Long Term Care Covid-19 Commission Mtg.

Meeting with Ontario Hospital Association
on Monday, October 5, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 5th day of October, 2020, 2:00 p.m. to 4:00 p.m.

BEFORE:

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

PRESENTERS:

ONTARIO HOSPITAL ASSOCIATION:
Anthony Dale, President & CEO
Melissa Prokopy, Director of Legal Policy and Professional Issues
Gillian Kernaghan, CEO St. Joseph's Health Care
Elizabeth Carlton, Vice President, Policy and Public Affairs
David Brook, Vice President, Labour Relations & Chief Negotiations Officer
Barbara Collins, CEO Humber River Hospital

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat

John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, let me thank you all for coming. I am Frank Marrocco. I am Chair of the Commission. You know Jack Kitts, and I guess some of you know Ms. Coke too, so that makes it a little easier.

Let me give you the same -- I have sort of said this to everybody that has come here, but I think it helps hopefully set the conversation or the context.

Typically, when there is a Commission called, it is something that has happened, and the Commission is looking back at what has happened to try to explain it. It does an investigation. It holds public hearings, and it writes a report. And typically that can take a couple of years.

Ours is different because we have been called into existence, if you like, in the middle of something, something that isn't over.

And so really there is no mold, except maybe what happened with the SARS Commission, but even then it was different.

So what we are trying to do is see if

we can come up -- we are doing it a bit reverse order. Before we start looking back at what happened, we are trying to figure out if there is some constructive recommendations that we can make in the short run that will be useful. We don't know how long wave two will be here, but maybe there will be wave three. We don't know.

I noticed that there were some adverse results for two of the vaccine candidates today, nothing serious, at least it didn't seem serious to me, but it seemed serious enough to them that it got publicized.

So that is what we are about, and we are doing that by interviewing people and really want their input, and then we'll try to figure out what, if anything, we are going to do with it.

We have a court reporter, our transcriptionist, Deana, is here, and there will be -- there is a transcript, there will be a transcript. We have tended to post them on the website because we want to make ourselves as transparent as we can, but we can't do it by way of the traditional way of doing that because it will just simply take too long.

So with that introduction,

notwithstanding the technology, I still resort to a pen and a piece of paper from time to time to collect my thoughts, and we have followed the practice of interrupting and asking questions rather than waiting until you are finished and going back.

So if that is okay, then we'll continue to follow that practice.

So with that, we are ready when you are.

ANTHONY DALE: Well, thanks very much, Mr. Marrocco, and it is a privilege to be invited to speak with you and the other members of the Commission.

Perhaps before we get into an outline of how we thought we would frame our comments to you today, we could introduce ourselves as individuals. So I am Anthony Dale, and I am President and CEO of the OHA, and along with me today are several members of the OHA staff, as well as two CEO's from organizations that are part of the OHA and have been involved on the frontline of the pandemic.

Perhaps I'll invite Gillian and Barb to introduce themselves first. Please, Gillian.

GILLIAN KERNAGHAN: Thank you. My name is Dr. Gillian Kernaghan, and my background is family in medicine. My current role is the President and CEO of St. Joseph's Health Care London. I will introduce to you to St. Joseph's. Part of my role in being here is I was asked to provide regional lead for our old LHIN boundaries. We call it LHIN 2 or the South West, for the hospital system, but also for the long-term care system in the South West during wave one and continue to provide that support in wave two.

So we'll share with you some of the learnings from the 70-plus homes in providing that leadership across this region.

ANTHONY DALE: Thanks, Gillian. Barb?

BARBARA COLLINS: I'm Barb Collins. I'm President and CEO at Humber River Hospital. My background is nursing for over 40 years, initially in long-term care, moved to critical care, operating room, emergency departments, and acute care hospitals. I have been at Humber River for, I guess, 19 years and became the CEO about four years ago. The reason I'm here is we supported nine homes in many congregate settings, but we had a Management Order, a Mandatory Management Order, in

one long-term care facility and a Voluntary Management Order in a second, and we are still helping with those and the other nine homes, and I'll provide you some information about that later.

ANTHONY DALE: Elizabeth.

ELIZABETH CARLTON: Good afternoon, everybody. I'm Elizabeth Carlton. I'm VP of Policy and Public Affairs with the OHA, and it is really largely my team, in addition to Dave's team, that really supports the sort of COVID effort at the OHA.

ANTHONY DALE: David?

DAVID BROOK: Sorry. Good afternoon, David Brook, I'm Vice President, Labour Relations and Chief Negotiations Officer, and again, with Elizabeth, working with our team to support hospitals over the past few months in the response.

ANTHONY DALE: And last, but not least, of course, the anchor for the OHA staff is Melissa. Go ahead.

MELISSA PROKOPY: Hi, everybody. I'm Melissa Prokopy. I'm the Director of Legal Policy and Professional Issues, and my department in particular has been providing policy and legal supports both within the Policy and Public Affairs

Division and cross-support to David and his division in the context of labour.

ANTHONY DALE: So that is who you have with you today. In terms of a rough outline of how we thought we would proceed, keeping in mind we agree completely the importance of a conversation and dialogue throughout this, is that we thought we would do a quick overview of the OHA and our members, talk about our role as an organization supporting hospitals and other providers during the pandemic so far.

Then shift into hospital preparation for COVID-19 and support to long-term care, as we saw it.

Hone in on some observations about labour and the work force and its relevance to this.

And then we have been working for six to eight weeks on compiling firsthand kind of testimonials and reflections and recommendations from a very wide range of OHA members, so we have some reflections to start to address your emerging impetus for an interim report in fairly short order.

