

# Long-Term Care COVID-19 Commission Meeting

Medical Update Panel  
on Thursday, March 4, 2021



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom Videoconferencing, with all
15	participants attending remotely, on the 4th day of
16	March, 2021, 11:03 a.m. to 1:02 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Commission Chair

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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9 PRESENTERS:

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11 MEDICAL UPDATE PANEL:

12 Dr. Allison McGeer, MD, FRCPC, Infectious Disease

13 Consultant, Sinai Health System; Professor,

14 Departments of Laboratory Medicine and Pathobiology

15 and Dalla Lana School of Public Health, University

16 of Toronto; Sinai Health

17 Dr. Nathan Stall, MD, FRCPC, Geriatrics and

18 Internal Medicine, Sinai Health and the University

19 Health Network Hospitals; Research Fellow,

20 Departments of Medicine and Health Policy,

21 Management and Evaluation, University of Toronto;

22 Sinai Health

23 Dr. Hugh Boyd, MD, CCFP(COE), Chair of the Section

24 on Long-Term Care and Care of the Elderly; Ontario

25 Medical Association

1 Dr. Samir Sinha, MD, DPhil, FRCPC, AGSF, Director  
2 of Geriatrics, Sinai Health System and the  
3 University Health Network; Director of Health  
4 Policy Research, National Institute on Ageing;  
5 Sinai Health System and the University Health  
6 Network; National Institute on Ageing  
7 Dr. Jennie Johnstone, MD, PhD, FRCPC, Infection  
8 Prevention and Control Medical Director, Sinai  
9 Health; Infectious Disease Physician, Sinai Health  
10 and University Health Network; Associate Professor,  
11 Department of Laboratory Medicine and Pathobiology,  
12 University of Toronto; Associate Professor, Dalla  
13 Lana School of Public Health, University of  
14 Toronto; Sinai Health.

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17 PARTICIPANTS:

18 Alison Drummond, Assistant Deputy Minister,

19 Long-Term Care Commission Secretariat

20 Ida Bianchi, Senior Legal Counsel,

21 Long-Term Care Commission Secretariat

22 Kate McGrann, Co-Lead Commission Counsel,

23 Long-Term Care Commission Secretariat

24 Derek Lett, Policy Director, Long-Term Care

25 Commission Secretariat

1 Dawn Palin Rokosh, Director, Operations,  
2 Long-Term Care Commission Secretariat  
3 Jessica Franklin, Policy Lead, Long-Term Care  
4 Commission Secretariat  
5 Alain Daoust, Team Lead, Long-Term Care Commission  
6 Secretariat  
7 Adriana Diaz Choconta, Senior Policy Analyst,  
8 Long-Term Care Commission Secretariat  
9 Angela Walwyn, Senior Policy Analyst, Long-Term  
10 Care Commission Secretariat  
11 Angeline Hawthorn, Senior Policy Analyst, Long-Term  
12 Care Commission Secretariat  
13 Rose Bianchini, Senior Policy Analyst, Long-Term  
14 Care Commission Secretariat  
15 Angela Walwyn, Senior Policy Analyst,  
16 Long-Term Care Commission Secretariat  
17 John Callaghan, Co-Lead Commission Counsel, Gowling WLG  
18 Lynn Mahoney, Counsel, Gowling WLG  
19 Michael Finley, Counsel, Gowling WLG  
20 Patricia Brooks, Counsel, Gowling WLG  
21  
22  
23  
24 ALSO PRESENT:  
25 Judith M. Caputo, Stenographer/Transcriptionist

1                   JOHN CALLAGHAN: So, Commissioners,  
2 today we have an esteemed panel of medical experts,  
3 most of whom have appeared before you in the past:  
4 Dr. Stall and Dr. Sinha, who are in the geriatric  
5 field; Dr. Johnstone and Dr. McGeer, who are on the  
6 IPAC field, and whom you've seen before.

7                   We have a new participant, Dr. Boyd,  
8 who I don't believe you have met before.

9                   I wonder, Dr. Boyd, if you can just  
10 give a short introduction as to what your field of  
11 practice is.

12                  DR. HUGH BOYD: I'm a Care of the  
13 Elderly Physician, I'm kind of a cross between a  
14 family doc and a geriatrician. I'm not as well  
15 trained as my esteemed colleagues here, but I  
16 practice full-time long-term care. This is all I  
17 do; it is my bread and butter.

18                  I'm a medical director of two homes and  
19 chief of staff [inaudible] but that also has  
20 long-term [inaudible].

21                  We have met before. I presented the  
22 recommendations from the Ontario Medical  
23 Association, and also the Ontario Medical  
24 Association Section.

25                  JOHN CALLAGHAN: I may have missed

1 that, so my apologies.

2 So, as I indicated, this is an  
3 opportunity for our esteemed colleagues to tell us  
4 where we are now that the Commission is winding  
5 down. It's oral presentations, and for the  
6 Commissioners, as needed, to ask whatever  
7 questions. There is no set format.

8 Dr. Stall and I, and the others met  
9 last night. And I think Dr. Stall agreed to take a  
10 shot at figuring out where to go. I'm not sure  
11 what's on the screen...

12 DR. NATHAN STALL: I just put up the  
13 sort of roadmap that we had drafted last night.

14 JOHN CALLAGHAN: All right. So do you  
15 want to lead off then, Dr. Stall, and get everybody  
16 engaged? I can hop in as a commissioner as well.

17 Before you do, I should say on the  
18 record, that there were two reports which I sent  
19 around, a science table report that Dr. Stall and  
20 his group did; and then Dr. Sinha's group at  
21 Ryerson has published some additional stuff, and I  
22 believe he's got some more stuff coming. And they  
23 all know that we have deadlines, and if they update  
24 their material, they'll send it along.

25 Go ahead, Dr. Stall.

1 DR. NATHAN STALL: First I'll thank  
2 you, Commissioners, for having us here again and  
3 thanks for all the work you've been doing over the  
4 last several months, with all the very important  
5 interim recommendations that you've issued.

6 We hope we can provide you with some,  
7 you know, more contemporary perspectives on what  
8 has evolved since each of us have last presented to  
9 you, in a more general sense, sort of clinical  
10 lessons, or lessons that we have all learned  
11 providing both clinical care and support in many  
12 different roles to long-term care homes during the  
13 pandemic.

14 Since you are aware of the science  
15 table brief, but just, you know, I know one of the  
16 questions that John and I had talked about was sort  
17 of where are we now in terms of the pandemic with  
18 respect to long-term care homes and how has, you  
19 know, particularly the tail end of the second wave  
20 been different compared to the first wave.

21 So I'll just set the context with that,  
22 which is we have now, thankfully, reached a point  
23 where we've seen a dramatic drop-off, as I'm sure  
24 you're aware, in cases among residents, staff, in  
25 long-term care homes, a dramatic plummeting of

1 outbreaks and, thankfully, a flattening of deaths.

2 Which is due to a combination of both  
3 declining transmission in the community, and also  
4 very good vaccine uptake among long-term care  
5 residents, over 90 percent.

6 The uptake among staff has been less,  
7 not as good, it's at about 55 percent. But, you  
8 know, that did take nine weeks to get that, and I  
9 know you've heard presentations on the speed of the  
10 vaccine rollout. But what we do know from wave 2  
11 is that wave 2, unfortunately, had a death toll, as  
12 of March 3rd, 2021 of 1,897 residents who have  
13 died. So we've surpassed that wave 1 death toll.

14 And so just to remind you, wave 1 went  
15 up to August 31st. Wave 2 started September 1st.  
16 We consider it ongoing. No one has really  
17 established when wave 3 is going to start. It's  
18 probably going -- starting, we're in a grey area  
19 now between wave 2 and wave 3, but we unfortunately  
20 eclipsed that wave 1 death toll.

21 There were some important differences,  
22 as we'll get into, between wave 1 and wave 2. And  
23 the science brief that we've provided you with  
24 outlines that there were some very different  
25 features of wave 2 compared to wave 1 that, you

1 know, the growth in resident cases. It was more  
2 stretched out over time is the best way I would  
3 qualify it.

4 In the first wave, and particularly end  
5 of March and really in April, we saw an explosion  
6 within the sector.

7 Here we had more protracted cases that  
8 stretched over months. Really, the bulk of it  
9 happening -- picking up at the beginning of  
10 November, and then lasting through mid-January,  
11 until we could get decent vaccine uptake among  
12 long-term care residents.

13 There are some caveats, but we saw that  
14 the case fatality rate, so the number of residents  
15 who had COVID-19 and then went on to die, did  
16 decrease a bit.

17 I think some of these things, as we'll  
18 get to, are related to -- not fully, and there are  
19 many forms of incompleteness -- but some  
20 improvements in the sector as it pertains to  
21 understanding of the disease, some -- and again,  
22 very incomplete improvement in infection prevention  
23 and control. There's a lot that we'll get to on  
24 that topic.

25 And also, really, I would say

1 improvements in terms of clinical care that, in  
2 terms of earlier recognition of cases, and we saw  
3 some of that actually still fall apart towards the  
4 end of the second wave.

5 So there were some improvements, but  
6 certainly, the overall sector did fall short and  
7 did reach that point of eclipsing that first wave  
8 death toll.

9 So that sort of sets the stage for the  
10 things that we wanted to talk about. And we've  
11 assembled a group of individuals who can speak to a  
12 lot of, you know, what were the lessons learned?  
13 Why did we fail twice, essentially, where there was  
14 such a catastrophic number of deaths in wave 1; how  
15 could they not be prepared, and what was not fully  
16 prepared that allowed the sector to not repeat its  
17 mistakes of wave 1?

18 COMMISSION CHAIR FRANK MARROCCO: Before you  
19 start, I think one of the things that I'm  
20 interested in is why a sector -- if the conclusion  
21 is the sector wasn't as prepared for wave 2 as it  
22 should have been, I'm curious about why, why that  
23 is. Let's leave it at that.

24 DR. NATHAN STALL: Dr. McGeer, you had  
25 pretty poignant thoughts about that last night. Do

1 you mind starting that off?

2 DR. ALLISON McGEER: No, I'm happy to  
3 do that.

4 I think everybody, and I don't think  
5 this is a sector issue, I think this is broadly  
6 across government, and physician leads in  
7 hospitals, and the sector itself. I think  
8 everybody believed, as tends to happen, that the  
9 improvements made after wave 1 were going to  
10 stabilize the sector and made it okay. And that  
11 applied even to some of my colleagues in infection  
12 prevention and control.

13 Most of us, I think, who are more  
14 experienced in infection control, and know how deep  
15 the inadequacies are in the system, I think, looked  
16 at it and were confident that that (A) it is not  
17 possible to change the behaviour of 75,000 staff  
18 members who, generally speaking, have deeply  
19 inadequate training and education in a four-month  
20 period. You're not going to change culture in an  
21 entire sector in that period of time.

22 And (B) a number of proposals went to  
23 the Ministry about what could be done; and all of  
24 them were deemed by the Ministry to be too  
25 expensive.

1                   And I think, in fairness to the  
2 Ministry, because the Ministry also thought that  
3 this problem had been solved, and they didn't think  
4 they needed to spend the money in order to do this.

5                   But I believe a piece of the discussion  
6 we had last night was Québec hired, you know, put  
7 infections control people in place, they hired a  
8 large number of additional staff. We chose not to  
9 do that in Ontario. And I do think that people  
10 were substantially better prepared for the second  
11 wave. I do think things went better for a while,  
12 but then the further we got into the second wave,  
13 the deeper the problems got.

14                   You know, people had, you know,  
15 additional staffing plans for how they were going  
16 to manage outbreaks. They had people that they  
17 could move from one facility to another to provide  
18 support; and that was fine, until there were 37  
19 outbreaks going on at the same time. And then when  
20 there were 37 outbreaks going on at the same time,  
21 everything just fell completely apart again.

22                   I don't think we could have fixed wave 2.  
23 I think the issues were too big to be solved in  
24 that four-month period. But I also think that  
25 there were a number of things that we chose not to

1 do, because pretty much everybody got fooled into  
2 thinking that it was going to be okay in the second  
3 wave.

4 COMMISSION CHAIR FRANK MARROCCO: If I  
5 can just interrupt for a minute.

6 When you say "the Ministry", Ministry  
7 of Health, Ministry of Long-Term Care, both? Which  
8 Ministry is telling you, is saying, you know, we  
9 think it's too expensive, or we think it's  
10 basically fixed?

11 I just wasn't sure, because you said  
12 "the Ministry".

13 DR. ALLISON McGEER: So the people I  
14 heard from were both Ministry of Health people and  
15 Ministry of Long-Term Care people. For me, a lot  
16 of this is secondhand.

17 I know, for instance, that a proposal  
18 went in from hospitals in Toronto for mechanisms to  
19 provide support for long-term care. I think that  
20 went into the Ministry of Health and was rejected.

21 So I can't tell you specifically about  
22 who in those organizations.

23 COMMISSION CHAIR FRANK MARROCCO: No,  
24 no, I wasn't asking for -- I just wanted to get a  
25 sense of whether it was the Ministry of Health, the

1 Ministry of Health Long-Term Care, or both.

2 DR. ALLISON McGEER: I think it was  
3 predominantly the Ministry of Health, but it  
4 possibly could be both.

5 DR. NATHAN STALL: You gave three  
6 specific suggestions of proposals that were put  
7 forward that may have been suggested that weren't  
8 acted upon. Can you be specific about that?

9 DR. ALLISON McGEER: So the most  
10 detailed one that I know about was a proposal for  
11 hospitals to support long-term care facilities  
12 through the second wave.

