Long-Term Care COVID-19 Commission Meeting

Medical Update Panel
on Thursday, March 4, 2021

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 4th day of March, 2021, 11:03 a.m. to 1:02 p.m.

BEFORE:

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

PRESENTERS:

MEDICAL UPDATE PANEL:
Dr. Allison McGeer, MD, FRCPC, Infectious Disease Consultant, Sinai Health System; Professor, Departments of Laboratory Medicine and Pathobiology and Dalla Lana School of Public Health, University of Toronto; Sinai Health
Dr. Nathan Stall, MD, FRCPC, Geriatrics and Internal Medicine, Sinai Health and the University Health Network Hospitals; Research Fellow, Departments of Medicine and Health Policy, Management and Evaluation, University of Toronto; Sinai Health
Dr. Hugh Boyd, MD, CCFP(COE), Chair of the Section on Long-Term Care and Care of the Elderly; Ontario Medical Association

Dr. Samir Sinha, MD, DPhil, FRCPC, AGSF, Director of Geriatrics, Sinai Health System and the University Health Network; Director of Health Policy Research, National Institute on Ageing; Sinai Health System and the University Health Network; National Institute on Ageing
Dr. Jennie Johnstone, MD, PhD, FRCPC, Infection Prevention and Control Medical Director, Sinai Health; Infectious Disease Physician, Sinai Health and University Health Network; Associate Professor, Department of Laboratory Medicine and Pathobiology, University of Toronto; Associate Professor, Dalla Lana School of Public Health, University of Toronto; Sinai Health.

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Senior Legal Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Co-Lead Commission Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director, Operations,
Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Alain Daoust, Team Lead, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angeline Hawthorn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat
John Callaghan, Co-Lead Commission Counsel, Gowling WLG
Lynn Mahoney, Counsel, Gowling WLG
Michael Finley, Counsel, Gowling WLG
Patricia Brooks, Counsel, Gowling WLG

ALSO PRESENT:
Judith M. Caputo, Stenographer/Transcriptionist

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

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

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

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

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

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

JOHN CALLAGHAN: I may have missed

that, so my apologies.

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

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

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

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

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

Go ahead, Dr. Stall.

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

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

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

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

outbreaks and, thankfully, a flattening of deaths.

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

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

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

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

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

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

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

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

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

And also, really, I would say

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

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

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

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

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

you mind starting that off?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ministry of Health Long-Term Care, or both.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You had the Premier of Québec in May

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

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

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

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

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

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

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

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

So we literally have some agency

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

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

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

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

DR. SAMIR K. SINHA: Thank you.

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

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

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

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

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

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

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

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

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

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

DR. SAMIR K. SINHA: Yes.

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

DR. JENNIE JOHNSTONE: Thanks, Dr. Stall.

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

But post-SARS, we have PIDAC, which

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

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

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

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

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

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

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

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

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

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

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

COVID-19 pandemic.

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Dr. Kitts?

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

(Interruption in the proceedings due to connection difficulties).

-- OFF THE RECORD DISCUSSION --

COMMISSIONER JACK KITTS: Back to Dr. Johnstone.

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

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

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

And the one other thing I want to add

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Oh, I see.

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

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

COMMISSION CHAIR FRANK MARROCCO: All right.

Commissioner Coke, you were trying to ask a question.

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

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

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

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

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

long-term care for physicians in the province.

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

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

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

DR. SAMIR K. SINHA: If I can interrupt

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

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

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

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

When Dr. Boyd is doing this, you know,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IPAC lead; is that what you're saying?

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

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

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

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

I think someone made the term, the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. ALLISON McGEER: Go ahead, Jennie.

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

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

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

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

infection control.

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

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

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

DR. ALLISON McGEER: Yes. And one of

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

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

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

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: Dr. Boyd?

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

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

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

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

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

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

One question I was going to ask was --

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

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

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

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

of medical director training.

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

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

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

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

doing since 2020, certainly.

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

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

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

JOHN CALLAGHAN: Thank you.

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

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

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

DR. HUGH BOYD: Thank you.

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

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

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

Leaders are not born, they are created.

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

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

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

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

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

the one they had.

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

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

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

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

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

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

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

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

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

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

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

wait until they were literally legally --

[Connection difficulties]

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

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

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

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

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

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

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

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

DR. HUGH BOYD: Thank you, Justice Marrocco.

The downside to that is that the medical director would now be reportable to Chief of Staff who, historically speaking, likely knows

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

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

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

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

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

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

DR. HUGH BOYD: Thank you.

We have to be careful, because this is a home. We're trying to not do it as an institution, despite the obvious fact it is. And we have to be careful about taking institutional policies and applying it to someone's home.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Mr. Callaghan, were there other topics? I think we've exhausted --

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

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

DR. NATHAN STALL: So what we showed

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

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

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

So just to give you the actual data, if

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

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

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

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

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

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

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

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

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

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

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

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

This is consistent with decades of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reporting to the local hospital? Not necessarily.

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

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

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

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

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

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

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

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

DR. HUGH BOYD: Yes, Commissioner Coke.

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

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

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

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

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

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

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

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

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

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

No, okay.

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

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

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

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

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

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

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

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

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

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

The issue that I want to speak to, and

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

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Commissioner Coke?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. SAMIR K. SINHA: Right.

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

DR. SAMIR K. SINHA: A hundred percent.

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

this home, for example, from Accreditation Canada".

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

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

Dr. Boyd.

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

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

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

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

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

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

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

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

Coke pointed out, it's not enough.

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

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

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

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

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

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

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

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

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

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

And so it's trying to improve care,

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

And so the inspection program we have now, most of us view it as an absolute necessity, but view it as a very stressful and very punishing experience to go through to try to maintain those standards. And, of course, the punishments have escalated massively in the last few years. Understandable, because there are bad apples. And our people need to know that those bad apples will be rooted out, and they will be identified and there will be improvements.

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

So if your home had a good history,

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

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

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

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

There's been lots of press talking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

they feel they don't want to.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

basic financial means to make their co-payments.

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Commissioner Kitts.

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

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

deliverable in terms of managing the future.

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

DR. SAMIR K. SINHA: Yes. So will we have a cure for dementia in the next ten years? No, we won't.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

-- Adjourned at 1:02 p.m.

REPORTER'S CERTIFICATE

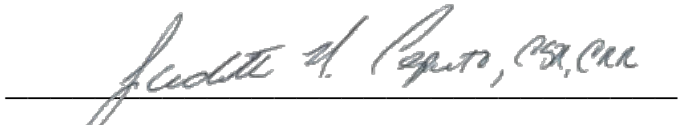
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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.



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

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"

WORD INDEX