And then also relevant is some

considerations for wave two and how to make sure that the residents of long-term care remain as safe as possible during this next fall and winter season.

So what is the OHA? The OHA is about a hundred years old. It is one of the largest trade associations in the country. We are obviously a member organization comprised of hospitals and health systems, governed by our own board.

It is important to note we are not a regulator of hospitals, but the membership of the OHA does rely on the OHA for ongoing support, guidance, policy, consulting and so on, in a whole range of areas, and that has certainly been brought to the fore during the pandemic.

I think it is worth saying that we know we are fortunate to be blessed with significant resources and significant capabilities and that has helped us not only support hospitals, but the wider systems, specifically long-term care.

And our anchor role in supporting the membership during the pandemic is probably unique of the health provider associations in the province. What I mean by that is by the depth and breadth of the supports we have provided.

Just very quickly, some of the roles we play, both before the pandemic and through the pandemic, are ongoing advocacy in respect to raising issues and concerns and priorities with the government of the day.

We have a large program that provides learning and other educational opportunities for OHA members and other health providers. That has been focussed into a specific stream through the first wave of the pandemic.

We have a history in collective bargaining and labour relations that is unique in the province for an association, beginning back into the 1970s when collective bargaining was consolidated on a provincial scale in hospitals. The OHA has been funded by the government of Ontario to support hospitals in their ongoing collective bargaining and labour relations.

This has provided us with a centre of expertise that is unique in the province and is a key area that we offered in terms of advice and recommendations to the government as the pandemic unfolded in its early months.

We have our own data and analytics program which is used to -- still fairly new, but

is used to provide hospitals with different administrative and operational comparative data. We have adapted and evolved that programming to also support them in different data set requirements in different service offerings that they can use to utilize data as they navigate the pandemic, particularly in the area of PPE.

And why don't we just quickly move through those, Melissa. Those are just some other sort of mainstream areas that are not essential to the pandemic response.

In terms of hospitals, I just wanted to take a moment to reflect on the fact that, as Gillian will emphasize, you will hear significantly the Ontario hospital sector is an extremely diverse sector. When people think of hospitals, they often think of acute care and emergency departments, and certainly those organizations play a very prominent role in the health services delivery system of the province.

But there are a very wide range of other hospital types too. We have specialized organizations that are stand-alone, like Gillian's. Others are a combination of diverse other non-acute or post-acute services, and I know both Barb and

Gillian will speak to that diversity later on.

But you will see before you there on the chart some of the kind of core information about our 141 public hospitals operating across 262 sites right across the Province of Ontario.

All hospitals are contributing to the pandemic response at the moment, but I think it is fair to say that because the pandemic is concentrated so far in the City of Toronto, the Greater Toronto Area, Ottawa, and in parts of the southwest, that it is organizations, particularly very large ones in those parts of the province, that have had an anchor role in serving their communities in very, very diverse ways.

Keep going, Melissa, please.

So we just thought it would be valuable to frame for you our perspective heading into January and February of this calendar year, and just maybe to emphasize a couple of things.

One is that over the past 10 to 15 years advocacy has come to play an increasingly prominent role in health care decision-making, and so heading into the pandemic, the culture of engagement and relationships between all kinds of health providers and their member associations is

founded on the advocacy that takes place literally every day with the government of the day, no matter what the stripe, at Queen's Park and with the public service.

And that is just a feature of our society, and it is a very healthy one. I do think that the culture of advocacy has played a role, though, in shaping the pandemic response, and the kind of culture of decision-making has had to shift quite rapidly to adapt to an environment that is far more appropriate in the sense that command and control is necessary for the government and its relationship with the field.

Speed and rapid decision-making are necessary, and the challenge in that context is timely information, accurate information, contextual understanding of the field, contextual understanding of health and human resource issues. These are the kinds of things that you'll hear us talk about through our time with you today.

The health care system is also going through a very significant restructuring, just as the pandemic hit, so Local Health Integration Networks and a regionalized model being changed and adapted to create an Ontario Health agency, so

many, many agencies coming together to create a new way of providers working together in terms of governance oversight.

I think that the creation of Ontario Health rather fortuitously has been a real asset to the pandemic response and the creation of the five regions, but the truth is that the system was also undergoing quite a lot of change and evolution at the very moment the pandemic struck.

So traditional processes of communication, traditional processes of engagement, were in a state of change, if not upheaval, and we think that is worth saying at the outset.

From our perspective -- and I know this is reflected in some of the government's own evaluations to date -- with a Ministry, with Ontario Health, with LHINs, with various provider agencies, with hospitals, with long-term care homes, with so many different organizations, the structure of decision-making through, I guess, an evolving and incident management structure has been complex and at times challenging.

And to this day, it is clear that tight, efficient, effective, timely decisions are not always the case, and this is clearly a factor

heading into the pandemic as we got deeper and deeper.

COMMISSIONER FRANK MARROCCO (CHAIR):

If I can interrupt you for a minute, just as a person with no particular background in the area to start with, it does seem that there is a lot of these tables, different kinds of tables, and it is very difficult to figure out, at least from an outsider's point of view, who is in charge. I mean, is that just me, or is there something to that?

ANTHONY DALE: No, you are right. You are definitely right.

I think, you know, operational implementation of the pandemic response through Ontario Health has been an asset to the pandemic response.

Ontario Health has matters within its purview. Sometimes there are policies that are guidance to the field. But often times that can be interpreted or confused by the field as the equivalent of, say, a directive or an order of the Chief Medical Officer of Health for Ontario or an order issued by the Provincial Cabinet or any number of different authoritative mechanisms.