13 But I think Dr. Stall and Dr. Brown  
14 also put forward a number of proposals for trying  
15 to empty out the four-bed rooms, so that we didn't  
16 have three or four residents in a room throughout  
17 the second wave.

18 We talked, there was at least  
19 discussion, about systems for moving -- as Hong  
20 Kong and Israel did -- for moving positive patients  
21 out of long-term care or maybe even exposed  
22 patients out of long-term care.

23 I don't know how far any of those  
24 discussions went with the Ministry, but I think the  
25 sense among my IPAC colleagues was that there

1 probably wasn't much point in trying to push those  
2 forward, because there was no hope that anything  
3 that cost that amount of money was going to be  
4 undertaken.

5           JOHN CALLAGHAN: Dr. Sinha, could you  
6 also tell us your efforts? And could you also  
7 perhaps tell us what went on in Québec, because I  
8 know your recent article touches a little bit on  
9 perhaps the differences between what went on in  
10 Québec and Ontario.

11           DR. SAMIR K. SINHA: Yes. I think it's  
12 at the fundamental piece, again, we're talking  
13 about a pandemic, we're talking about infection  
14 prevention and control.

15           I think one thing that I realized, when  
16 you start looking at influenza and respiratory  
17 outbreaks, we know that, actually, if you look at  
18 the last five years of data from Public Health  
19 Ontario, for example, we know that long-term care  
20 homes have, on average, three and a half times the  
21 number of respiratory outbreaks in a given year  
22 that retirement homes will have, where people are  
23 living in individual rooms. They're less frail.  
24 They're less likely to be each receiving hands-on  
25 care.

1                   But it really tells you that long-term  
2 care homes, this is not a COVID thing. This is  
3 actually, you know, like an overall -- a story of  
4 IPAC, really. And the need to recognize that in  
5 these sorts of congregate settings, this is where  
6 you're going to have these issues that really need  
7 to be top of mind.

8                   Just as much as we think about, you  
9 know, other forms of resident-centred and  
10 family-centred care, it really has to be  
11 underpinned. Because it's almost that we've  
12 normalized, on an annual basis, kind of the fact  
13 that every fall and winter, we will lose a few  
14 thousand people, because that's what happens. Flu  
15 comes in, it gets a bunch of people, and we just  
16 fill the beds with new people, and then the cycle  
17 starts again.

18                   And really it was, I think, you know,  
19 places like BC, in particular, that actually  
20 created a mechanism, so that as soon as a home in a  
21 health authority had an outbreak, you literally had  
22 Public Health at the door on day one. You had PPE,  
23 you had actual additional management and support.

24                   I think Hugh can speak to this, about  
25 that importance of good, solid medical direction.

1 You know, people who actually understand how  
2 long-term care works. "What can we do? You tell  
3 us what you need, so we can fill it in." As  
4 opposed to the home slowly falling into collapse  
5 until, all of sudden, seven ambulances arrive at  
6 the door of Mount Sinai and we're saying, "Oh,  
7 something must be going on at Home X today."

8 We talk about IPAC, for example, and I  
9 think to build -- and Dr. McGeer and Dr. Johnstone,  
10 they will always be good at telling me when I  
11 haven't quite hit the mark on this. But I think,  
12 you know, understanding that we already had  
13 fundamental issues, I would say, in IPAC to begin  
14 with, as a baseline.

15 Then I think, you know, to Dr. McGeer's  
16 point is, I think by the end of the summer, people  
17 thought that, well, our inspectors now, they're  
18 going in and asking about your PPE supplies.  
19 They're now asking. And we now have PPE, so we  
20 fixed that fundamental issue. Because wasn't it  
21 just a lack of PPE? And now that we have it,  
22 that's great.

23 And we now have all the staff watching  
24 videos, right? So if you watch a video and you  
25 have IPAC, you're good to go.

1           So, really, when the Ministry made an  
2 investment, you know, to Dr. McGeer's proposal,  
3 there were several good ideas being approached.  
4 One being kind of, I believe, the Québec model,  
5 saying: We should have an infection prevention and  
6 control team in every single home. That was the  
7 same proposal that was made in Québec. That was  
8 the same thing that was funded.

9           Québec was interesting because, again,  
10 they not only funded a dedicated IPAC team for  
11 every home; and that might be a lead, like someone  
12 dedicated to a care home. They didn't mandate that  
13 for the retirement homes. They said that that was  
14 more of an optional piece. But for their long-term  
15 care homes, they said, no, you have to have a team  
16 there, period. And you have to have that.

17           Number two, IPAC with PPE means  
18 nothing, in my view, unless you have stable and  
19 adequate staffing. And I think this was the  
20 challenge that, I think, didn't get paired up.

21           So (A) you have the piece on IPAC. But  
22 the staffing piece, again, was something that, you  
23 know, say a province like, for example, Québec also  
24 recognized.

25           You had the Premier of Québec in May

1 saying, "Where did all the workers go?" They lost  
2 10,000 frontline PSWs by the end of wave 1.

3 Ontario, similarly, if you talk to our  
4 colleagues at the Ontario Long-Term Care  
5 Association, AdvantAge Ontario, a lot of staff left  
6 the sector. Agency employments start to skyrocket,  
7 if you will, for a variety of reasons, for example.  
8 But staffing wasn't stabilized by the end of this.

9 Staffing was already a problem, as the  
10 Commissioners know, pre-pandemic. And by the end  
11 of wave 1, you had a lot of people who lost trust,  
12 who didn't feel protected by the system, who left,  
13 for example. And then homes that have lots of  
14 money to hire people, but in fact, they were  
15 struggling to hire.

16 So what was different about Québec's  
17 approach, which I think the Commissioners know, is  
18 that they actually said, "We're going to hire  
19 10,000 new people." They announced that in May.

20 They had 79,000 applications. And they  
21 took away the barriers to training. They realized  
22 that most of these people who are going take this  
23 are low-income people, who may have other  
24 caregiving and other needs as well, that they can't  
25 afford an exorbitant tuition fee. That if you're

1 going to take time out to get trained, what are you  
2 not doing? What other employment are you giving  
3 up?

4           So by paying for people to get their  
5 training done, by thinking about those barriers,  
6 they were able to get just over 7,000 people on the  
7 frontline by September. And by October, they had  
8 about 8,000 new frontline PSWs there who were  
9 full-time, who were actually trained in a IPAC,  
10 because that was part of the training there. And  
11 all of a sudden, with that combination of good IPAC  
12 support, dedicated people who actually belonged to  
13 the home, were part of the home team; were all  
14 singing from the same hymnbook, that was important.

15           Because as wave 2 went on, and as homes  
16 continued to experience outbreaks and have those  
17 spectacular collapses in care, when you have a  
18 whole bunch of staff off, what do you rely on? You  
19 rely on agency staffing; you try and work with  
20 that. But a lot of the new agency models that were  
21 popping up were, especially in a gig economy, where  
22 you don't want to get caught in the legal issue  
23 that if you treat them like employees, you might  
24 actually have to pay them like employees.

25           So we literally have some agency

1 workers where I could actually sign up for this  
2 PSW shift on an app, I'll get paid, say, \$35 an  
3 hour versus the \$29 I might get at the highest  
4 unionized rate. So I'll get 35 bucks an hour. And  
5 what it tells you is, "bring your own PPE". I was  
6 calling it, saying like "BYOPPE". You know, "bring  
7 your own PPE" to the party.

8           And I'm like, that makes no sense at  
9 all. Because again, if I show up and I say,  
10 "Hey, Jennie, hey, Allison, I'm here to work the  
11 shift and I brought my own goggles that I got off  
12 of Amazon, and I've got this and that," and I don't  
13 even know how they've been trained in that sort of  
14 support. It just really kind of was creating too  
15 many loopholes that weren't doing this.

16           But I think it's (A) the combination of  
17 staffing; fixing the staffing issues. And these  
18 are two concrete things that I believe could have  
19 been adequately done over the summer. And for  
20 everybody who says they couldn't be, I just say,  
21 "look at la belle province next door". And you can  
22 see they really addressed those two issues.

23           COMMISSION CHAIR FRANK MARROCCO: Can I  
24 stop you for a second?

25           DR. SAMIR K. SINHA: Thank you.

1                   COMMISSION CHAIR FRANK MARROCCO: No,  
2 no, I wasn't doing it for that reason.

3                   The distinction has been made by people  
4 who have appeared here, where there's been a  
5 reference to Québec, to the fact that they were  
6 orderlies and not PSWs.

7                   Is there a difference in Québec between  
8 an "orderly" and what we call a "PSW"?

9                   DR. SAMIR K. SINHA: No, Commissioner,  
10 it's the same thing.

11                  COMMISSION CHAIR FRANK MARROCCO: It's  
12 the English translation of the French -- correct me  
13 if I'm wrong -- it's the English translation of the  
14 French word for the person who does what a personal  
15 support worker does here in Ontario that gets you  
16 the word "orderly"?

17                  DR. SAMIR K. SINHA: Yes. And it's the  
18 notion that the term "PSW" is a very Ontario-centric  
19 term.

20                  So I will happily submit to the  
21 Commission something that we developed with PHAC,  
22 through the NIA, which is basically how long-term  
23 care is referred to in every province. And what  
24 that term of "orderly" or "healthcare aide" or  
25 "continuing care aide" or "personal support worker"

1 is referred to as well. Because there's about ten  
2 different names for that same role.

3 But fundamentally, people will say,  
4 "oh, they were orderlies. These were cleaners, if  
5 you will, or housekeepers". No, these were  
6 actually people doing frontline care in that way.

7 COMMISSION CHAIR FRANK MARROCCO: So  
8 the distinction is a distinction without a  
9 difference?

10 DR. SAMIR K. SINHA: Yes.

11 DR. NATHAN STALL: I wanted to bring  
12 Dr. Johnstone in here to talk about sort of what,  
13 specifically, when it came to IPAC measures in her  
14 role specifically as the regional hub for Toronto  
15 and knowledge across the Province that was missed  
16 opportunities between wave 1 and wave 2 and what  
17 the outstanding needs are moving forward.

18 DR. JENNIE JOHNSTONE: Thanks,  
19 Dr. Stall.

20 I would like to back it up even  
21 further, if that's okay with the Commissioners, in  
22 terms of SARS and post-SARS. So coming out of  
23 SARS, for which I was, you know, a trainee at the  
24 time and not in Toronto.

25 But post-SARS, we have PIDAC, which

1 made recommendations for the entire healthcare  
2 sector. So that included both hospitals, as well  
3 as long-term care. And there are recommendations  
4 that have always been, since PIDAC made the  
5 recommendations going back post-SARS, that  
6 long-term care should have approximately one  
7 infection control practitioner for 200 beds.

8           And I just want to spend a moment, and  
9 I know you've heard about what an infection control  
10 practitioner is. But these are trained and  
11 dedicated individuals. This is not something that  
12 somebody does as a role on top of their current  
13 job, and it's not something done on the side of a  
14 desk. Because I can tell you that with every push  
15 and pull, every single crisis, every single thing  
16 that happens in every single day in healthcare,  
17 infection control will always get pushed to the  
18 side; because that's just the nature. Prevention,  
19 working on prevention, it's the thing that gets  
20 tacked on.

21           So that is why the PIDAC best practices  
22 do say that it needs to be dedicated, because if  
23 you do not have a dedicated role, people will not  
24 get to it. So that recommendation has been there  
25 for a very long time.

1                   And for reasons that Dr. McGeer could  
2 probably speak to better than I, the hospitals did  
3 embrace this, and infection control has become  
4 entrenched and is very much core within the  
5 hospital sector.

6                   We knew that this needed to also happen  
7 in the other healthcare sector, and specifically in  
8 long-term care. But, again, I do not know the  
9 history, and I don't know why it is, but it did not  
10 get taken up to the same degree.

11                   So when wave 1 hit, then obviously it  
12 made sense that without that, I guess, capacity and  
13 I would just say philosophy and culture within the  
14 home, that there were going to be problems, and of  
15 course we saw that.

16                   Now, the challenge, of course, is these  
17 are trained individuals, and they don't grow on  
18 trees and they are not everywhere. And so to try  
19 and create that, between wave 1 and wave 2, would  
20 have been very difficult because they just don't  
21 exist. It is going to take us years to grow enough  
22 infection control practitioners who are able to  
23 then be incorporated into the sector.

24                   We did do the IPAC hub-and-spoke model,  
25 and I think you have heard, Commissioners, about

1 the IPAC hub-and-spoke model for which the  
2 hospitals were able to sort of help provide some  
3 capacity and support to the homes. And I do think  
4 that that helps to a certain degree, certainly when  
5 there are outbreaks and when there were specialized  
6 events that were unfolding, and be able to provide  
7 the support also to Public Health. And I think  
8 that that did help in wave 2.

9 But what we were not able to do is  
10 build that prevention and build it all the way  
11 through and change the culture within the home. I  
12 think you've heard that, I mean, the IPAC hub did  
13 not get formally struck until, I think it was  
14 November. So, you know, all of that time in the  
15 summertime, there was perhaps some degree of  
16 prevention building that occurred between IPAC hub  
17 supporting the homes, but it wasn't maximized, in  
18 my opinion.

19 So, again, I think that helped in wave  
20 2, but I think this is a long way. And I guess  
21 when I look to the future, what I hope from all of  
22 this is that we do then internalize the need for  
23 those dedicated infection control practitioners, in  
24 the way that hospitals did after SARS. And I know  
25 there are lots of differences between SARS and the

1 COVID-19 pandemic.

2           However, we know that we need to do  
3 this. We needed to do it in the hospital  
4 post-SARS, we needed to do it in long-term care,  
5 quite frankly, post-SARS. I really hope that post  
6 COVID-19 pandemic, we are able to then fully  
7 integrate that infection control practitioner role  
8 within the long-term care home sector.

