

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.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9

10 Matthew Anderson, President and CEO, Ontario

11 Health;

12 Ashley Dent, Acting General Counsel, Ontario

13 Health;

14 Jeffrey Simser, Legal Director, Agencies;

15 Catherine Brown, Interim Executive Lead, Health

16 System Performance and Support, Ontario Health.

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18

19 PARTICIPANTS:

20

21 Alison Drummond, Assistant Deputy Minister,

22 Long-Term Care Commission Secretariat;

23 John Callaghan, Counsel, Long-Term Care Commission

24 Secretariat;

25 Derek Lett, Policy Director, Long-Term Care

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

13
14 ALSO PRESENT:

15
16 McKaya McDonald, Stenographer/Transcriptionist.
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1 -- Upon commencing at 2:00 p.m.

2

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So I just want to thank you all for taking the time
5 to meet with us.

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

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

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

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

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

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

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

10 MATTHEW ANDERSON: Wonderful.

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

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

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

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

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

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

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

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

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

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

25 As you will hear, we have multiple

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

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

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

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

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

23 So next slide please, Janice.

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

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

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

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

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

22 Go to the next slide, Janice.

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

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

8 12 of those 13 board members are also
9 cross-appointed again by the Lieutenant Governor in
10 Council to each of the 14 LHINs and, again, are
11 accountable to the Minister of Health.

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

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

21 We can go to the next slide.

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

1 Care Act that gives Ontario Health its legislative
2 authority.

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

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

18 Jeff?

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

25 And they are separate corporate

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

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

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

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

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

1 governance framework that Ashley's already
2 described.

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

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

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

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

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

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

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

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

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

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

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

6 JEFFREY SIMSER: Sure.

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

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

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

15 ASHLEY DENT: Correct.

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay. Anything we can do to help you, Mr. Mathai.
24 Carry on, please.

25 MATTHEW ANDERSON: Great. Thank you.

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

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

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

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

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

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

1 new agency from that respect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Ontario Health created travel screening

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

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

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

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

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

25 Ontario Health distributed and

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

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

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

12 CATHERINE BROWN: Yes.

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

15 CATHERINE BROWN: Absolutely.

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Sure.

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

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

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

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

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

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

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

4 Does that --

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

7 CATHERINE BROWN: Yes.

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

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

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

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

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

1 CATHERINE BROWN: Not at that point,
2 no.

3 COMMISSIONER KITTS: Okay. Thank you.

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

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

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

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

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

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

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

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

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

1 response.

2 Matt?

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

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

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

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

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

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

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

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

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

25 Some had a rich history and were

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

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

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

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

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

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

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

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

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

1 Across our broad regions, more than
2 2 million visits have been made to assessment
3 centres with individuals returning more than once.
4 To date, assessment centres have performed over
5 2 million COVID-19 tests.

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

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

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

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

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

6 If we can move to the next slide.

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

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

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

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

25 Through this time, Ontario Health also

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

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

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

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

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

1 limited capabilities and expertise on accessing
2 much-needed PPE.

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

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

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

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

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

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

12 Next one, please.

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

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

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

1 there?

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

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

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

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

22 COMMISSIONER KITTS: Yes. Thank you,
23 Catherine.

24 CATHERINE BROWN: Thanks.

25 MATTHEW ANDERSON: Great. Thank you.

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Mr. Anderson, excuse me for interrupting. I was on
5 mute when I was trying to --

6 The 457 homes -- and we've heard at
7 different times that there's approximately 626 or
8 25 homes in Ontario.

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

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

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

20 MATTHEW ANDERSON: Absolutely, yes.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Yeah, okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Provincial Diagnostic Network.

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

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

12 I'm going to stop --

13 Oh, yeah, Dr. Kitts?

14 Oh, you're on mute, Jack.

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

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

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

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

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

9 COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 work underway.

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

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

13 CATHERINE BROWN: Yes.

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

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

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

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 So is the view that that was a successful
12 deployment of -- or a successful initiative?

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

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

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

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

6 Commissioner Coke?

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

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

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

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

25 There are physicians that provide

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

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

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

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

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

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

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

1 ongoing relationship.

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

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

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

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

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

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

1 Do you have adequate health and human resources?"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 CATHERINE BROWN: Another excellent
12 question. So they --

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

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

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

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

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

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

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

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

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

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

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

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

21 MATTHEW ANDERSON: Right.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Right.

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

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

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

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

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

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

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

1 and the long-term care needs them.

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

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

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

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

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

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

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

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

19 MATTHEW ANDERSON: I would -- maybe --

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 No, sorry.

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

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

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

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

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

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

18 CATHERINE BROWN: Correct.

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

21 MATTHEW ANDERSON: M-hm.

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

1 CATHERINE BROWN: Correct.

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

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

9 Sorry, Matt, you were going to say
10 something?

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

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

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

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

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

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

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

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

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

1 home, she took that measure.

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

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 And I guess there's no -- I guess a directive or
9 something would be helpful in over --

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

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

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

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

25 Can you just avoid all of that and

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

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

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

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

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

1 MATTHEW ANDERSON: M-hm.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 -- wouldn't it be a good idea to establish those
4 relationships as part of everybody's way of doing
5 things?

6 CATHERINE BROWN: Yeah.

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

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

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

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

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

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

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

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

22 MATTHEW ANDERSON: Absolutely.

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

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

3 CATHERINE BROWN: It's okay.

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

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

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

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

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

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

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

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

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

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

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

1 Mr. Anderson just said.

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

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

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

11 CATHERINE BROWN: Absolutely.

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

14 CATHERINE BROWN: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 we had gather in the previous outreach.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 available and willing to work in homes.

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

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

11 COMMISSIONER COKE: Catherine?

12 CATHERINE BROWN: Yes, Angela.

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

16 CATHERINE BROWN: Yes, it is.

17 COMMISSIONER COKE: To the same extent?

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

1 currently qualified; they have to be
2 recredentialled.

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

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

12 COMMISSIONER COKE: Okay.

13 CATHERINE BROWN: Sorry, yes. Go
14 ahead.

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

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

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

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

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

13 COMMISSIONER COKE: Right.

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

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

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

25 So the person would work. They would

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

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

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

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

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

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

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

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

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

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

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

24 Matt, were you going to respond? No?
25 We'll take that advice back. I

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

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

12 Okay.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Please do.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 As such, smaller homes were not

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and so forth.

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

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Okay.

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay.

3 Commissioner Kitts?

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

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

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

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

24 COMMISSIONER KITTS: Thank you.

25 CATHERINE BROWN: That concludes my

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

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

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

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

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

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

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

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 All right. Well, thank you all very much.

15 Angela? Ms. Coke? Commissioner Coke?

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

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

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

1 Catherine Brown: Sure.

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

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

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

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

25 Catherine, anything else you want to

1 highlight there?

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

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

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

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

25 There have been a number of training

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

5 COMMISSIONER COKE: Thank you.

6 CATHERINE BROWN: Thank you.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Well, thank you again. And with your permission,
9 we may come back to you with further questions as
10 we get more familiar with what we're doing.

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

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

15 CATHERINE BROWN: Thank you.

16 MATTHEW ANDERSON: Bye for now.

17 -- Adjourned at 4:00 p.m.
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1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, CSR, Certified
4 Shorthand Reporter, certify:

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

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

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 30th day of September, 2020.

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