And you are right, there are many tables that aren't even at times transparently known to the field. It is not to say what is going on at those tables isn't very important and relevant, but it is a big role for the OHA in sense-making all of this and providing practical, focussed, on-topic advice and guidance to the field.

So that was a huge role, especially in the early days when government was shaping policy so quickly to respond to the pandemic. So we have an incident management team at the OHA that at the time was meeting every day for hours at a time, and our job was to really sense-make the environment and make sure the members and even the wider health system got the quick and timely information that they needed to prepare for the pandemic response.

And that role of the OHA that I alluded to, not all sectors are able to do that, and we recognize that, but that also may have been a factor in the pandemic response as it relates to long-term care.

You know, we are not kind of equipped to fully judge that because, you know, they have some great staff and resources at the Long-Term

Care Association and AdvantAge Ontario, but just by OHA's size and depth in these different areas, we were able to play a different, I think, kind of anchor role in terms of the understanding and interpretation and then application of all these various orders and directions and other kind of communications from the province.

I think it is fair to say that right from the very beginning long-term care has been treated separately from the rest of the health care system when it comes to the coordination of the pandemic response. Right from the very time when the Ministry established a stakeholder relations table comprised of a very wide range of health provider organizations, the two long-term care associations were not present. They hadn't been invited, and it took weeks for that to be rectified.

And I think that in a nutshell reflects the challenge that faced long-term care in the early stages of the pandemic. By creating a kind of separate, stand-alone, tiny Ministry that really is just the inspectorate, plus some specialized policy and funding expertise, I don't think it will have -- I don't think history will judge the

decision last summer -- a year ago last summer to create a stand-alone long-term care Ministry as having been a wise one.

I think that its separation from the Ministry of Health has created systemic kind of silos and barriers to integrated thinking for the response, and you will see in a moment some of the communications and actions we took after we realized that long-term care was not -- the needs of long-term care and the need for speed and substantive planning and preparation for the pandemic response, once we realized that those were not being met, we chose to act and undertake some actions to address that.

COMMISSIONER FRANK MARROCCO (CHAIR):

Can you just help me. So for some reason long-term care isn't thought of as a stakeholder initially. I am trying to understand why it would take weeks to rectify that. Let's assume it is an oversight. I don't understand how the oversight happens, but do you have any -- can you help me at all with why it takes weeks?

ANTHONY DALE: Well, I can't explain it either, and it has been, I think, the area of surprise and concern for us that there was a delay,

and, you know, personally I felt, you know, starting in February and in talking with some of the long-term care community, that it was evident that they felt more on the outside than on the inside of the government's communications and engagement for the pandemic response.

And I personally, once the declaration of emergency was declared, I, at the invitation of the Ontario Long-Term Care Association, attended a meeting, I think it was on March 21st, a teleconference meeting, with the Deputy Minister of Long-Term Care, Barbara Yaffe, Dr. Andy Smith from Sunnybrook, several other individuals, and the purpose was to try to bring to the Ministry's attention the fact -- attention to the fact that there was infection prevention and control capability within the hospital community that really could be mobilized very, very quickly to support long-term care homes.

And we had people from the hospital community, like Andy, to speak to its viability and the willingness of that community really to support long-term care. And it was a frustrating meeting because it was really evident that the public service was sort of learning how to kind of grapple

with this proposal, and there were a lot of questions about implementation.

And I personally felt that the conversation could have had a more urgent tone to it, but that is just my own personal opinion.

But if you fast-forward to Good Friday, once we had reached the decision that there was a state of paralysis or indecision at a minimum with respect to action on long-term care, the OHA wrote a letter to Premier Ford, which was in your pre-reading which we sent on Friday, really insisting on immediate action to prevent unnecessary loss of life in long-term care homes and other congregate settings for seniors.

And the core of the recommendation was to mobilize the hospital work force that was available because of the shutdown in elective activity. So the good news is that shortly thereafter, the following week, the government undertook the decisions and the actions needed to do that, and it accelerated what had already started to happen through on-the-ground relationships and decisions by hospitals with their own local long-term care homes. Many were just already going in on a volunteer basis seeing the

urgency.

But I think it was a very worrying time. It was a confusing time. You know, I spoke to the Minister of Long-Term Care. The day our letter went into the Premier, she called me, and she expressed gratitude for the OHA's recommendations, and she felt it would help generate momentum for necessary change.

But of course the Minister will speak for herself, I'm sure, on her own impressions of that time.

COMMISSIONER FRANK MARROCCO (CHAIR):

I don't want to pour gasoline on the fire, but I do feel I have to ask this question. What is the reluctance to turn to the local hospital for help, like for the expertise to deal with this pandemic? I mean, if the people got sick, you might put them in an ambulance and send them to the hospital. In normal time, anyway, that is what you would do.

And I guess what I don't understand is why this wouldn't have been kind of an obvious it is an emergency. We don't have time to scour the world and recruit all these experts and duplicate what is already in the hospital, or at least in the

hospital network.

Can you help me with that at all?

ANTHONY DALE: Well, I think it gets to the bifurcated decision-making between Health and Long-Term Care. I think -- in retrospect, I think both Ministries would probably agree that accountability, role, clarity, both for the pandemic response and for other aspects of long-term care was, you know -- it was evident that it needed improvement.

And it is important to remember, like this Ministry of Long-Term Care has never been a separate portfolio that I can recall in Ontario's history, modern history, so the name of the Ministry of Long-Term Care was created I think back in the late '90s or the year 2000, right around then. But it was in August of the previous year that it was turned into its own portfolio.

And again, to me as an observer, it was primarily to house the inspectorate and focussing in on the government's commitment to expand long-term care construction. So when the pandemic hit, I think you saw the lack of role clarity play itself out.