9           Whether or not there's a role for the  
10 IPAC hub, I don't know. I think that should be  
11 explored. I think there have been relationships  
12 that have been built, and I do think that they  
13 played a role. But I think what I would see it as  
14 is, you know, just leveraging that capacity and  
15 availability but, truly, the infection control  
16 practitioner has to be within the home and part of  
17 the home, and owned by the home, and on the ground  
18 in the home.

19           And I think that, again, IPAC hubs, I  
20 think many of us would happily continue to play a  
21 role, if that made sense. And I will leave it to  
22 the policymakers to make those decisions, but I  
23 think fundamentally we need those ICPs within the  
24 home.

25                           COMMISSION CHAIR FRANK MARROCCO: Dr. Kitts?

1                   COMMISSIONER JACK KITTS:  Yes.  We  
2 interviewed Dr. Gary Garber, who was Head of  
3 Infection Control in Ottawa after SARS.  And he  
4 talked about four LHINs based on the SARS report  
5 created --

6                   (Interruption in the proceedings due to  
7 connection difficulties).

8                   -- OFF THE RECORD DISCUSSION --

9                   COMMISSIONER JACK KITTS:  Back to  
10 Dr. Johnstone.

11                   So he talked about, it was The Walker  
12 Report, the panel report that recommended the -- at  
13 the time they called it "RICN", which is "Regional  
14 Infection Control Networks".

15                   And it was really to move -- not to  
16 move, but to create IPAC expertise outside the  
17 hospital, where it was all in the academic or  
18 teaching hospitals.  And so it moved into the  
19 community hospitals, and so on.  I guess it didn't  
20 go from there into the long-term care homes.

21                   So I'm kind of -- I'm asking the  
22 question, do these RICNs, or hub-and-spokes exist?  
23 And if they do, is it a natural evolution to take  
24 it from there into the long-term care homes?

25                   And the one other thing I want to add

1 is, I like the term you used as "IPAC practitioners",  
2 because there's a lot of confusion over "IPAC  
3 specialists", "IPAC experts", and they're in  
4 different hospitals, for good reasons. But I think  
5 "practitioners" would be a good term, and I'd like  
6 to get your opinion on that.

7 DR. JENNIE JOHNSTONE: So what I would  
8 share is, I mean, I think it has evolved over time,  
9 and Dr. Garber was the right person to comment on  
10 the role of the RICN, and then following the role  
11 of Public Health Ontario, for which the RICN moved  
12 into Public Health Ontario.

13 And also similarly, the IPAC hub, I  
14 think where we are served best is providing that  
15 mentoring and capacity building. But if you're  
16 asking my opinion, I think we need infection  
17 control practitioners, dedicated infection control  
18 practitioners on the ground.

19 And I don't know that the RICNs were  
20 ever designed to be that. Again, I think it was to  
21 build the IPAC understanding and education, but not  
22 necessarily to be boots on the ground, so to speak,  
23 within the homes. And I think what we're seeing is  
24 there -- I'm sure there will be a role for Public  
25 Health Ontario for the IPAC hubs, but not to be the

1 individuals on the ground. I think we can be  
2 there, however it looks in the future, as support.  
3 But, again, we need that culture change on the  
4 ground, in the homes, just like we need them in the  
5 hospitals.

6 COMMISSION CHAIR FRANK MARROCCO: Can I  
7 just ask before you continue.

8 Who trains them? If you're going to  
9 create them, somebody has got to do the training,  
10 and somebody that has to certify that this is a  
11 trained person that I'm dealing with. How do you  
12 think that should happen?

13 DR. JENNIE JOHNSTONE: I think Dr. McGeer  
14 will be the best person to answer that question.

15 COMMISSION CHAIR FRANK MARROCCO: Okay.

16 DR. ALLISON McGEER: I just want to  
17 weigh in on this, because I think I may have said  
18 to the Commission last September. You know, this  
19 is one of our fundamental problems in infection  
20 prevention and control, which is that infection  
21 control practitioners, or as the Americans call  
22 them, "infection control professionals", there is  
23 no designated training for them.

24 So, if I want a nurse, I hire somebody  
25 who's graduated from nursing school. If I want a

1 public health inspector, I hire somebody who's  
2 graduated from a public health inspector program.  
3 If I want a respiratory therapist, I hire a  
4 respiratory therapist. If I want an infection  
5 control practitioner, I hire one of those other  
6 people, and I spend five years training them how to  
7 be an infection control practitioner.

8           So before I die, we are going to have a  
9 training program for infection control  
10 professionals. But I need to warn you, that  
11 Dr. Andrew Seymour, whose name you may recognize in  
12 infection prevention and control, was going to have  
13 this done before he retired, and he did not manage  
14 to do this. This has been on everybody's agenda  
15 for a long time. But to me, it's a critical piece  
16 of maintaining infection prevention and control,  
17 not just in long-term care, but across hospitals.

18           We need to sort a training program.  
19 There is an American certification for infection  
20 control. So we do have certification, which is  
21 good, but we need to recognize this group of people  
22 as essential to our healthcare system, and to have  
23 a training program developed that will be  
24 functional. Because what we have now is -- we're  
25 doing much better in acute care hospitals, but it's

1 still a struggle in acute care, and moving it out  
2 of acute care is just really hard.

3 COMMISSION CHAIR FRANK MARROCCO: But  
4 my question was slightly different.

5 Who? Community colleges, like who? If  
6 someone said, okay, there should be a program to  
7 create people with the skill, because we need them;  
8 where would that be? Would that be in a community  
9 college? Would the hospital take on, create the  
10 educational materials? I'm trying to understand  
11 who. I understand they need training, but who?

12 DR. JENNIE JOHNSTONE: I mean, there  
13 are courses. I mean, there are courses, through  
14 university and colleges, in terms of the coursework  
15 for infection control.

16 I think what Dr. McGeer is referring to  
17 is almost for the internship portion, and so one of  
18 the challenges is that --

19 COMMISSION CHAIR FRANK MARROCCO: Oh, I  
20 see.

21 DR. ALLISON McGEER: They're  
22 introductory courses, Dr. Johnstone. There's not a  
23 program that somebody can take and walk out and be  
24 competent as a beginner in infection prevention and  
25 control.

1 I think, Justice Marrocco, that it  
2 could either be a community college or a  
3 certificate, like a postgraduate certificate, for  
4 people who already have a nursing degree or another  
5 health professional degree. I think there are --  
6 there are different options, all of which might be  
7 successful.

8 COMMISSION CHAIR FRANK MARROCCO: All right.  
9 Commissioner Coke, you were trying to  
10 ask a question.

11 COMMISSIONER ANGELA COKE: I was just  
12 wondering, what has been the barrier to date to  
13 having this type of program be in place?

14 You talk as if it's been a real  
15 struggle. I'm trying to understand what has been  
16 the barrier to this.

17 COMMISSION CHAIR FRANK MARROCCO: Dr. Boyd,  
18 you wanted to answer?

19 DR. HUGH BOYD: If I may say, this is  
20 all of health professionals' fault. We can look at  
21 talking about blaming staffing on population  
22 change, a few other things, but this is something  
23 we, as health professionals, need to own.

24 I am probably the only long-term care  
25 physician who holds a certificate in IPAC in

1 long-term care for physicians in the province.

2 I am the son of an infection control  
3 nurse who ran a RICN before its funding was cut six  
4 years ago, so I'm unique that way.

5 But, I mean, we've forgotten our  
6 history. It's shameful. And infection prevention  
7 and control is clearly critical, it has been for a  
8 very long time, and will be with emerging  
9 infectious diseases in the future, including  
10 antimicrobial resistance.

11 These programs are out there. They can  
12 be scaled, they can be expanded. And at every  
13 single level, we need help with this. And while  
14 with the survey that the Commission and the OMA  
15 tried to develop and bring forward, while  
16 28 percent agreed we needed dedicated IPAC  
17 professionals, the triad of leadership, the medical  
18 director, director of care and administrator,  
19 probably need to be the most responsible because  
20 this is so critical, it needs to be acted at all  
21 levels. And it doesn't matter if you're a  
22 physician, if you're a nurse, if you're in  
23 housekeeping, we are all saving lives by doing  
24 these basic things.

25 DR. SAMIR K. SINHA: If I can interrupt

1 there. The one thing to add to that, though, I  
2 think two aspects. And again, I'd like my  
3 colleagues to disagree if they do.

4 But I think it's not only thinking  
5 about how do we have a program to train IPAC  
6 practitioners, like a dedicated piece there where  
7 we say, this is a clear certificate; or an  
8 internship in that way that a nurse or another  
9 healthcare professional can do. But there needs to  
10 be funding for this.

11 I think that's Commissioner Coke's  
12 question is: Why isn't this happening? Well,  
13 fundamentally, Dr. Boyd just talked about, well,  
14 his mother was working in a RICN until the funding  
15 got cut, for example.

16 Ultimately, at the end of the day, if a  
17 home -- you know, if I hire -- you know, if I'm  
18 saying, "okay, I need to have an IPAC practitioner  
19 in my home". And I have an excellent nurse, or  
20 someone who would like to take on that role, right,  
21 I have funding available where I can send them to  
22 this course. So that the school of nursing, or the  
23 school of whatever it is, will allow them to  
24 actually do that; because these are the barriers.

25 When Dr. Boyd is doing this, you know,

1 I don't think he received funding. Maybe he did in  
2 an enlightened environment. No, he did this on his  
3 accord. And I'm not saying that the answer is  
4 always that somebody else has to pay for it.

5 But sometimes, if we do value this --  
6 and I think part of the issue, I think why  
7 hospitals have really done a lot better post-SARS,  
8 is because hospitals recognized that we need to be  
9 doing this. And there came with, I believe, some  
10 dedicated Ministry funding, so that hospitals will  
11 be actually creating better structures.

12 I don't think that this is something  
13 that necessarily exists, that I know, in the care  
14 envelope budget, the personal care envelope budget.  
15 I know that, really, the challenge that you have  
16 when it comes to, you know, IPAC measures,  
17 housekeeping, laundry services, environmental  
18 cleaning services, that comes under the other  
19 accommodations envelope, which we know that if  
20 you -- you know, the better you do on squeezing  
21 that envelope, you know, the more potentially you  
22 have money to do other things with.

23 So I do think there needs to be some  
24 dedicated funding to actually support something  
25 like this, where people can actually go get

1 training. There's a mechanism for both physicians,  
2 medical directors; but also, you know, IPAC  
3 practitioners to build those teams out.

4 But I also would just say the other  
5 thing, too, is thinking about, I believe IPAC in a  
6 hospital is different than IPAC in someone's home,  
7 like a long-term care home.

8 So how do you not only think about it,  
9 it's not an IPAC general certificate, but it's  
10 understanding that when 90 percent of our residents  
11 in a care home have cognitive impairment,  
12 60 percent are living with dementia, IPAC is a  
13 completely different story there.

14 And so it's how to actually balance,  
15 you know, that idea of, how do we develop really  
16 good? Because all of a sudden, you take a course  
17 that works in a hospital, and now you're saying,  
18 "Well, everybody is wandering around. What do we  
19 do? How do you do that?"

20 It's getting that additional  
21 understanding of, how do you IPAC in an environment  
22 with a population that's very unique and that  
23 actually is a person's home as well.

24 COMMISSION CHAIR FRANK MARROCCO:  
25 Dr. Kitts, you wanted to ask a question.

1                   COMMISSIONER JACK KITTS: I think this  
2 is for Dr. Boyd. I think we've touched on this  
3 when you met with us through the OMA. I think --  
4 the matter of getting the funding, I think you have  
5 to be extremely clear on who's teaching and who's  
6 learning, and we sort of have a mish-mash of  
7 options on each side.

8                   And I was wondering -- so you're an  
9 option, the medical director. We've heard that the  
10 IPAC person should be on site. We've also heard  
11 there should be one FP per 200 residents. So I'm  
12 not sure that the medical director would be the  
13 most likely one.

14                   But we also heard from nurse  
15 practitioners that in some of the homes, I think  
16 25 or 26, they're on site and they're doing other  
17 things. And unless the home is 200 beds, you're  
18 not going to get a full practitioner, and that  
19 takes away from the on-site.

20                   So is it someone who can do more,  
21 including IPAC, in a lot of the homes that are  
22 smaller? And would it be a nurse practitioner  
23 level or another one?

24                   DR. HUGH BOYD: Fair question. If  
25 you're talking about someone who is going to be the

1 IPAC lead; is that what you're saying?

2 COMMISSIONER JACK KITTS: Yes, the IPAC  
3 practitioner for the home.

4 DR. HUGH BOYD: Yes. So I mean, I  
5 would support that to be an individual who's there  
6 regularly. And I'm not sure that if it's going to  
7 be a full-time position, I don't think a nurse  
8 practitioner or a physician is necessarily going to  
9 be the key resource.

10 We want the best people to do this.  
11 I'd rather have a PSW, or a housekeeper, highly  
12 trained in IPAC leading my home, than have one of  
13 my fellow nurse practitioners or physicians lead  
14 this. I don't think it's necessarily the level who  
15 can be that resource. I think these skills can be  
16 developed and trained.

17 I was referring to the responsibility  
18 for IPAC needs to go to the highest levels. And so  
19 while you have that resource, someone who's charged  
20 with the highest experience, the responsibility and  
21 the accountability needs to go to that high  
22 triad -- the director of care, the medical director  
23 and the administrator -- because this is not  
24 something to just put to the side.

