so you work and you study or what -- however they would choose to do that. At the same time, and it --

You get some compensation for working either because you get paid for working or the educational part of it is reduced. And then you're introduced into the system with the credential, and then if you want to keep working and studying and so on, you can improve or get a different credential.

CATHERINE BROWN: We'll take that back to the --

Matt, were you going to respond? No?

We'll take that advice back. I

emphasize the Quebec piece because they undertook it during what I now refer to as "peace times" in the summer where we were not in the same place we're in now.

Looking for homes and willing applicants to go in and work in a long-term care environment right now is a bit more challenging, but I think those are interesting suggestions that we can feed back into the considerations of those tables where we're talking about health and human resources. Thank you. Shall I continue?

Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Please do.

CATHERINE BROWN: Thank you. So just talking a bit about testing in long-term care, and then I'm going to move to talk about the work of the Armed Forces.

So as part of the province's long-term care action plan, on April 15th, a priority action was to increase testing in long-term care homes of all residents and staff.

Testing had already been happening in homes on a regular basis throughout the province, but there was a direction to increase testing to

ensure all staff, asymptomatic and otherwise, and all residents had testing undertaken.

Ontario regions were asked to help support the delivery of the testing for homes, and Ontario Health worked with local partners working with assessment centres locally to deploy teams from the assessment centres into homes to deliver on-site testing for long-term care staff and residents so staff did not have to take time out to go to a testing centre.

And we deployed mobile testing teams to help with swabbing -- from Ontario Health staff to help with swabbing of staff and residents. And between April 15th and May 31st, 26,687 residents and 31,000 staff had been tested across the province.

The testing of surveillance testing of long-term care staff continues to be a direction to long-term care homes that staff should be tested every two weeks, once every two weeks.

So by mid-April, the critical staffing shortage in many homes was debilitating, as we've just discussed. And existing workers and administrators were sick and tired. Other workers were in quarantine or on leave because of fear, and

new workers with in short supply. Homes were desperate for help.

On April 23rd, with over 100 homes in outbreak in Ontario, some for many weeks, we were advised that the government had accepted the offer of assistance from the Canadian Armed Forces.

OH was notified that the province was accepting support from the Canadian Armed Forces and asked to provide a list of homes from which five homes would be selected for support.

The Ontario Health regions were asked to submit homes that were in greatest need on that day in those areas. A list was compiled and reviewed with each regional lead to identify homes in the greatest need, a very difficult selection given the number of homes that were in significant need at that time.

There were no restrictions on what homes could be put forward. No location restrictions, geography or otherwise. However, we were advised that the larger homes would benefit more from the efforts of the Canadian Armed Forces just given the number residents and therefore the number of staff needed to support care.

As such, smaller homes were not

selected, and it should be noted that while the Canadian Armed Forces was one important aspect of the team support that was going in, all regions were working with hospitals, as we've mentioned before, and other partners locally to support homes in need.

Five homes were then selected for support. In the Central Region, Hawthorne, Eatonville, and Holland Christian Manor.

And in East Region, a home -- Altamont and Orchard Villa that we mentioned earlier.

The long and short lists were provided to the Ministry of Long-Term Care and the incident management structure that had been set up by that time for their further consideration. No changes were made to the selection of five homes that we put forward.

Once the list was confirmed, Ontario Health reached out to all five homes to make them aware and confirm their support to receive the support of Canadian Armed Forces.

An Ontario Health lead was identified that, would be me, and began working with the Canadian Armed Forces as a liaison for the work with the homes in Ontario.

We worked with the CAF and the homes to schedule recognizance visits, liaised with the Canadian Armed Forces on the work throughout, and support the Canadian Armed Forces management of the work through regular check-ins and updates.

As homes became stable, we worked with the Canadian Armed Forces to have them exit the homes and report provincially and federally who were asked to seek further support to keep the Canadian Armed Forces in Ontario longer than they had originally planned.

Over all, the Canadian Armed Forces supported seven homes in Ontario with two additional homes being supported after they had left two of the original five.

The first five began their supports in early April and ended some time in mid-June. And the last two homes, Downsview and Woodbridge, both began on June 1st. And the last of those two, Woodbridge, the Canadian Armed Forces left in early July.

I then go on to talk about Ministry orders, and I'm going to just quickly read through it. I think we've covered off most of it, but I want to make sure I didn't miss anything.

I just want to be sure. Yeah, I think I've covered off everything. I'll just quickly talk about the orders.

The first of the orders that you see on that list were in late May for a River Glen Home and Southlake Hospital and Downsview Home, a long-term care home, and the Humber Regional Hospital.

Between late May and mid-June, several more voluntary management contracts or volunteer orders were put into place for another seven homes. many that had struggled to stabilize after outbreak, including several of the CAF homes -- Eatonville, Orchard Villa, Hawthorne, and Altamont -- continued to be supported by their hospital partners long after the Armed Forces had left.

These homes that have been supported by the Armed Forces were also reported on in late May in the CAF observations report which, as you know, was released on May the 25th.

These tools remain valuable for hospitals to enable them to oversee the operations of the home and step into lead the recovery of the homes, stabilizing staff, implementing training,

and so forth.

Though many other homes have hospital partners supporting them, these homes benefitted from that extra oversight and leadership. Most of the management orders have concluded. A number more have started since we put this slide together.