And I think the government still

struggles with it to this day. Some of the -- we have been very active with the government writ large really strongly encouraging it to make sure that it has its contingency plan ready for the fall, and the government has just completed a kind of week or week and a half of the news cycle releasing it.

We really worked very hard with the long-term care provider associations and other health care associations to make sure that long-term care got unique attention in that context because it requires it, and it certainly requires it going into the second wave.

So I think it was a mistake, personally -- that is one person's opinion -- to have hived it off a year ago, but I doubt very much the government at that time thought that it would be facing this pandemic either.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay, thanks.

ANTHONY DALE: So let's move ahead here, Melissa.

This is a very important slide for any of our hospital leaders and really any health system leader because it shows a terrible historic

dysfunction within our health care system.

So this is a chart telling -- or showing to all of you the time series of a number of alternate level of care patients in Ontario hospitals.

So an alternate level of care patient is someone who has finished their time in hospital and is waiting for discharge to another more appropriate setting, and the number one destination for discharge from hospital is long-term care.

It is a sign of a system not in proper balance. It is a sign that we don't have enough capacity in long-term care. It is certainly a sign of the need for more capacity in terms of home and community services, important rapidly growing services like mental health and addiction and so on, all outside of the classic institutional setting.

So -- and I will invite certainly Barb and Gillian to comment on the dependence and interdependence, I should say, between hospitals and long-term care, but there is a high degree of need from a hospital point of view to be able to discharge patients in a timely manner. Otherwise, we keep a very high number of those ALC patients in

a place where they really shouldn't be and in a pandemic that is an increasingly serious problem.

Long-term care patients, the reason -- one of the most significant reasons why this is a major health policy issue is it contributes to hallway health care, and of course in a pandemic you can't have hallway health care.

But maybe I'll just stop here for a minute and invite Gillian and Barb to really comment firsthand on this dynamic from a health leader point of view.

BARBARA COLLINS: Gillian, do you want me to start? I'll say that years ago hospitals used to themselves arrange to move patients to the long-term care home. They had the coordinators to discharge people that did it.

By virtue of that, you had a closer relationship with your long-term care homes. Over time that model has evolved. There were people in the LHINs, people in the regions, that were making the move to move patients.

The shortage of long-term care beds and the speed at which you move patients and then a significant number of blockages like the patient is too heavy or they wander or whatever, the other

issues are -- really led to people not being transferred in a quick enough manner to the long-term care home.

I will just go back and comment on one thing, and you wondered why, you know, maybe we didn't focus soon enough on long-term care. I think -- and we did a lot of modelling in acute care and of course acute care was the big pressure, and the modelling in the meetings we sat in in acute care were about how overwhelmed the intensive care is really going to be, how overwhelmed the in-patient units were going to be, how overwhelmed the emergency departments are going to be.

And I think, you know, we will never know whether those models were right in ramping back and focussing so much on it helped, or the models led us in a direction that was maybe a little bit different.

I do not very early on in the disease remember ever thinking or reacting to the fact that if the older population in the long-term care homes get affected or congregate settings we will have trouble. I believe that came later, and there was just enough time for us to miss, focus on acute care, which is always think we are the centre of

the world, right? So focus on acute care, focus on emerg, focus on critical care, and not focus enough on long-term care, and some of the lessons in other parts of the world might have showed us that it was the elderly population most affected by this disease. So that goes back, Mr. Marrocco, to the other question you were asking.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

ANTHONY DALE: Gillian.

GILLIAN KERNAGHAN: A comment I would make -- I won't repeat anything that Barbara said, but I think the other comment that was made is when we were originally planning for wave one, the emphasis was to move as many people out of hospital into long-term care and take up every available long-term care bed.

And the challenge that that posed was -- and this is not a criticism because decisions were made on what they thought was best at the time, but it meant that when long-term care started to see cases with COVID, they had no places to isolate people because they were full.

So it created some limitations. They also had limited access to PPE at the beginning,

and we can talk about that as we go on, as far as our more detailed experience.

But I think that the other factor was we filled up long-term care as much as possible to decant the hospital, and if you look at the numbers of people that were transferred in February and March, there was a significant upswing in getting everybody out of hospitals as much as possible and to create the capacity in the hospital.

And it was after that there was a recognition that we were heading into challenges within long-term care.

ANTHONY DALE: So certainly what Gillian and Barb have said is right from the perspective of having been in the field with hands-on roles in leading regional pandemic planning efforts, and in combination with the other pieces we have just talked about in terms of the governance of the health system and provincial level pre-pandemic planning and then pandemic management, you know, you can see that long-term care was clearly vulnerable in retrospect.

COMMISSIONER FRANK MARROCCO (CHAIR):

Do I understand this chart correctly, the one that was there before, that in September

2020, if you moved all of the people out that shouldn't be there, it would create 5,000 beds in the hospital?

ANTHONY DALE: Yes. So there is about 30,000 beds, acute and post-acute, in Ontario. About one in six are occupied by someone who, you know, has finished their time there, but through no fault of their own can't be discharged.

And, again, the reason for this is truly historic in the sense that successive governments have never built the capacity required to re-balance things. And in fact, for years leading up to the pandemic, really I think the previous government had an informal policy of choosing not to construct much in the way of long-term care capacity, feeling that focussing on home and community services as an alternative was preferred.

And to us, this is an excruciating topic because for years the OHA has been calling for an evidence-based health system capacity plan for the province, so taking data and population health need and using all of our complex programs and information systems to start accurately forecasting what we need to build and invest in to

meet the future needs of the province, and when you don't do that for 20 years, you end up with this, one in six people in hospital who really should be in another setting that is better suited to their needs.