25 I think someone made the term, the

1 chief nagger is sometimes what IPAC professionals  
2 are described as. The accountability needs to go  
3 to the absolute top.

4 COMMISSIONER JACK KITTS: Okay. So let  
5 me try this, then.

6 So if we go with the hub-and-spoke, the  
7 hub is the hospital that has the IPAC specialists;  
8 I think that's the term.

9 The spoke should have an IPAC --  
10 someone with the knowledge of -- my sense, it could  
11 be the medical director who's sort of the conduit  
12 between the hospital and the home, and in the home  
13 it would be a PSW who's properly trained by a  
14 certificate or a diploma course. Is that what a  
15 hub could look like?

16 DR. HUGH BOYD: It could. Forgive me,  
17 I've learned some about the hub-and-spoke model. I  
18 think Dr. Johnstone probably has a bit better an  
19 answer than I.

20 DR. JENNIE JOHNSTONE: So getting  
21 around the challenge of the bed ratios, I guess, if  
22 you will. So, for example, having one infection  
23 control practitioner for 200 beds. My preference  
24 would be, in my opinion anyway, would be to have  
25 that infection control practitioner who may be

1 shared amongst two 100-bed long-term care  
2 facilities. And alternatively, if you have a  
3 400-bed long-term care facility or home -- excuse  
4 me, Samir has taught me well -- that you would have  
5 two infection control practitioners for that home.

6 So it may not necessarily be that  
7 there's one person per home, only that it is one  
8 individual who's dedicated for that home.

9 So again, if -- you know, you can  
10 become certified in infection control through a  
11 different -- a number of different backgrounds.  
12 And I think that whatever background it is, I think  
13 the key here is -- because I've heard mention of  
14 PSW, or cleaner or whoever.

15 I think the idea here is, they would no  
16 longer be a PSW or a cleaner. They are going on to  
17 do their education, to get certified in infection  
18 control, to do their on-the-ground training,  
19 because you cannot write your Canadian Infection  
20 Control exam until you have on-the-ground training  
21 for two years before you get that certification.

22 So that the key here is they are  
23 dedicated to that role. So wherever they came  
24 from, whatever background they came from, they are  
25 no longer functioning in that role anymore, once

1 they are that dedicated infection control  
2 practitioner. Otherwise, their job will get  
3 consumed by whatever other responsibilities they  
4 have, and they won't get the infection control  
5 aspect.

6 So I understand that there are  
7 challenges in the ratios, but I also think that we  
8 are better connected, I think, as a health system  
9 now than we were a year ago. And that there are  
10 opportunities for connections between homes that  
11 may not have been there before, and that they can  
12 then share one infection control practitioner,  
13 because it is hard to hire part-time. So you can  
14 have one infection control practitioner who may go  
15 between two homes, or three homes, as it may be.

16 COMMISSIONER JACK KITTS: Thank you.  
17 That's clear.

18 JOHN CALLAGHAN: The question I was  
19 going to ask was, we heard evidence from a number  
20 of hospitals that went in and said that it's not  
21 just the IPAC, the environmental cleaning staff  
22 were not well equipped and they didn't know how to  
23 clean.

24 Now if you move to your model -- back  
25 to Dr. Johnstone or Dr. McGeer -- would the IPAC

1 specialist have responsibility to make sure the  
2 cleaning staff was using the proper kill rate in  
3 the infections -- in the products? Would they have  
4 responsibility for that, too? Is that the idea?

5 DR. JENNIE JOHNSTONE: Go ahead, Dr. McGeer.

6 DR. ALLISON McGEER: Go ahead, Jennie.

7 DR. JENNIE JOHNSTONE: Maybe I'll just  
8 speak to what our roles are within the  
9 organization.

10 So within a hospital setting, the  
11 infection control has its fingers everywhere. So  
12 it's to understand exactly what is going on in all  
13 aspects. Environmental cleaning is just one.

14 So, for example, in our hospital, the  
15 environmental services wouldn't bring in a  
16 different product until that was approved and  
17 discussed with infection control. And I think  
18 where infection control has a role, it's not -- I  
19 mean, the environmental cleaners have their own  
20 specialty to understand how to clean properly.

21 But in terms of what they're using; how  
22 they're doing it; making sure that it's up to the  
23 best practice guidance documents; being aware of  
24 the best practice documents; and being able to spot  
25 when things are going awry, that is the job of

1 infection control.

2 So it's not necessarily the  
3 responsibility, per se, of the cleaners, but  
4 understanding the products, how they're doing it,  
5 making sure that they are also trained, that it is  
6 not environmental service cleaners who are -- have  
7 another job. That they are doing dedicated and are  
8 consistent with the best practice guidance; I think  
9 that's where the infection control practitioner  
10 would be able to spot the challenges that might be  
11 occurring.

12 JOHN CALLAGHAN: So to put it another  
13 way. If the Commissioners were to adopt this kind  
14 of suggestion about the IPAC specialist, one per  
15 200 or whatever, we could expect there to be some  
16 oversight on the environmental cleaning as well  
17 through that process?

18 I mean, the stories we heard were very  
19 telling, where your colleagues at other hospitals  
20 were concerned they were moving people to beds that  
21 hadn't been properly decontaminated of COVID, like  
22 as they tried to -- so I mean there was a real IPAC  
23 element. But I'm just trying to understand whether  
24 there would be some oversight in that process.

25 DR. ALLISON McGEER: Yes. And one of

1 the possibilities is, I think, remembering that in  
2 smaller hospitals -- we have a general rule of one  
3 IPAC professional for 100 beds in acute care  
4 hospitals. We have still quite a number of smaller  
5 hospitals, and they've solved that problem in a  
6 number of different ways.

7           Sometimes the IPAC person also does  
8 occupational health. Sometimes they're an  
9 environmental cleaning person, who does  
10 environmental cleaning and IPAC. Sometimes they're  
11 in a hospital cluster, and so there's one person  
12 who covers three of the smaller hospitals in the  
13 Grey Bruce, Owen Sound area.

14           So I think there are a number of  
15 approaches to do it. And one of the potential  
16 shared responsibilities, that are shared in some  
17 smaller hospitals, is environmental services and  
18 IPAC, because those are two things that are linked.

19           But a little more challenging in  
20 long-term care, because we don't have -- you don't  
21 have quite the same range of roles that you need in  
22 pieces in hospitals.

23           But I just want to reiterate Dr. Johnstone's  
24 point about the -- one of the intrinsic problems of  
25 any role that works in prevention within our

1 healthcare system, is that there are always crises.  
2 When there's not a pandemic, there are always  
3 crises that are more important than prevention.  
4 And so people get sucked -- unless you designate  
5 infection control, unless the Ministry says, "we  
6 are sending this money" -- I can't tell you how  
7 valuable it was in acute care hospitals to have  
8 dedicated Ministry funding that needed to be  
9 justified to the Ministry every year: "We are  
10 using this money to pay for this person in IPAC."  
11 Sounds a bit silly, wasn't that much money, but it  
12 really helped.

13           And so whatever the system is, we need  
14 to be really clear that there is a trained,  
15 certified person responsible for IPAC with a  
16 designed amount of time to do it, if we expect this  
17 to work in long-term care.

18           DR. NATHAN STALL: To Dr. McGeer's  
19 point, I was just going to say, someone once said  
20 to me that the reason it's hard to convince people  
21 -- I think, like many public health measures in  
22 general -- is that when it's working, no one  
23 notices anything happening. And I think in  
24 long-term care, what we saw, and Dr. Sinha spoke  
25 about this is, we normalized the deaths of people

1 before COVID-19 in infectious diseases outbreaks,  
2 so there was some normalization there.

3 But when things are going well,  
4 Dr. Johnstone, Dr. McGeer, their whole team,  
5 Dr. Boyd, they're doing their hard work, but we  
6 don't notice anything that's going on because it's  
7 working. And that's always a hard thing to  
8 convince decision makers to pay for something when  
9 the success is measured by nothing happening.

10 DR. JENNIE JOHNSTONE: Mr. Callaghan,  
11 just to answer your specific question, though, I  
12 definitely would see it within the purview of the  
13 infection control practitioner to be able to spot  
14 those gaps and those lapses when they occur, in  
15 terms of any gaps in environmental cleaning. That  
16 is definitely what we do. And that's the  
17 importance of having those boots on the ground, so  
18 they can know, when there is a new cleaner, making  
19 sure that they were trained properly, what are the  
20 processes, what are the SOPs for the cleaners. It  
21 is to have those eyes, and that speaks to the  
22 importance of that person.

23 JOHN CALLAGHAN: Dr. Boyd?

24 DR. HUGH BOYD: We don't necessarily  
25 have to re-invent the wheel on the accountability

1 side. And that's why I came back to that triad of  
2 leadership, in terms of responsibility. The  
3 resource is absolutely critical, and I fully agree  
4 with everything that's been said.

5 But if we compare it to things like  
6 abuse, or the long-term care inquiry around  
7 intentional harm, responsibility needs to go to the  
8 absolute top on this.

9 And there are, you know, quality  
10 measures that could be made where, while it may  
11 seem like not much is going on when things are done  
12 well, there are absolutely process measures, and  
13 occasionally outcome measures, that can celebrate  
14 when IPAC is being done well: hand hygiene audits,  
15 cleaning tool audits.

16 There is a wealth of tools that  
17 Ministry inspectors could easily use to enforce  
18 this. And that would mean that the resource is  
19 still there exactly as described, but the  
20 accountability is with the home's highest power, to  
21 make sure that they're listening, that their staff  
22 are following that amazing resource.

23 JOHN CALLAGHAN: Dr. Stall, I wonder  
24 whether we should move on.

25 One question I was going to ask was --

1                   COMMISSIONER JACK KITTS: Just before  
2 we go, I don't want to lose sight of it, it's  
3 changing the topic, but for Dr. Boyd, you talked  
4 about having a diploma or certificate or something  
5 in long-term care management. Where is that  
6 offered? And is that something that long-term care  
7 medical directors should have, or certainly be  
8 considered to have?

9                   DR. HUGH BOYD: So I took this course  
10 in 2018. It was offered as a joint venture between  
11 the Centre for Disease Control and the American  
12 Medical Directors Association.

13                   It was a brilliant -- it was a long  
14 course. It's nothing compared to what my  
15 colleagues are describing about the wholesome  
16 certification with the exam. But it did -- it was  
17 targeted to physicians and nurse practitioners  
18 working in long-term care, specific to IPAC. And  
19 it included training on outbreak management, it  
20 included training on antimicrobial resistance,  
21 antibiotics stewardship and antimicrobial  
22 stewardship, and a number of critical topics.

23                   And, yes, this course equipped me with  
24 phenomenal skills that I've been trying to share  
25 with others, but I would recommend that it be part

1 of medical director training.

2 On that topic, there is a certification  
3 for Ontario Medical Directors in Ontario, offered  
4 by the Ontario Long-Term Care Clinicians, and they  
5 do have a component of infection prevention and  
6 control in that course.

7 I took that course ten years ago, and  
8 that component was very brief then, I'll say, and  
9 now it's probably bigger, and I would be happy to  
10 help them beef it up even more on topics of  
11 outbreak management, because there are  
12 evidence-based skills that would be incredibly  
13 important. And that's why there's such a massive  
14 urgency to make sure we immediately mandate all  
15 medical directors to take medical director  
16 training.

17 COMMISSIONER JACK KITTS: So you highly  
18 recommend it, and you are willing to help set up  
19 the course so that they don't have to go to  
20 CDC or...

21 DR. HUGH BOYD: I'm absolutely willing  
22 to help. And of course would want the amazing  
23 skills of Dr. McGeer, Dr. Johnstone, and I could  
24 name countless of other local experts so we don't  
25 have to trust the CDC, which I have difficulty

1 doing since 2020, certainly.

2 So I think the bare minimum is that all  
3 medical directors have medical director training,  
4 because they will at least get a component of that  
5 in addition to countless other massively important  
6 skills.

7 And then from there, whether we decide  
8 to set up an entire course specifically on that, I  
9 think that could be very beneficial if we want  
10 physicians to be one of the people that  
11 Dr. Johnstone is talking about.

12 I honestly don't know how popular that  
13 will be, so I think it's probably better focusing  
14 on what we do have, because typically the infection  
15 control champions are not physicians. So happy to  
16 help it out, but I'm not sure that would be the  
17 fastest and most efficient avenue.

18 JOHN CALLAGHAN: Thank you.

19 DR. NATHAN STALL: On that topic, John,  
20 sorry, I just wanted to get -- one of the things I  
21 really want to cover, just springboarding off of  
22 that was, Dr. Boyd's sort of perspective during the  
23 pandemic; and particularly between waves 1 and 2,  
24 on medical services within the long-term care home,  
25 the leadership within the long-term care home, and

1 what needs to be done in the wake of COVID-19 to  
2 improve that.

3 I think you just touched on a little  
4 bit of it there, but I think that's really  
5 critical, because what we noticed, particularly in  
6 some of the devastating outbreaks that happened  
7 really right before vaccines were provided to some  
8 homes, was that we had a collapse of leadership  
9 within homes and leaders leaving, actually  
10 resigning, medical directors resigning, in the  
11 middle of outbreaks when all of the residents were  
12 infected. So I really think -- I wanted Dr. Boyd  
13 to -- and give him the opportunity to speak to some  
14 of that.