But regardless of having exited the original management orders, all the hospitals to your early questions remain partnered with those homes.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Brown, is it possible to get an order that is one of those orders or so we can see, you know, what the actual order looks like?

U/T CATHERINE BROWN: Certainly. We'll work with Mr. Mathai and get you one of those. They are a Ministry of Long-Term Care order, but that shouldn't be a problem. We'll get it other over to you.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CATHERINE BROWN: I would suggest, just to add to that, there are two types. One is mandatory; one is voluntary. So we'll try and get you a copy of both of those.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

Commissioner Kitts?

COMMISSIONER KITTS: Yeah. Just to follow up, so the local Public Health officer has the authority to write an order compelling a hospital and long-term care to work together.

These long-term care orders, are they one-sided? Are they compelling the long-term care home to let the hospital in, or is it an order that compels both partners to get together and fix things up?

CATHERINE BROWN: It's a little bit of both, but the emphasis is on the home. So the home is required to let the hospital come in, and the authority then goes to the hospital to oversee the home.

Obviously the hospitals are an interested party in the contract, and so that's why they review the contract and look at the implications for them as an organization in taking on that responsibility. But the order is to the home or the operator of the licensee, yeah.

COMMISSIONER KITTS: Thank you.

CATHERINE BROWN: That concludes my

portion of the remarks. I'll turn it over to Mr. Anderson to wrap up.

MATTHEW ANDERSON: Great. Thank you, Ms. Brown. So just a couple of quick comments from me, Commissioners. First is just to acknowledge -- I want to acknowledge that today our presentation has been focussed on Ontario Health and Ontario Health contributions.

In no way would we want to suggest that all of this has been done with Ontario Health solely. This has all been done through tremendous partnerships with our Ministry colleagues; our colleagues at the Public Health Ontario; and, on a really high level, tremendous partnerships with our Public Health units; hospitals; many other players; our Indigenous Primary Health Care Council; and others who -- so just to say this is a great partnership effort. Today we just spoke about our role in the work that was done.

We also -- just for the -- you may not have felt it, but we did try to be brief on the things that we had done or contributed to with respect to the response to COVID.

We did not talk about, for instance, the work that we contributed to -- with respect to

digital infrastructure in the rapid expansion and use of virtual care.

Over the summer, we've continued to worked with our colleagues and partners all across the health system to help plan for Wave 2. And notwithstanding that work, we continue to see the impact of rising case numbers and outbreaks within -- as we head towards a Wave 2 in Ontario, and we're still very much engaged in all of those steps and processes in Ontario's response to COVID. So thank you again for this opportunity to speak with you today.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, thank you all very much.

Angela? Ms. Coke? Commissioner Coke?

COMMISSIONER COKE: Sure. I'm assuming, you know, these strategies continue, the ones you used in Wave 1 for Wave 2.

Is there any additional things that you're thinking of or doing for Wave 2 that you may not have done in Wave 1 or any gaps that you see need to be filled or done differently than the first go-around?

MATTHEW ANDERSON: Maybe, Catherine, do you want me to -- I'll make a few comments.

Catherine Brown: Sure.

MATTHEW ANDERSON: And then please join in. So I would say, by and large, much of what we've talked about today, particularly as it relates to long-term care, does continue.

And I would say that are our homes are in a different place than they were in the summer particularly when it comes to areas like IPAC as it refers to the PPE. You know, the supply chain work that we described earlier on, that has all stayed in place from a distribution perspective. The lab network has been placed from a functional perspective. So mainly those pieces are there.

I would say that, as Ms. Brown referenced in her talk around HHR, there's still much work to do with respect to HHR and ensuring that we have the resources and the right types of resources in place.

Again, to Ms. Brown's point, that issue started before the pandemic, and so solving it even during a pandemic is a bit of a challenge. So work continues with respect to that area. So some work still to be done. A lot of what we've described has continued into our preparations for Wave 2.

Catherine, anything else you want to

highlight there?

CATHERINE BROWN: Just emphasize that on the infection prevention and control, we have been working with the Ministry of Health and our partners at the Ministry of long-term care.

We have identified sort of hubs across the region, numbers of them, that will be working with all congregate settings, not just long-term care homes, but requirement homes, group homes, other congregate settings that may need support in infection prevention and control.

The Ministry is moving forward with some announcements about funding for the spokes as well so that those homes on the receiving end can get some resources to help build their capacity in infection prevention and control. So it's taken what was a volunteer effort and is formalizing it a bit more.

We still see that need for a real build on the -- in some long-term care homes. They just don't have that capacity, and IPAC resources, generally, are not easy to find. And so we're looking at how we can expand that with extenders and other training.

There have been a number of training

pieces put in place to try and help homes with that as well. And these hubs, we think, will help in extending that capacity. So it's just one more tool that -- yeah.

COMMISSIONER COKE: Thank you.

CATHERINE BROWN: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you again. And with your permission, we may come back to you with further questions as we get more familiar with what we're doing.

MATTHEW ANDERSON: Of course. It would be our pleasure. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. Bye-bye.

CATHERINE BROWN: Thank you.

MATTHEW ANDERSON: Bye for now.

-- Adjourned at 4:00 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, 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 30th day of September, 2020.

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