And unfortunately, this is a big risk for the province, as we head into the fall and winter, because with hospitals playing so many roles in the pandemic response, running the assessment centres, the laboratories are going 24/7, many hospitals, both formally and informally, continue to support long-term care. There is a backlog of surgical activity that they are trying to catch up on. There is the planned and ongoing elective activity that also still has to happen in addition to the catch-up, and then there is, of course, emergency departments and trauma and all of the things that all sorts of different kinds of hospitals do.

So there is a huge amount of risk uploaded into the system, and with our colleagues in long-term care facing the challenges that they are, even with the assistance of hospitals, this is quite a precarious situation, and it is why we have been so aggressive in calling for new public health

measures to stop community spread because it is likely not possible to discharge this many alternate level of care patients quickly and in a timely manner to the setting that they need to be in.

So that, in combination with, say, a COVID surge where there is increased hospitalization, increased ICU occupancy and all the other roles, means we all have our work cut out for us.

So that is the dynamic unfortunately that continues, and these are historic high numbers, unfortunately. Sort of around 5,000, up to 5,300 ALC patients I think was the high in June or so. It has come down a bit, but the summer is usually a quiet season -- quieter, I should say, and the fall and winter, with flu season and so on and all the different demands on the health system, this is -- it is why we have chosen to be very clear in the public domain in recent days that this is -- there are extraordinary pressures facing our hospitals heading into the next -- into the fall and winter season and the second wave of COVID-19.

GILLIAN KERNAGHAN: Anthony, if I could just add one piece of information. The other thing

that is aggravating in keeping the numbers high at this point in time was the decision that individuals who are in three- and four-bed rooms could not be admitted or re-admitted. So if they ended up in the hospital, they couldn't be re-admitted to a three- and four-bed room.

So then we are waiting to find an alternate bed, whether it is in that home or may require somebody to look at an alternate home.

We lost in the South West, which it was the old LHIN 2 boundary, we lost 674 beds as a result of that decision because we have a disproportionate number of older homes in the rural communities, and so that puts a significant upward pressure on the individuals who need an alternate level of care that is actually appropriate for long-term care, and with about 65 percent of people in long-term care having some cognitive challenges, home care isn't always an option, even if home care was available.

So I think that has aggravated these numbers and will only continue to aggravate them as we head into the fall.

COMMISSIONER JACK KITTS: Anthony, it is Jack. Unlike wave one where long-term care

homes were full, hospitals weren't.

So wave two we are going into with both long-term care and hospitals full.

ANTHONY DALE: Right.

COMMISSIONER JACK KITTS: And I am just wondering what conversations are being had about finding capacity, because if they are both full, we are going to have to find some place for them.

So are you aware of conversations around capacity?

ANTHONY DALE: Yes, the Ministry of Health has created regional health capacity -- health service capacity plans for the winter and, you know, it would be best for public officials to present to you on that. Mike Heenan is the Assistant Deputy Minister responsible for it.

But I would characterize it as a combination of providing support, funding support, for alternate health facilities such as, you know, field hospitals or hotels, motels, that can be repurposed safely and correctly to care for patients in a surge environment, some additional bedded capability within hospitals as well. I believe they also have enhanced funding for home care in order to maintain stability in terms of

their volumes. I am told that their volumes dropped quite significantly, and so that is also a factor, as you know, Jack, very well in terms of flow for a hospital.

But I wonder, Gillian and Barb, if you could comment from your own firsthand experiences on where we are with regional health service capacity planning for the surge?

BARBARA COLLINS: So we are back at talking, as you know, the outlet is going to be cancel elective surgery cases if in fact there is nothing else, and the 4 or 5,000 patients in acute care waiting for long-term care, not that much higher than the days when we were sitting on the hospital hallway medicine task force.

So that is a known factor. We survived last time, largely because we cancelled surgery. It is being spoken about as a dimmer switch this time. So maintain 85, 90 percent occupancy and ramp down, if we need to, I think is going to end up being the only out with exception of some of the things that Anthony mentioned. Health human resources becomes a bit of a problem when you start trying to staff and build hospitals and hotels and places like that.

So it causes some concern, and I can foresee if we meet some of the worst case scenario that there will be no choice.

And as you will recall, once you start cancelling elective surgery, you can begin to free beds up within 48 hours, and so dimmer switch is the -- kind of the phrase being used now.

COMMISSIONER FRANK MARROCCO (CHAIR):

But are they actually creating these alternate facilities? Like wouldn't it take time to build a field hospital or re-purpose existing space?

GILLIAN KERNAGHAN: I can speak to that, if you would like.

Within the southwest for wave one, we did build a field hospital, and it is still in place, and we have maintained it still in place, both in London and in Owen Sound as physical capacity.

The challenge is that long-term care homes, hospitals, home care, are all facing human resource shortages right now, and so it is not actually the physical capacity we are worried about right now actually. We do have physical capacity we can create, and we have looked across our

region, and we can create the physical capacity.

We are very concerned as a system about the human resource capacity, and there is now money that has been made available to long-term care to hire staff. In many of our rural regions, there is no staff to hire. It is not for lack of trying, I can assure you, but there just aren't people to hire to staff up because they are having to screen at the door. They have got lots of increased demands on them with their limited staff. There is no child care, emergency child care, available in the rural settings, and so people are at home because of child care. They are home because of fear.

And so long-term care particularly is hard hit because of staffing challenges, but the rural hospitals are facing substantive staffing challenges as well.

And so we are not sure, even if we create the physical space, that we'll have actually the people to man the spaces or staff to actually care for people in those spaces.