15 DR. HUGH BOYD: Thank you.

16 I am not privy to the same level of  
17 information some of my colleagues here are. I can  
18 tell you that I spoke to a number of medical  
19 directors who were forced into resignation. I did  
20 not speak to a single medical director who was  
21 comfortable, or not devastated or heart-broken  
22 about their resignation.

23 And there was a massive breakdown in  
24 leadership in many levels throughout this.  
25 Understandably, it was a very scary and disturbing

1 time, and we had to step up in ways that we never  
2 expected. And despite my efforts to try to coach,  
3 support and mentor, I was never quick enough. And  
4 I usually connected with these medical directors  
5 after they were forced out of their jobs. And they  
6 were devastated, because they brought decades of  
7 experience, and were not -- I don't believe --  
8 given an opportunity to receive the coaching, the  
9 mentoring, and to have those skills to manage such  
10 a brutal, terrible crisis.

11 Leaders are not born, they are created.

12 And despite the long-term care inquiry  
13 recommending that medical directors all receive  
14 medical director training, that was years ago; that  
15 was not implemented. And we are suffering a  
16 massive catastrophe and loss of opportunities of  
17 leadership because that recommendation wasn't  
18 implemented.

19 I believe that we could have, and I  
20 hope to, in the future, build that capacity and  
21 those leadership skills so that our medical  
22 directors can have the skills they need to do their  
23 jobs well, because it's an incredibly difficult  
24 job, and to do it without any leadership training  
25 at all is just heart-breaking to hear.

1 I do know, also, that there have been  
2 countless success stories, medical directors who  
3 have stepped up and done amazing things. Who have  
4 helped support other physicians, other medical  
5 directors. Who have recognized the need for  
6 medical services to be dynamic, that you can't use  
7 the same way you've been providing care for the  
8 last ten years during a crisis; and the medical  
9 services shifts and changes. And that they know  
10 who to call for help, that they're able to beef up  
11 the medical services, using nurse practitioners and  
12 attending physician colleagues. They know how to  
13 make sure that the medical services fit the needs  
14 of the patients rather than what the resources are  
15 available.

16 And so we have heard countless amazing  
17 success stories, as well as some really  
18 heart-breaking stories. And there is clearly an  
19 unacceptable variability that can be corrected  
20 quite easily, both through standard education and a  
21 required leadership hierarchy.

22 Long-term care homes often hire a  
23 medical director, not knowing what the job  
24 description of a medical director is. I was hired,  
25 and I gave my home a better job description than

1 the one they had.

2           And so we know that the homes don't  
3 fully understand how powerful this role can be.  
4 And that's one of the reasons why I'm also calling  
5 for an immediate creation -- along with other  
6 colleagues -- immediate creation of a Medical  
7 Officer of Health for Long-Term Care. Because we  
8 know that these leadership skills exist; we know  
9 that those medical directors are quite often  
10 accountable to long-term care homes that don't  
11 fully understand the role of physicians. And I  
12 think that the Chief Medical Officer of Health for  
13 Long-Term Care could really be a powerful advocate  
14 to make sure that we can share those success  
15 stories happening in some parts of the province,  
16 and make sure we've reduced that variability so  
17 that we can all provide quality care.

18           I also truly believe that in addition  
19 to that hierarchy, an immediate creation of local  
20 networks of medical directors to provide a more  
21 unified voice to negotiate with the hospitals about  
22 care needs, because they have done wonderful  
23 things, but to share those models of care that are  
24 working elsewhere in the province, provide feedback  
25 to the Chief Medical Officer of Health, and to

1 share those innovations about what's working across  
2 the province.

3 We created a similar group in Hamilton  
4 in a crisis, under the amazing leadership of  
5 Dr. Tammy Packer. She brought together, in two  
6 days, a community of medical directors and  
7 attending physicians; some who refused to go into  
8 the home, most who ended up going into the home  
9 thanks to this amazing, supportive and  
10 collaborative team.

11 We developed an order set to minimize  
12 variability, to provide a standard level of care  
13 that was coached by internal medicine and  
14 infectious disease, and we incorporated palliative  
15 care as well, so that when a crisis happened and  
16 you have thousands of people you care about so  
17 deeply dying, you have a simple, efficient tool so  
18 that you can provide quality care to everyone.

19 She started this in two days, and we  
20 saw improvements within a week. And I have tried  
21 to share this innovation with the Ontario Hospitals  
22 Association, and was declined. I've tried to share  
23 this with other chiefs of staff and were declined.

24 But we know this has been massively  
25 helpful in Hamilton. And the Ontario Medical

1 Association is looking at ways of implementing this  
2 with or without the Ontario Hospitals Association,  
3 with or without the government. Because we know  
4 reducing variability and supporting physicians and  
5 nurse practitioners provides higher quality care  
6 directly to the residents.

7 COMMISSIONER JACK KITTS: Just to  
8 follow up. We've heard also that the medical  
9 directors could be part of a hospital MAC if  
10 they're partnered with a hospital. That would be  
11 different than the Chief Medical Officer of Health.

12 Can you sort of tell us what the pros  
13 and cons might be of that model versus the Chief  
14 Medical Officer of Health?

15 DR. HUGH BOYD: The pros of having the  
16 medical director reportable to the Chief of Staff  
17 at the hospital -- because that's what that  
18 structure would do is it would create the hierarchy  
19 where the medical director of the nursing home is  
20 now reportable to the hospital's Chief of Staff --  
21 could provide benefits such as requiring the  
22 hospital to allow the medical director to provide  
23 input at the medical advisory council, that the  
24 hospitals would no longer be able to ignore the  
25 needs of long-term care residents; would no longer

1 wait until they were literally legally --

2 [Connection difficulties]

3 COMMISSION CHAIR FRANK MARROCCO: We  
4 lost you there, Doctor.

5 While we're waiting for Dr. Boyd to  
6 come on, is that generally the view that --

7 DR. HUGH BOYD: I'm so sorry. How is  
8 that now?

9 COMMISSION CHAIR FRANK MARROCCO: Oh,  
10 that's fine, you're back.

11 DR. HUGH BOYD: What was the last thing  
12 I was monologuing about?

13 COMMISSION CHAIR FRANK MARROCCO: You  
14 were reciting advantages to having the medical care  
15 director, I don't know exactly what the correct  
16 word is.

17 DR. SAMIR K. SINHA: Integrated with  
18 the --

19 COMMISSION CHAIR FRANK MARROCCO:  
20 "Integrated", yes, that's very tactful. Integrated  
21 with the hospital medical advisory committee.

22 DR. HUGH BOYD: Thank you, Justice Marrocco.  
23 The downside to that is that the  
24 medical director would now be reportable to Chief  
25 of Staff who, historically speaking, likely knows

1 nothing about the care in long-term care, and would  
2 not technically be even a physician on staff in the  
3 nursing home. Because the legislation requires, in  
4 order for a physician to be providing care, they  
5 need to be on contract with the nursing home.

6 And so you'd have someone reportable in  
7 a governance structure to someone who really  
8 probably knows nothing about long-term care.

9 And while there may be benefits of  
10 having those voices together, I think that that can  
11 be achieved through other realms, such as the one I  
12 described where you have a community of medical  
13 directors who come together, who share their  
14 stories, share their discussions, and share their  
15 problems. Because this global catastrophe needed  
16 local solutions.

17 And those medical directors in that  
18 community of practice do have the opportunity to  
19 feed that information to whomever they need to. If  
20 it's the Chief of Staff of the hospital, if it's  
21 the Chief Medical Officer of Health, they're able  
22 to make sure that their patients get the care that  
23 they need to. And then they're also reportable to  
24 someone who knows long-term care. They're not  
25 reportable to someone who's never stepped foot in a

1 nursing home. They're reportable to someone who  
2 gets it, who understands.

3 DR. NATHAN STALL: Just to follow up,  
4 just to be specific. You've spoken a lot about the  
5 medical director, what kind of training they might  
6 need. Just to close this section -- and I know  
7 Dr. Sinha has a comment afterwards -- can you  
8 speak, Dr. Boyd, to what you think of in terms of  
9 appropriate time commitment for the physicians in  
10 the home, you know, sort of in the wake of  
11 COVID-19, what the requirement would be for  
12 physical presence and maintenance of competency,  
13 and credentialing? Because I think this is a  
14 really important thing in the wake of COVID. And  
15 then the wake of COVID-19 in terms of improving the  
16 medical model of leadership of the home.

17 DR. HUGH BOYD: Thank you.  
18 We have to be careful, because this is  
19 a home. We're trying to not do it as an  
20 institution, despite the obvious fact it is. And  
21 we have to be careful about taking institutional  
22 policies and applying it to someone's home.

23 Nowhere, quite often even in the  
24 hospitals, there isn't necessarily a specific  
25 requirement for physical attendance beyond

1 something like once a week in some situations. And  
2 so applying such strict standards for long-term  
3 care home, I think it's challenging, and I think  
4 may have risks of institutionalising something that  
5 is supposed to be someone's home.

6 What I would strongly encourage more on  
7 the quality of care is helping our medical  
8 directors to understand what the medical services  
9 are, establishing standards for medical services.  
10 That is, patient and family-centred, not doctor or  
11 nurse practitioner-centred; that is, focused on:  
12 Are your residents and patients getting their  
13 medical needs met in a timely manner?

14 And this can be done through a few  
15 different versions, it is not a cookie cutter  
16 approach, but it means that you're establishing  
17 that if someone has a concern, and it's  
18 significantly threatened their life or their  
19 comfort, then they are getting a proper assessment  
20 within a timeframe that we accept, such as 24 hours.

21 If we use family medicine as the model  
22 of care, the worldwide family medicine community  
23 has said, same day or next day access to a family  
24 doctor is a marker of quality. In Canada, we're  
25 doing terribly in the community on this measure.

1 It's truly embarrassing. But we can -- it's a  
2 clear quality indicator, it's something that can be  
3 measured, and it's something we could try to  
4 enforce in the long-term care setting.

5 It doesn't necessarily say that every  
6 resident needs an in-person assessment. It says  
7 that they need their care needs addressed, because  
8 sometimes that might be virtual, and sometimes that  
9 might be in person.

10 But it will also require the medical  
11 director to do their job, which is currently to  
12 monitor the medical services and make  
13 recommendations around the quality of those medical  
14 services.

15 So, if you have a home where suddenly  
16 your doctor is only doing virtual care, do what I  
17 do: Go through those notes, take a look at them,  
18 and comment yourself, "Hmm, was that appropriate  
19 that you decided to do virtual care for that  
20 particular thing? Or would I have suggested  
21 something different?" And provide that feedback to  
22 the physician, so that there's opportunity for  
23 quality improvement.

24 There's lots of quality measures we  
25 could do to allow a dynamic medical services model

1 that is patient-centred, not doctor-centred, that  
2 can make sure that when there's a crisis, such as a  
3 catastrophic COVID outbreak I manage, where we also  
4 had a staffing crisis. You need to go in, in  
5 person, each day for a bit. Oh, and now the  
6 staffing crisis is over? "Okay, you know, our  
7 patients maybe don't need me there every day..."

8 So having a cookie cutter approach is  
9 not nearly as important as having the medical  
10 directors well trained and build an understanding  
11 what quality medical services are, and measuring it  
12 and holding them accountable for it.

13 COMMISSION CHAIR FRANK MARROCCO:

14 Mr. Callaghan, were there other topics? I think  
15 we've exhausted --

16 JOHN CALLAGHAN: There's one topic  
17 that's sort of associated to this, that I thought  
18 I'd just bring out, which comes from Dr. Stall's  
19 recent report, where they concluded that the  
20 hospital admissions during COVID were down for  
21 long-term care.

22 It wasn't clear from the paper how you  
23 had attributed that, and what the outcomes were,  
24 and what prescription we might take from that fact.

25 DR. NATHAN STALL: So what we showed

1 was, we looked at -- and I think I presented some  
2 earlier data when I testified in November -- but we  
3 showed that, particularly early on in the pandemic,  
4 the number of residents who died of COVID-19, a  
5 vast, or the great majority of them, were not  
6 transferred to hospital, in comparison to community  
7 dwelling older adults who died of COVID-19.

8           Now, that's not unexpected. Most  
9 long-term care residents, as Dr. Boyd and others  
10 will know, many of them do die in the long-term  
11 care homes, and that's their choice.

12           What we noticed, though, was while the  
13 proportion of older adults who lived in the  
14 community dying of COVID-19, stayed relatively  
15 stable throughout the month of the pandemic.  
16 Meaning, that each month somewhere between 70,  
17 around 75 percent of the community dwelling older  
18 adults died in the community, or died -- of  
19 community dwelling older adults were hospitalized  
20 with COVID-19, we noticed that there were  
21 substantial variations in the proportion of  
22 long-term care residents who died in the hospital.  
23 And, you know, one would not normally expect such  
24 temporal variations in something like that.

25           So just to give you the actual data, if

1 you looked at it. Overall, community dwelling  
2 residents, 81.4 percent were hospitalized prior to  
3 death; only 22.4 percent of long-term care  
4 residents were.

5 The community dwelling residents, that  
6 stayed stable from 75 to 80 percent.

7 But in the long-term care dwelling  
8 population, it varied between 15.5 percent, which  
9 actually happened in March and April. The real  
10 highest concentration of deaths, had the lowest  
11 amount of transfers to hospital, and it ranged from  
12 15.5 percent to 41.2 percent in terms of monthly  
13 transfers to hospital prior to death.

14 And that, I think, that reflects some  
15 of -- and we spoke about the initial  
16 misunderstandings within the healthcare system,  
17 hesitancy to transfer people to hospital, to give  
18 the impression of preserving the acute care system.

19 Some of the issues Dr. Boyd spoke  
20 about, and there were both well intentioned and  
21 poorly intentioned factors, that led to people not  
22 being on site to even make decisions about  
23 transfer.

24 And, of course, there was collapse in  
25 staffing. And we've seen this, tragically, as

1 recently as January, in some of the really large  
2 outbreaks of Ontario, where there was, you know,  
3 just a lack of staffing to even identify at times  
4 who was sick and who was dying to get them medical  
5 care in a timely fashion.

6 So, you know, unfortunately, that  
7 problem has still persisted in terms of sort of  
8 disparities in terms of access to acute care among  
9 the long-term care population.

10 JOHN CALLAGHAN: Is it policy? Is it  
11 caused by perception, or policy, or both? And what  
12 do we say about that?

13 DR. NATHAN STALL: There was never any  
14 official policy to deny transfer of long-term care  
15 residents to hospital.

16 Well, Dr. Boyd, do you want to clarify  
17 that? You seem to feel differently.

18 DR. HUGH BOYD: Not from the  
19 government, but we did see policies issued by  
20 emergency departments. And sometimes the medical  
21 director was also the medical director of the  
22 emergency department, and we did see firm  
23 recommendations that patients will not be  
24 transferred.

25 This is consistent with decades of

1 brutal ageism and discrimination against long-term  
2 care. You may have heard the word "GOMER", a  
3 horrific term, short form for "get out of my ER",  
4 popularized on television.

5 As Dr. Stall reported, it is the worst  
6 outcome from far too long of discrimination that  
7 should have been crushed a long time ago.

8 Unfortunately, many of our long-term  
9 care physicians were not well supported, and  
10 networked to fight back and push back on this.  
11 Many of us did, a lot of us did. But some  
12 succumbed to that pressure, and that was not the  
13 government's fault, that's healthcare's fault.

14 COMMISSION CHAIR FRANK MARROCCO: Dr. Sinha,  
15 you've wanted to say something for a while now.

16 DR. SAMIR K. SINHA: Yes, I just wanted  
17 to tie it back with Dr. Boyd's previous comments as  
18 well with it, because I think it really gets to the  
19 fundamental things.

20 So the Commissioners will get a copy of  
21 a CIHI report. I understand that you had CIHI meet  
22 with you the other day, but just to give you a  
23 sense about the -- because we looked at all the  
24 transfers across Canada and Ontario that were going  
25 to hospital, so diagnoses for hospitalization.

1                   Basically, if you had a hip fracture as  
2 an older person in a long-term care home, the  
3 change between, you know, normal times versus  
4 during the pandemic, less than 1 percent. Meaning,  
5 that if you fractured your hip, you were going to  
6 the hospital pre-pandemic or after pandemic.

7                   But if you had something like  
8 pneumonia, if you had a urinary tract infection, if  
9 you had heart failure or COPD, chronic obstruction  
10 pulmonary disease, you know, diseases that often  
11 require a clinician's diagnosis, right back to  
12 Dr. Boyd's mentioning, it's just mentioning that  
13 someone needs to actually have that diagnosis made  
14 and that would prompt a transfer. Those transfer  
15 rates were down anywhere between 36 to 51 to 58  
16 percent, basically.

17                   So the idea was that -- and I think  
18 part of this reflects the fact that, I think with  
19 some of the hospitals, and I think some of that  
20 relationship, I think also there's a lack of  
21 understanding to Dr. Boyd's point.

22                   Again, sometimes, you know, colleagues  
23 who work in the hospital, don't appreciate, you  
24 know, what is a long-term care able to do? You  
25 know, what is the medical model?

1           They say there are nurses there, right,  
2   it's a nursing home. There are personal support  
3   workers. There's doctors. There's a medical  
4   director. Clearly, you can do all this care there,  
5   right? You know, you can do everything. So,  
6   Dr. Boyd, no need to transfer them, right? We're  
7   worried about getting overwhelmed.

8           And I don't think it comes from a bad  
9   place. I think it really comes from a lot of  
10   misunderstanding, and I think that's where I had  
11   numerous calls from medical directors around the  
12   province saying, "How do I negotiate with my local  
13   hospital that's basically saying, you know, try and  
14   do it as best you can on your own", when they just  
15   didn't feel that they had the resources necessarily  
16   to do so. And I think that is something that  
17   Dr. Boyd heard.

18           I think to the point about, you know,  
19   fundamentally, we're talking about skill sets and  
20   roles that I think in legislation, it says that  
21   there needs to be an RN on staff 24/7. It says  
22   there needs to be a medical director. But it  
23   doesn't get to the subtleties, for example -- and I  
24   might be wrong about saying it has to have a  
25   medical director, and it has to have physician

1 services. But I think it's also talking about how  
2 do you make sure that, you know, in a long-term  
3 care home -- the example we gave about IPAC funding  
4 to hospital. Dr. McGeer mentioned, for example,  
5 that hospitals have to be accountable, that we have  
6 money for IPAC, and if we don't spend it on IPAC,  
7 then we have to say we're not doing that.

8 But the idea that for a medical  
9 director, for an IPAC professional, for any of  
10 these folks, it's not only saying that these are  
11 roles, but also being able to say, there's funding  
12 for a medical director to go and do a medical  
13 director course. You know, they might not all run  
14 to do it. But, frankly, if we take away barriers,  
15 for example, I think these are ways in which we can  
16 (A) facilitate this sort of stuff happening. I  
17 think we strengthen the culture there, because  
18 there's so much turn-over in these environments,  
19 from physicians, to nurses, for personal support  
20 workers, because I don't think we're giving people  
21 the opportunity to develop the skills, the  
22 knowledge, the framework, and that community of  
23 practice.

24 And, finally, what Dr. Boyd was saying  
25 is that: Do we tie that medical director into

1 reporting to the local hospital? Not necessarily.

2 I think, again, you can think about  
3 Ontario Health in the region. You can think about,  
4 you know, a regional lead, for example, that gives  
5 that regional structure for medical directors to  
6 get together to communicate. That's certainly  
7 something that the Winnipeg Regional Health  
8 Authority, other health authorities do, where they  
9 actually have communities of practice that they've  
10 established amongst their local medical directors,  
11 so they're talking to each other, they're sharing  
12 ideas.

13 There are other mechanisms to not  
14 actually tie it into the hospital, but some -- what  
15 the State of Florida did, which was actually quite  
16 interesting, was because of the issue of their  
17 relationships between their long-term care homes,  
18 and hospitals, and emergency services; in their  
19 disaster and emergency response legislation, they  
20 actually state that all local long-term care homes  
21 have to develop a pandemic or an emergency response  
22 plan. And, they have to do that in collaboration  
23 with the local hospital and emergency medical  
24 services. So that's in legislation.

25 So you've come up with a plan, but it's

1 not like a plan that you hide on your own. It's a  
2 plan that you have to go and take it to your local  
3 partners and say, "So, if we were in the situation,  
4 how are we all going to do that?"

5 Because it has to almost be signed off  
6 together, to make sure that actually when these  
7 things do arrive, we're not negotiating in the  
8 middle of a pandemic; we know who our partners are;  
9 we know how we're supposed to work together. And  
10 it creates a bit of structure in which that can  
11 move forward.

12 DR. NATHAN STALL: Dr. Sinha, I just  
13 wanted to -- oh, sorry, Commissioner Coke, go  
14 ahead.

15 COMMISSIONER ANGELA COKE: I just  
16 wanted to clarify one thing about the medical  
17 directors.

18 There's a medical directors course, and  
19 to my understanding, that is not a mandatory thing,  
20 it is a voluntary thing that people take that or  
21 not?

22 DR. HUGH BOYD: Yes, Commissioner Coke.

23 COMMISSIONER ANGELA COKE: Is there any  
24 specific requirement for what the medical director  
25 must take?

1 DR. HUGH BOYD: Absolutely none,  
2 whatsoever. In the legislation, there's a  
3 description of the role of the medical director,  
4 and there are key required components.

5 And it typically includes, to sum up,  
6 essentially to create, monitor and report on the  
7 quality of the medical services model that's being  
8 provided.

9 There's certainly requirements, four to  
10 five risk requirements of the attending physicians,  
11 but the medical director job description is  
12 horribly small.

13 And I think maybe we were at -- to  
14 disagree with Dr. Sinha -- we were at the time to  
15 offer funding alone, two years ago when we had --  
16 at the time with Canada's worst serial killer  
17 devastate our community, that was when it would  
18 have been nice to just provide funding. I think  
19 we're past that. It needs to be funding and it  
20 needs to be mandatory now.

21 DR. NATHAN STALL: To Dr. Boyd's point,  
22 you know, we spoke about this. There is a stipend  
23 attached to the medical director. Often, if there  
24 are few physicians that work in the home, they will  
25 just split up the medical director role on a

1 quarterly basis, and each take the stipend for that  
2 time, without necessarily always assuming the  
3 responsibilities and leadership that are attached  
4 to that role.

5 DR. HUGH BOYD: The Ontario Medical  
6 Association, along with the Ministry of Health and  
7 Long-Term Care, developed a sample contract ten  
8 years ago; ten years ago. And it has been shared  
9 with long-term care homes, and shared with  
10 attending physicians, and the Ontario long-term  
11 care clinicians have provided a lot of input to  
12 that. These are still voluntary, they're not  
13 adopted by every home, and they're also ten years  
14 old.

15 So we're looking at updating them, but  
16 there's variability that is not an accident, and  
17 that variability can be narrowed with a bit of  
18 better standardization and recognition of the  
19 importance of training, skills and expertise.

20 COMMISSION CHAIR FRANK MARROCCO: Were  
21 there any other questions from the Commissioners?

22 No, okay.

23 DR. NATHAN STALL: Justice Marrocco,  
24 there was one other topic we wanted to touch on  
25 briefly, if there was time.

1                   COMMISSION CHAIR FRANK MARROCCO: Yes,  
2 there is. Go ahead.

3                   DR. NATHAN STALL: Maybe I'll start  
4 with Dr. Sinha here, which is the topic of -- and  
5 also, I'm curious to hear as well for Dr. Boyd's  
6 experience going through several of these -- but  
7 the role of inspections, accreditations and  
8 enforcement moving forward.

9                   And I know you have some direct  
10 thoughts with that, Dr. Sinha.

11                  DR. SAMIR K. SINHA: Yes. I think the  
12 Commissioners have already learnt a lot about the  
13 inspections process. And, certainly, you know, I  
14 wholeheartedly agree with your interim  
15 recommendations.

16                  For example, like the role of the RQIs,  
17 for example, and the problem of having a  
18 complaints-driven only process.

19                  I'm going to ask Dr. Boyd, after I  
20 speak to, you know, kind of how the process works  
21 now versus how it's worked in the past, in terms of  
22 a complaints-driven process versus the role of  
23 those RQIs, as you've already noted, really had  
24 that opportunity to, in an unannounced way,  
25 understand, for example, how is the home set up for

1 around infection prevention and control measures,  
2 those emergency preparedness plans, these key  
3 things.

4 We know that we haven't really had any  
5 thorough reviews of that work in the last two years  
6 alone for the majority of the homes in Ontario. I  
7 think when we start thinking about what is the role  
8 of inspections and enforcement, and the idea that  
9 when you think about, you know, (A) you want to  
10 have a system that can identify problems, and then  
11 have, you know, the appropriate stick or measure to  
12 actually address that. You know, I think we  
13 understand how that can probably be made better,  
14 and more responsive and more comprehensive, and not  
15 simply asking people to voluntarily take a measure  
16 to deal with an issue of abuse.

17 But how do you actually mandate that  
18 these things need to be done, and there's  
19 follow-ups. Because I don't know, when I look at  
20 these reports, whether anything was done or what  
21 was done, and was it sufficient. And is the IPAC  
22 practitioner, for example, or the medical director  
23 responsible for making sure that issue got dealt  
24 with.

25 The issue that I want to speak to, and

1 I think you did hear from the leads out of  
2 Accreditation Canada, for example, and HSO, was  
3 this issue of accreditation. Because, again, we  
4 think about inspection and enforcement, and how  
5 that system could be more robust, and better and  
6 supportive. And then there's the issue of  
7 accreditation.

8 I think it's interesting, because I  
9 think Dr. McGeer and Dr. Johnstone can really speak  
10 to how part of the cycle that we go through of  
11 accreditation at a hospital level, really includes  
12 this concept of making sure that everyone in the  
13 organization from, you know, from the chief right  
14 down to a clinician, knows those required  
15 organizational practices, right? There's a  
16 mechanism to make sure.

17 And I know, like we'll be honest.  
18 Before accreditation comes, we all know it's  
19 coming, we all know that any of us can be asked,  
20 you know, do you know your five moments of hand  
21 hygiene? Or whatever the question could be. And  
22 we're training, we're being drilled. Because  
23 Jennie and Allison are not going to let us, you  
24 know, show that we don't actually know that  
25 knowledge as well.

1                   And so it's that idea how accreditation  
2 is different, because it's an opportunity to really  
3 try and develop, improve quality standards.

4                   But as you learnt already, and I was  
5 quite surprised when I found out that, you know, if  
6 you go to Québec, for example -- so, in Ontario,  
7 100 percent of hospitals are accredited with  
8 Accreditation Canada. That's all hospitals across  
9 Canada use Accreditation Canada.

10                  In Québec, same thing, but all  
11 long-term care homes in Québec, for example, use  
12 one accreditation. They all have to participate in  
13 accreditation, and they all use a Canadian entity  
14 that we trust to do all other parts of our system,  
15 if you will.