COMMISSIONER FRANK MARROCCO (CHAIR):

Is that generally -- is that peculiar to the southwest, or is that general across your

membership that there is physical space available but no people -- or not enough people?

GILLIAN KERNAGHAN: I would suggest it is a bigger issue outside of the major urban centres across the province.

BARBARA COLLINS: I would agree with that. I think the challenge we are seeing, though, in the urban centres is now parents home with children who have COVID or who have been sent home from school because there has been an outbreak, and then if you normally, as many of our families do, our neighbourhood rely on your parents or grandparents to care for the children, you are not sending them there at this time because we have heeded the warning about keeping that disease away from older people.

So we suspect we will see big numbers of people home waiting their ten-day isolation period.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ANTHONY DALE: So let's keep moving, and I am going to turn it over to Elizabeth Carlton in a moment, but just to say that these two slides here really summarize the fact that we have tried

to play a proactive leadership role right throughout this pandemic in advising the government and making practical, solutions-oriented recommendations to them, always oriented toward swift action.

So you can see that on March 13th we strongly recommended that the government declare the state of emergency, given emerging evidence about the gravity of the situation.

We have made clear recommendations on the need for an incident management system. I have referred to this letter, but the letter on April 10th about how to mobilize hospital workers to support long-term care, keep residents safe and prevent unnecessary loss of life.

You know, perhaps draw your attention to the letter on June 11th, which was also intended to be very practical and hands-on advice and guidance on planning for the second wave, and it covers off some of the topics that we'll be covering over the next few minutes when it comes to long-term care.

So I'll stop there. Just those were in your pre-read, and I am happy to answer any specific questions you have on them, but let's turn

it over now to Elizabeth for a kind of concrete quick primer on how hospitals prepped for the second wave.

MELISSA PROKOPY: Actually I think this is my section, and I am going to go very quickly through these sections. Much of this was covered off in the, as Anthony said, the pre-reading, but just to highlight in particular -- you know, I think we learned a lot from SARS, but in particular we have talked about the strength of hospital IPAC, and certainly that was one of the big themes coming out of SARS, the need for the development of those robust emergency management plans.

So certainly thinking about preparation for wave one of COVID, as Anthony alluded to, lots of discussions about ALC patients and transitioning, working on all aspects of staffing, so thinking about re-deployment considerations, training on donning and doffing and doing simulations for potentially riskier-type procedures, examining the entire infrastructure within the organization, so this is where many of hospitals leveraged their pandemic plans to really start to map out all of the various components or considerations.

Assessing supply and procurement ability for things like PPE, I think all of these contributed to the hospitals' ability to react in such a nimble way heading into the first wave.

So I am just going to quickly speak to the kind of foundational aspects that sort of govern the hospital existence, and hospitals are not-for-profit corporations with voluntary boards. They are governed by an overarching piece of legislation called the Public Hospitals Act, and effectively I'll just focus in on the three committees that are required, two in particular.

One is the Medical Advisory Committee and the other is the Quality Committee, and in terms of their funding, they have an accountability agreement with formerly the LHIN but now Ontario Health, and this really sets out kind of all of their accountability and performance obligations.

And we shared with you the accountability and transparency tool kit which outlines all of this in much more detail.

I just wanted to highlight a couple of things that are pertinent to the work that you are doing and some of the comments that we are making today.

The MAC and their roles and responsibilities are quite robust, but I have included two here.

So for the most part, physicians are not hospital employees. There are certainly exceptions for individual specialties and certain organizations, but for the most part, it is the MAC's responsibility to recommend the appointment of physicians or the provision of privileges.

But the other responsibility that the MAC has is in the recommendations to the Board around the quality of care that is provided in the hospital by the medical staff, and certainly that is something that -- I know Gillian and Barb will speak to the level of expertise and support that was provided by many of their staff within long-term care.

I would also just point out a specific provision in the Public Hospitals Act that requires hospitals to have a plan or have management develop a plan for emergency situations and, again, David is going to speak to labour, but specific requirements in the Occupational Health and Safety Act around obligations for measures and procedures for the health and safety of workers.

So the legislative regime kind of governing hospitals is quite robust and has certainly been in place for a significant period of time.

I would also just point out the Excellent Care for All Act. This has been around for about a decade, and it really reinforced the kind of shared responsibility between government and management for quality of care. So hospitals have through this statute a broad mandate for oversight of patient care. This includes things like the Quality Improvement Plan, the creation of a quality committee of the Board, and a number of both mandatory and discretionary indicators that must be incorporated into hospitals' quality improvement planning.

So before I turn it over to David, I just wanted to set up for you kind of the existing framework, existing relationships or pre-existing relationships between hospitals and long-term care.

So a number of our members, about 51, have what we call hospital long-term care homes that are co-located. So this can mean a number of different things. It can mean a same building that is separated by a hallway or a different wing. It

can be a single campus with two buildings. You can have various kind of configurations where the hospital is the licence-holder.

But there are a significant number of our members that have this type of arrangement.

And then within this arrangement and even outside of it, you have these sort of more informal collaborations and partnerships. So I know Gillian will speak to this because the southwest has done a really great job of integrating all of the providers together, but looking at how you can share resources and training and expertise in all of those things.

So I just want to frame the genesis of the hospital involvement in long-term care. David will speak to the labour pieces, but there was a regulation amendment early on that allowed hospitals to re-deploy staff to assist in long-term care homes, and this was both the physical redeployment, and also I have noted there assessments in relation to things like infection prevention and control and clinical supervision.