16                  However, if you learnt in Ontario,  
17 which was surprising to me, accreditation is  
18 optional. It is funded, 36 cents per resident per  
19 day, first of all, if you do participate in it.  
20 But 15 percent of homes do not participate in this  
21 process, which I think is really about quality  
22 improvement and raising the standard.

23                  And then what we see is that you have  
24 two potential accreditors allowed to work in  
25 Ontario: One that the majority of the

1 not-for-profit municipal homes use -- and Dr. Boyd  
2 can speak about experience with one versus the  
3 other -- that the majority of the for-profits use,  
4 that's a U.S.-based firm, that may not understand  
5 or design their standards around the Canadian  
6 context or what's really important about what we do  
7 in Canada.

8 I really think there's an opportunity  
9 here to say, you know, should we be following the  
10 model that many of the other provinces across the  
11 country have adopted, where they actually say it's  
12 not optional whether you want to participate. We  
13 will fund you, as we already are; you will  
14 participate. And you will participate, you know,  
15 with one provider that can actually serve as the  
16 mechanism to really develop that quality over a  
17 long-term process. That in partnership with an  
18 inspection, and an inspections process, for  
19 example, can really kind of create a both/and to  
20 really, again, help raise quality and then ensure  
21 quality is actually being attained.

22 I'm just going to stop there, but I  
23 really wanted to emphasize that.

24 COMMISSION CHAIR FRANK MARROCCO:  
25 Commissioner Coke?

1                   COMMISSIONER ANGELA COKE: Yes. So I'm  
2 thinking there are a portion of them that don't go  
3 through it, but the majority seem to be, 85 percent  
4 or whatever it is.

5                   But what is missing in that process?  
6 If you're saying all of 85 percent of them have  
7 their accreditation, but they're in the condition  
8 that they are in; what is somebody to make of that?  
9 There's some gap there still --

10                  DR. SAMIR K. SINHA: There is a gap.

11                  COMMISSIONER ANGELA COKE: -- in terms  
12 of having a quality management mindset. It doesn't  
13 appear to be there for a lot of these homes.

14                  DR. SAMIR K. SINHA: I'll say this, and  
15 then I'll ask Dr. Boyd to comment.

16                  But I think number one, as you noted,  
17 15 percent of homes don't participate at all;  
18 that's concerning to me. I think everyone should  
19 participate. But you rightly point out that if  
20 85 percent of homes are participating, how are they  
21 participating?

22                  I think we generally have understood  
23 that our municipal and not-for-profit homes have  
24 been performing better, for a variety of reasons.  
25 But I also think to the matter of, you know, I

1 think they're using -- they're choosing to use a  
2 more difficult standard of accreditation to attain,  
3 where they have to demonstrate better knowledge and  
4 capacity.

5 I think, you know, the for-profits have  
6 generally tended to rely on a U.S. provider, which  
7 by my understanding, for example, it's not as hard  
8 to attain accreditation, you know, through that  
9 mechanism and, frankly, it's cheaper as well.

10 You know, to the issue that you have  
11 is, okay, well, if we just get 100 percent of homes  
12 participating, are we really helping the process?

13 I think this is where this conversation  
14 about federal long-term care standards, right,  
15 trading national standards that really recognize  
16 all the issues we've been talking about, and trying  
17 to up their game. I think that's an important  
18 piece that will happen, as I understand, with the  
19 revision of those standards, or an improvement of  
20 the standards that we have that, frankly, should  
21 underline accreditation and, frankly, that we  
22 should have all homes in Ontario participating in.

23 But I don't know how you would get a  
24 U.S. firm to do that. Unless, again, through the  
25 Commission, through the Ministry, they say, you can

1 have whatever you -- (A) you have to participate in  
2 accreditation; (B) you can use whatever firm you  
3 want to, but they have to follow maybe these new  
4 national long-term care standards that focus on  
5 that.

6 Maybe, Dr. Boyd, you can speak to your  
7 experience with accreditation, and if it's valuable  
8 and how it could be more valuable.

9 COMMISSION CHAIR FRANK MARROCCO: Before you  
10 do, I think, wasn't Tendercare Living accredited?

11 DR. SAMIR K. SINHA: It was accredited,  
12 absolutely.

13 COMMISSION CHAIR FRANK MARROCCO: What  
14 we heard, I think it was from North York General  
15 about what they found when they went in there --

16 DR. SAMIR K. SINHA: Right.

17 COMMISSION CHAIR FRANK MARROCCO: --  
18 would cause you to reflect on the accreditation  
19 process, I think.

20 DR. SAMIR K. SINHA: A hundred percent.

21 And, again, I don't work for the  
22 accrediting body. But it raises -- I mean, I  
23 actually put out a Tweet that actually, you know,  
24 because I remember the picture that you saw in the  
25 paper every day, it says, "exemplary standing for

1 this home, for example, from Accreditation Canada".

2 And I thought, wow, from the inspection  
3 report I read, I'm not necessarily understanding  
4 that.

5 But you remember that the current  
6 accreditation process that actually exists is a  
7 every four-year process. And that's why, again,  
8 the question is I'm not -- I think it needs to be  
9 something on a more rolling basis. And I  
10 understand that that's something that's being  
11 implemented by Accreditation Canada, recognizing  
12 that it -- when Tendercare was last accredited, if  
13 that was four years ago, well, then what were we  
14 doing in between to kind of maintain that standard  
15 of care, for example, as well.

16 Dr. Boyd.

17 DR. HUGH BOYD: Thank you for your  
18 comment. I think it's very wise and it shows a few  
19 things.

20 First of all, just very quickly,  
21 Googling Tendercare, their accreditation was from  
22 Accreditation Canada and occurred in November of  
23 2019. And so there's no one fix for all.

24 I guess the one point I really  
25 emphasize is, just because a home had a devastating

1 or deadly outbreak, doesn't mean that they were a  
2 terrible home. When you incorporate the staffing  
3 crisis, plus a horrific deadly virus which makes  
4 the staffing crisis worse, we've seen good places  
5 just get devastated.

6 The one where the military went into  
7 the home, are probably one of the best medical  
8 directors in the province. This is a horrific,  
9 horrific virus. And I have trouble saying that,  
10 it's devastating. And North York General Hospital,  
11 lots of terrible things, absolutely, but they saw  
12 it after. The worst thing that can possibly happen  
13 to a nursing home.

14 So, Commissioner Coke, I fully support  
15 your question, along the lines of questioning  
16 accreditation isn't enough.

17 To Dr. Sinha's comments, just sharing  
18 this, too. I've been through accreditation  
19 processes on both of these major corporations.  
20 With Accreditation Canada, I was interviewed three  
21 times. With the other accreditation process, I  
22 barely knew it was happening.

23 And so I support the evidence, or  
24 that's some evidence that the two may not be  
25 providing the same standards. But, as Commissioner

1 Coke pointed out, it's not enough.

2 So if we look at monitoring quality, we  
3 think of it as a carrot and a stick, and the  
4 accreditation is purely a carrot. You get to put a  
5 fun little logo on your website, you get to say  
6 you're accredited, you get to say exemplary status.  
7 It's part of trying to attract business.

8 To most people, they don't always know  
9 what that means, and that's where the stick comes  
10 in play, and that's inspection.

11 Sorry, before I go on, is there any  
12 additional questions around accreditation before I  
13 talk about inspection?

14 COMMISSIONER JACK KITTS: Just a quick  
15 question. When you speak of the carrot and the  
16 stick, so Accreditation Canada is the carrot, and I  
17 guess the inspections are, you're going to talk  
18 about the stick?

19 DR. HUGH BOYD: Yes. And so the  
20 accreditation -- there's a bit of stick, because I  
21 think everyone is really motivated; we want to get  
22 it. And as pointed out, it's a rush to get  
23 accreditation.

24 They come up with really interesting  
25 standards that we think, you know, "I've actually

1 not thought about that, that's a brilliant idea.  
2 How do we make that happen so that we can provide  
3 that quality care?"

4           It's a positive building experience.  
5 And when you're going through accreditation, you  
6 get advice from people who have been all over the  
7 country, who can say, "Try this, try this, try  
8 this." And you get to figure out what works for  
9 your home. It's an amazing experience.

10           The stick is the quality inspections.  
11 The stick used to be a carrot and a stick. Ten  
12 years ago when we had inspections, the inspectors  
13 would share innovations that they saw at different  
14 homes. They would say, "You're really struggling  
15 with this. Down the block is another home that's  
16 tried this, or at another city they tried this and  
17 this. Why don't you try this to try to improve  
18 things?"

19           So they used to be very collaborative,  
20 but also punishing. And then a number of years ago  
21 that changed massively. And we no longer get any  
22 recommendation for improvements, whatsoever, from  
23 the inspectors. It's purely identifying  
24 deficiencies.

25           And so it's trying to improve care,

1 without recommending improving care. It's meant to  
2 punish poor care and try to force improvements  
3 elsewhere.

4           And so the inspection program we have  
5 now, most of us view it as an absolute necessity,  
6 but view it as a very stressful and very punishing  
7 experience to go through to try to maintain those  
8 standards. And, of course, the punishments have  
9 escalated massively in the last few years.

10 Understandable, because there are bad apples. And  
11 our people need to know that those bad apples will  
12 be rooted out, and they will be identified and  
13 there will be improvements.

14           The other big change historically  
15 that's happened is, the inspections have shifted  
16 from the annual inspection, which, as I mentioned,  
17 very stressful experience to go through, to a  
18 risk-based assessment, of which their goal was to  
19 still have annual inspections, but they would be  
20 briefer, they would be less intense, they wouldn't  
21 necessarily have people on your floor for two  
22 weeks. They maybe would go for a few days. They'd  
23 still try to touch on every single program, but a  
24 briefer inspection.

25           So if your home had a good history,

1 didn't have a lot of complaints, didn't have a lot  
2 of compliance orders from the past, then that  
3 annual check would just be smaller. And then those  
4 who maybe had higher risk, they would get that  
5 beefy quality inspection.

6           So that change happened, and I think a  
7 lot of us supported it. Because, in some way, it  
8 adds a bit of carrot, because now if you're doing  
9 really well, then you don't have this really,  
10 really brutally stressful experience every single  
11 year, but you still have those inspections coming  
12 in regularly.

13           We felt that was kind of a neat idea,  
14 because we could still maintain that assessment of  
15 quality, complaints and annual assessments would  
16 still do that. But I understand maybe it was a  
17 manpower issue or a womanpower issue, it was a  
18 logistics issue, those annual inspections didn't  
19 always take place, which was unfortunate.

20           I do support that risk-based  
21 assessment, because it does really focus in more on  
22 the homes that desperately need more, and it allows  
23 the Ministry to divert some of their resources more  
24 towards those high-risk homes.

25           There's been lots of press talking

1 about how failed long-term care facilities, and I  
2 think we need a deeper dive to figure that out.  
3 Because as we've seen, long-term COVID-19 large  
4 outbreaks, devastate homes no matter how good you  
5 are.

6 Some homes have done phenomenally  
7 better, thankfully, but I'm not personally sold on  
8 the -- if the home received a good inspection  
9 report, that there's something wrong with the home  
10 if COVID devastated them.

11 We need those inspections, we need  
12 those sticks, we know there's bad apples and we  
13 need those absolutely held accountable.

14 COMMISSION CHAIR FRANK MARROCCO: I'm  
15 having some difficulty with the fact that there's a  
16 waiting list.

17 So you have an inspection, you don't do  
18 very well, that's public, let's assume you make  
19 that public. But there's a waiting list, and it's  
20 a significant list, as you well know. So then you  
21 really don't have a choice anyway.

22 DR. HUGH BOYD: And that goes on to one  
23 of my third kind of blame games. You know, we  
24 blame IPAC on all health professionals; we all need  
25 to do phenomenally better.

1           The staffing issue, we blame the  
2 population for, because we're more interested in  
3 reading horrific stories in the newspaper than  
4 celebrating how much joy you can have ageing in a  
5 long-term care facility.

6           But we blame the waiting list on  
7 society at large. And this is a harder thing to  
8 realize, because long-term care used to be the last  
9 resort and is now the default when there isn't  
10 something ideal there.

11           And, unfortunately, that's something we  
12 all, as citizens, as voters, take responsibility  
13 for, because we've allowed a long-term care system  
14 which was a last resort become the default. And  
15 that waiting list is, if what I hear you saying  
16 correctly, I would agree that it's unacceptable.

17           COMMISSION CHAIR FRANK MARROCCO: I  
18 didn't mean to -- it is unacceptable, I think we  
19 all agree.

20           I was just saying that, you know, if  
21 you have a market, and you're not performing well,  
22 well, I'll go to somebody else. But my problem  
23 here is, I have no place else to go so, you know,  
24 it's -- I don't want to pick a particular home, but  
25 you're going there or you're staying on the waiting

1 list for a much longer period. And at the same  
2 time, we're told that the median time people spend  
3 in long-term care is somewhere around 12 to  
4 18 months.

5 So you might spend longer on the  
6 waiting list than you have left. And so I was just  
7 curious what you thought of that when you were  
8 dealing with inspections. I have no problem with  
9 the idea of a robust inspection regime. I can't  
10 imagine how you have effective regulation without  
11 it. But this is, it seemed to me, a complicating  
12 factor.

13 DR. HUGH BOYD: And add on to that, the  
14 financial coercion that takes place when a hospital  
15 starts charging your family rent because you're now  
16 at the hospital and you haven't been transferred  
17 to -- you either haven't gone home, or you haven't  
18 gone to a long-term care facility, and now there's  
19 additional financial pressures for you to choose  
20 whichever one is first available.

21 It is heart-breaking to see this  
22 happen. And not surprising, many times when  
23 patients become residents in long-term care  
24 facilities, I've often seen improvements in their  
25 health in the first three months. They get regular

1 medications, they get regular exercise, they get  
2 PSWs and nurses who have smiles on their faces, who  
3 make jokes, who create joy, and we see improvement  
4 in that first little bit. And then unfortunately  
5 diseases always win, and the disease takes over and  
6 their health progresses.

7 I think there are -- everyone here has  
8 been crying for years that there's efficiencies,  
9 improvements in home care that could be made to  
10 reduce that waiting list. There's creating  
11 opportunities to discharge people from long-term  
12 care. I've tried to discharge -- I've only done it  
13 twice in 11 years, have I been able to successfully  
14 discharge someone from long-term care. And if I  
15 could do that more, if this were seen as more of a  
16 possibly temporary situation, then maybe we could  
17 shorten that list as well.

18 That's a big issue. And I think  
19 everyone in the healthcare system wants to work  
20 together better to fix this. And I think our  
21 population, our people that this healthcare system  
22 is supposed to be focused on, deserve the choice  
23 that you're asking about. And they deserve the  
24 choices to be real choices. And one of those  
25 choices should be maybe not go to a nursing home if

1 they feel they don't want to.

2 DR. SAMIR K. SINHA: But I think that's  
3 just the fundamental issue here, right? I wrote  
4 about this back in 2012 when I did the senior  
5 strategy, is that, again, most people want to age  
6 in their homes for as long as possible.

7 That's not always going to be the  
8 possibility for some. And as Dr. Boyd mentioned,  
9 yes, sometimes long-term care is the right place  
10 for someone to receive the care and the support  
11 they need.

12 But CIHI has demonstrated that between  
13 10 to 30 percent of those who are on our waiting  
14 lists right now, who are in our long-term care  
15 homes right now, could have been cared for at home,  
16 you know, with existing resources and programs.  
17 But because we don't necessarily have the  
18 flexibility of service delivery models and that,  
19 when we find that sometimes people are defaulting  
20 to then living in the hospital or living, you know --  
21 or having to just wait and go into a home. And I  
22 think the fact is that because we have these long  
23 waiting lists, right? We currently have,  
24 officially, 39,000 people on the wasting list --  
25 but I think Dr. Stall will correct me -- I think

1 right now we only have 70,000 people currently  
2 living in our care homes.

3 So literally, today, if we re-opened up  
4 everything and just said, "Okay, pandemic is over,  
5 open up the doors." Well, then we've reduced our  
6 long-term care waitlist right now by 19,000 people,  
7 and all of a sudden we are down to where we started  
8 back in 2012.

9 But I think it really speaks to the --  
10 but I think the fact that you have this chronic  
11 waiting list, you know, why would I redevelop a  
12 home? Because redeveloping a home kind of would  
13 hurt me financially to a certain extent, right,  
14 unless someone makes me whole. You take that out  
15 of the system, and frankly, you know, if you don't  
16 have a solid inspections process; if you don't have  
17 to do all these things; and you have a constant  
18 flow of people that will get you to your 98 percent  
19 capacity, that allows you to get a fully funded mix  
20 from the province, there really is -- we almost  
21 disincentivize the opportunity to really improve  
22 the care of those people who need to be there. But  
23 we're also creating a false, you know, a false  
24 situation when so many people who end up in care,  
25 don't even need to be there in the first place.

1                   And when we've done report after  
2 report. When the Ministry of Health's own numbers  
3 -- and this is what I released in November, in our  
4 Bringing Long-Term Care Home Report through the  
5 NIA -- it was really focusing on this notion that,  
6 you know, we can actually provide much better  
7 holistic and integrated care for a lot cheaper than  
8 it costs to actually provide care in a home, to  
9 some people, not all. But yet we're not willing to  
10 actually build our entire system to think about how  
11 we need to care for an ageing population. Because  
12 this notion that we simply need to just build  
13 thousands of more beds, you know, I hesitate on  
14 building more beds, when we don't even have our  
15 current program working well within the beds that  
16 we currently have. I think we need to start there.

17                   I think there are actually ways in  
18 which you can provide high quality long-term care  
19 not within a building as well. And I think we  
20 could better serve many of the people who are  
21 currently on our waitlist, and frankly people in  
22 our homes.

23                   JOHN CALLAGHAN: Can I just add the  
24 FAO, the Financial Accountability Office -- and I  
25 appreciate, Dr. Sinha, this is probably based on

1 current data -- but they would say that by 2033, I  
2 think it is, not that long away, we need 55,000  
3 beds built, of which I think the government has now  
4 committed to 15,000.

5           And your current report provided an  
6 obvious glimpse into the fact that -- I've  
7 forgotten the number -- but those living in the  
8 community were not affected by COVID nearly as  
9 much. It was astounding, the number; I've  
10 forgotten what it is.

11           So it sounds like it might be a  
12 combination of both. Where does everybody see the  
13 future going? You just talked about it. But where  
14 do people see the future going? What do you tell  
15 the Commissioners of what it's going to look like  
16 in 2033; if you do it properly?

17           DR. SAMIR K. SINHA: It's just a start.  
18 I think fundamentally, you know, we have to figure,  
19 you know -- first of all, we have to remember that  
20 40 percent of the people in our long-term care  
21 homes, they don't actually -- you know, they can't  
22 even make their basic co-payments, right?

23           So you have to remember that long-term  
24 care ends up being an option for a lot of people  
25 who frankly don't have financial means; and even

1 basic financial means to make their co-payments.

2 So, you know, people who do have  
3 options can stay out of a long-term care home  
4 longer. They can go to a retirement home. They  
5 can buy supplemental private care.

6 I think fundamentally, yes, we're going  
7 to have an increasing -- we have a growing ageing  
8 population. Soon in Ontario by 2030, one in four  
9 of us will be 65 and older. And by the time you're  
10 85 and older, one in three people is living in a  
11 residential care environment, whether that be  
12 long-term care or retirement.

13 I think the key that we need to focus  
14 on here is if you look at -- you know, again, this  
15 is where I always go to my favourite country of  
16 Denmark. Frankly, two-thirds of the long-term care  
17 they provide are in people's homes. The  
18 infrastructure needs are already met.

19 And what we saw during this pandemic  
20 was, well, we saw thousands of people die in our  
21 long-term care homes from COVID. You know, tens of  
22 thousands of cases, if you will. What we did see  
23 was that only a few hundred people out of the  
24 700,000 receiving government-funded home care  
25 actually got COVID, and only a handful of those

1 people actually died. And that's partly because  
2 just going into people's homes separately, you have  
3 to don and doff. You actually are forced to  
4 actually apply some IPAC principles before you're  
5 going in and out.

6 I think the fundamental piece is, is  
7 that we can actually afford to provide more  
8 long-term care options in people's homes. And  
9 that's something that we did between 2012 and 2017.  
10 That's the story that often doesn't get told. But  
11 we created 30,000 more spaces with extra funding in  
12 home care, for long-term care equivalent people.  
13 These are, they would meet the same criteria to be  
14 in a home, to stay in their own homes, because we  
15 had more dollars in the home care system. Are  
16 those dollars being used well? No. Can they be  
17 used better? Absolutely.

18 But the key is, we actually have  
19 demonstrated a la Denmark, that by investing more  
20 in our home care system, we can actually provide  
21 more people the option to stay at home, and often  
22 for a lot cheaper.

23 Because the FAO, the Financial  
24 Accountabilities Office will tell you, \$230 a day  
25 is our current cost to provide care for a person in

1 a long-term care home. It's \$103 a day for a  
2 person in Ontario receiving home care, if they are  
3 a long-term care equivalent resident.

4 We have about 120,000 people 75 and  
5 older, currently receiving care in their own homes,  
6 who are long-term care equivalent versus the 80,000  
7 who are actually equivalent individuals, if you  
8 match them, who are living in a long-term care  
9 home. That's what we've achieved by investing more  
10 in home care. And I'm not saying it's an  
11 either/or, I think it's a both/and. But we have a  
12 very lopsided system right now.

13 COMMISSION CHAIR FRANK MARROCCO:  
14 Commissioner Kitts.

15 COMMISSIONER JACK KITTS: Dr. Sinha,  
16 can I just ask, it seems to us that the growing  
17 number of ageing population and the prevalence of  
18 cognitive dysfunction and dementia is really the  
19 root of the long waitlist, because so many -- we've  
20 heard that 85 percent of residents have some sort  
21 of cognitive dysfunction and almost 70 percent have  
22 a dementia.

23 So it seems to us that either delaying  
24 the onset or, in fact, preventing dementia, or  
25 being able to manage dementia at home is a key

1 deliverable in terms of managing the future.

2 We haven't heard that either of those  
3 are very close on the horizon. Can you comment on  
4 that?

5 DR. SAMIR K. SINHA: Yes. So will we  
6 have a cure for dementia in the next ten years?

7 No, we won't.

8 Is there literature that shows that  
9 there's things we can do to prevent the onset of  
10 dementia? Absolutely.

11 You know, there are things we can do to  
12 improve vascular health, for example, has lowered  
13 the incidence of dementia over the last number of  
14 years. Is that going to solve our long-term care  
15 crisis in the next ten years? No.

16 Part of the challenge we had was (A)  
17 access to early diagnosis and intervention. When I  
18 talk about intervention, I don't mean a pill. I  
19 actually mean having a community-based social  
20 worker, or people through the Alzheimer's Society,  
21 caregiver supports and training, access to adult  
22 day programs, access to adequate home care.

23 Those are the things that actually  
24 allow most of my patients with dementia, because  
25 pretty much all of my patients are living with

1 dementia -- some of them will read the transcript  
2 and they'll disagree. But the point is that when  
3 you actually have a functioning system, right, with  
4 healthcare providers -- remember, we don't mandate  
5 geriatric training in any of our medical schools  
6 right now, right?

7           We have primary care providers who are  
8 excellent primary care providers, but not all of  
9 them have care of the elderly training like  
10 Dr. Boyd does as well. So we actually created in  
11 2017 an Ontario Dementia Strategy. We're very  
12 proud of that strategy.

13           The final PS services in year three  
14 never got funded. And that actually talked about  
15 networks support that were based in primary care  
16 that were really supporting us being able to do  
17 early diagnosis and intervention, linking people  
18 early into home care support. Because when you get  
19 people those supports early, it actually prevents  
20 that quick, rapid deterioration, but then gets them  
21 on a crisis placement list via a hospital bed and  
22 then into the system.

23           When you actually look at the people  
24 living with cognitive impairment, you're absolutely  
25 right, 90 percent of the people in long-term care

1 have cognitive impairment. The majority of people  
2 receiving government-funded home care in Ontario  
3 have cognitive impairment.

4 But the key is, if you even look at the  
5 types of people with cognitive impairment in our  
6 long-term care homes, CIHI notes that a number of  
7 them have mild cognitive impairment, like not FCI,  
8 but more mild dementia, that their needs are  
9 actually not that heavy and they could be met well  
10 at home.

11 But if we had a functional system from  
12 diagnosis, early intervention, you know, stronger  
13 community support, and then, obviously, long-term  
14 care with the properly supported staff to really  
15 provide that care to a very unique population, who  
16 may not understand what a pandemic is, and how to  
17 wear a mask and not to wander into other people's  
18 rooms.

19 That's a layer that I think throughout  
20 this entire thing is we can talk about more  
21 doctors, more nurses, more different people, but if  
22 they don't have that general training in care of  
23 the elderly, you know, I really feel that we often  
24 sometimes miss the subtleties that allows to  
25 provide excellent care throughout the system.

1                   COMMISSION CHAIR FRANK MARROCCO: If no  
2 one else has a view, I don't want to cut anybody  
3 off. But thank you very much.

4                   You know the rates we pay, so  
5 assembling all of you is something that we really  
6 appreciate. We really appreciate the contribution,  
7 and professionally, I think we understand the  
8 motivation.

9                   The questions we put are questions  
10 we're wrestling with, and it is very helpful to get  
11 your collective response and just to talk about the  
12 issues, and to have a transcript that we can go  
13 back to so that we can refresh our memory from it.

14                   But thank you very much for your help  
15 and your assistance. And we'll continue our work,  
16 which is gradually shifting towards writing than  
17 anything else.

18                   Anyway, thank you all very much on  
19 behalf of all of us.

20

21 -- Adjourned at 1:02 p.m.

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REPORTER'S CERTIFICATE

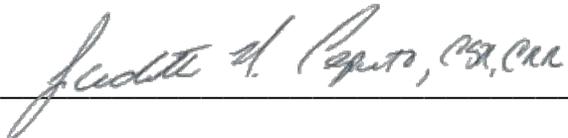
I, JUDITH M. CAPUTO, RPR, CSR, CRR,  
Certified Shorthand Reporter, certify;

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

That the statements of the presenters  
and all comments made at the time of the meeting  
were recorded stenographically by me;

That the foregoing is a Certified  
Transcript of my shorthand notes so taken.

Dated this 5th day of March, 2021.



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NEESONS, A VERITEXT COMPANY

PER: JUDITH M. CAPUTO, RPR, CSR, CRR.

C L A R I F I C A T I O N S

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Page 5, lines 19-20: Should be corrected to  
read, "chief of staff of a  
post-acute hospital that  
also has a long-term care  
facility."

Page 34, line 14: "OMA" not "OMAY"

Page 57, line 23: "medical advisory committee" not  
"medical advisory council"

<b><u>WORD INDEX</u></b>				
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