And the pretext for this was there were some long-term care homes -- certainly not all, a few -- that were somewhat resistant to hospital

support and expertise and offers in the context of infection prevention and control. So, you know, we have talked about some of the staffing challenges and certainly that was welcomed, but I think part of the genesis for moving towards the Mandatory Management Order was this kind of need to integrate some of the hospital IPAC expertise within the homes that were perhaps a little bit more resistant.

And as I have said, the context of order-making is not new. Certainly we have had the Health Protection and Promotion Act for a number of years, and there are authorities through that piece of legislation for local medical officers of health, but when we reached that critical juncture point in mid-May, the government made an Emergency Order under the emergency management legislation which effectively allowed them to issue these Mandatory Management Orders to long-term care homes.

And the kind of threshold was quite low. It was one case or more that they had the discretion to do this. We provided you with a chart that outlines in detail the 11 homes that came under hospital management through these

orders.

I will also just note that there was a limited indemnity that was provided to hospitals who were involved in these Mandatory Management Orders with long-term care, but this indemnity was really exclusive to situations where staff was physically deployed, so it didn't necessarily contemplate longer term support, which I know Barb will probably speak to, IPAC support and other kind of day-to-day oversight and collaboration with the home long after staff had returned to their hospital place of employment.

And we know that many of our hospitals provided similar supports to other congregate care settings, retirement homes, shelters and other settings, and these in particular were not provided with a similar indemnity for the supports that they were providing.

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I just stop you there for a minute.

MELISSA PROKOPY: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR):

You said that the Emergency Order that allows for the Mandatory Management Orders, did the local Medical Officer of Health have the authority

to issue an order to both a long-term care facility and a hospital in the face of a pandemic, a disease racing through the community that the community has no real way of stopping?

MELISSA PROKOPY: Uhm-hmm. So there are a couple of examples where that is exactly the route that they took. So earlier on in the pandemic there was a local order issued by the local Medical Officer of Health out in the Lakeridge area. They had an order through the Health Protection and Promotion Act, and I believe it is the same situation through the order that was issued more recently in the Ottawa area.

So yes, certainly they had that authority, but open to local discretion.

COMMISSIONER FRANK MARROCCO (CHAIR):

So was there some reluctance to use the authority?

MELISSA PROKOPY: I can't speak to that directly. I know part of the genesis of the broader Emergency Order under the EMCPA was both to create consistency, and I also know through the development of like a standard kind of management contract between the home and the hospital.

I suspect Barb, because she has been

involved in this quite significantly, can speak to this in a bit more detail, but I think they were -- I would suggest there is a large amount of discretion at the local level, and they probably wanted something that was a bit more centralized.

I don't know, Barb, if you have any insights that you want to share in that regard?

BARBARA COLLINS: So again, it goes back to we were very focussed on acute care. People were not paying a lot of attention to long-term care early on. The Ministries were separated. Ontario Health is who we were relating to.

The regional geography of Ontario, which Anthony explained, had recently changed, had some of us in two camps with both long-term care and retirement centers, and you were speaking to two groups.

It took a number of weeks to get -- and I was very involved with a home very early on. I will show you that when I do my presentation. It took a long time to find the right people to pull the leaders, and two of us in hospitals just finally started to work with a legal firm to develop a Management Order.

So you still need the requirement from the Ministry of Long-Term Care for a Mandatory Management Order and then you need the contract.

And to say that took five weeks of lots of discussion to even get to the point where we could have the Ministry issue it, it did, it took a long time to get there, and you will see that in the dates as you track it.

COMMISSIONER FRANK MARROCCO (CHAIR):

Because the negotiation could go on, if you are -- if there are two independent parties negotiating, that is fine, unless you are in the middle of something.

BARBARA COLLINS: Well, so a Management Order, a Mandatory Management Order from the Ministry of Long-Term Care requires the home operator to then enter into an agreement with the hospital for 48 hours.

But it took a long time for those to be issued.

MELISSA PROKOPY: Uhm-hmm.

BARBARA COLLINS: They were not issued very readily, and that was a new Ministry, had just formed, trying to sort out what was going on, and there was confusion as to what that would look

like, how it would look, and who would give indemnity.

So there was lots of time in that phase, end of April, middle of April, beginning of May, where we were still talking about how do we solve the problems that you can even go in there, despite having been told that you could send staff.

COMMISSIONER FRANK MARROCCO (CHAIR):

Was there a serious question about the hospital having to be indemnified?

ANTHONY DALE: There was.

BARBARA COLLINS: Yes, there is a serious question. Sorry, Anthony, go ahead.

ANTHONY DALE: No, Barb, please, I cut you off. Go ahead.

BARBARA COLLINS: There is a serious question about it. Actually we went in without it, but there were many hospitals who felt that was a silly move. We went in without it because we had one really problem home, but you have to look at, if you -- we don't report to the Ministry of Long-Term Care. No one had given us permission to go into the home. Bringing the patients to us was something that I strongly considered because within our walls we are responsible for what we do. It is

very hard to know who is responsible in that long-term care setting.

And if we and my hospital team make a decision, where is that indemnity coming from, where is the insurance coming from, who is protecting what.

Once we had the Management Order written, then all of that was clarified, but I believe what we needed was very quick indemnification and very quick Management Order.

And the legislation is there for it, is the time it took to recognize the need and get it written.

And some people -- and I am sure Gillian will tell you that -- did not need to do that because they already had previous relationships with homes.

COMMISSIONER FRANK MARROCCO (CHAIR):

The other thing is somebody would have to make a fairly practical assessment of what damages we are really looking at here. Like what are we -- it is a discussion lawyers would have, but I think they understand what I am saying. It is fine to, you know, say you are responsible and argue about that and worry about that, but the

second question is what is the amount of exposure. And in the face of an emergency, the exposure is limited. You know, I mean, I wouldn't want to speak out of turn, but if you have got a home and the disease is, you know, killing people in the home, and you move in there, it is difficult in that set of facts to understand how you could have made things worse. It is kind of ridiculous, actually.

BARBARA COLLINS: The Army documents, which I am sure you have read, will explain some of the scenarios some of us got into, and so you arrive, and you do not know what you are dealing with. You have no physicians on board, and you are bringing your own physicians in.

Now CMPA is asking who is protecting them, and you are right, at the end of the day, we went in and said we would do the right thing. But you don't honestly necessarily know what you are dealing with, and you don't know where the protection comes from, and it caused some anxiety.

COMMISSIONER FRANK MARROCCO (CHAIR):

A huge causation problem if somebody is trying to say that your intervention in the face of an emergency somehow made it worse than it was if

you hadn't intervened. That is a tall one really to try to sell to anybody.

But I am taking you off your presentation, so...

ANTHONY DALE: With this --

MELISSA PROKOPY: Do you want to add something there?

ANTHONY DALE: Just that this whole topic is a good example of an area where there are many outstanding issues to this day, hospital and non-hospital, which we could perhaps get to another day because we want to press ahead with the --

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead. I'll stop asking questions.

BARBARA COLLINS: Let me just clarify one thing too. These are privately-owned businesses, the homes, and so who are we to go in and take over? Who are we to march in there and say we are now running your home?

So to be fair, that was why you needed the Management Order because it is the Ministry of Long-Term Care that can say time to move. Whether we had a contract or not was another story, but a Management Order and indemnity and maybe not even indemnity, but packing up my bags, walking in and

helping to manage the homes was not going to be welcomed in some cases.

ANTHONY DALE: We should say, you know, obviously the vast majority of homes did reasonably well in the pandemic, but there is a large minority that did not, and that is obviously at the heart of what this Commission is all about.

And, you know, I do think we have to acknowledge the leadership of Barb and, you know, Gillian and all the other hospital leaders in the province who basically took matters into their own hands and put the health and safety of the residents first.

And they did plunge in, in the face of tremendous uncertainty, but they did it for the public interest and, you know, that has to be really emphasized here.

And, you know, Barb especially is alluding to the fact that we really wonder why we didn't do more as a province earlier, but...

MELISSA PROKOPY: I am going to turn it over now to Dave to cover off some of the labour considerations. David.

DAVID BROOK: Thanks, Melissa.

So on the slide, this next slide here,

you have a list of a number of events, and I guess I just want to spend a moment telling a bit of a story behind this and how some of the sequencing of events could have also contributed to some concerns.

I think you heard already in the initial stages of the pandemic the focus being so much on acute hospitals and concerns about what a surge of COVID cases would do and how to address that and be prepared for that.

So a lot of the work and then ultimately an Emergency Order was focussed on the ability for hospitals to re-deploy staff within their four walls, to respond to emergency functions, COVID, specific functions related to COVID, whether it is assessment centres, screeners, those other pieces, but also acknowledging the movement of staff that was available, because if you are ramping down surgeries and other activities, you have employees that could be utilized for those emergency functions elsewhere.

But I think what obviously became well apparent was the real focus of -- and the real need was in long-term care, and that is where the real challenges were arising.

So we saw serious staffing concerns, operators having challenges with staff not coming to work due to fear, illness, concerns about whether or not there were the appropriate IPAC precautions put in place, whether or not there was sufficient PPE, personal protective equipment, and, you know, we have also heard in sectors in certain parts of the province child care issues.

But also the reality that a lot of health care workers work for multiple employers and so they may have jobs with multiple long-term care operator or they may have a job with a long-term care home or a hospital or a home care, and so while they may be an employee of a long-term care home, they may have decided to focus their -- or not work there for the time being and go to their other employment during, if there are all these other concerns that we are having.

So you see in the materials we are articulating a number of these concerns in a letter to the Premier that Anthony talked about on April the 10th about there is probably a lot of reasons from an infection prevention and control perspective why there would be a need to limit the mobility of employees between multiple employers,

but it needs to be done in a planned way that recognizes that those are all employees that are working for the various employers. And if it is not planned, people could be making decisions that may take away from where there is the actual crisis or the true need for employees to be working, or there might be other considerations that would be giving rise to their decisions, including them being worried about their safety, or there is compensation reasons or other things that were giving rise to why they would be making decisions.

And so you can see through the course of events, I mean, a number of these issues became very prominent, and perhaps some of this in a way could have contributed to some of the challenges that are out there already.

So definitely focussing the efforts on IPAC and personal protective equipment and all those other efforts were extremely important in hospitals quickly mobilized to provide that assistance as they could.

And hospitals were also working on a very voluntary basis to try to obtain volunteers to assist with staffing, but I think there is also -- how the sequencing of events here worked, there

might have been, you know, some more challenges because the single employer directive, there was some guidance in earlier stages where people should be starting to think about how to address situations of employees working for multiple employers, but there wasn't a lot of parameters around it.

So people were making decisions without any assessment of where health human resources needs were and also how to provide the protections there that people were working in the places where the need was the greatest.

And on April 14th, a single employer directive was issued, but a lot of the other supports happened and decisions, including pandemic pay and different supports like IPAC and others happened after the fact, and so perhaps at that time there were a number of employees that would have elected to work at a hospital or a different employer than for the long-term care home than -- if perhaps the question or if that directive was done in a different way.

And of course some of them also had difficult decisions because they might be part-time and weren't provided with income supports to

reflect the loss of hours that they would have for not being able to work at another employer, and they may be making decisions based on those economic considerations as well, which all I think were a number of the contributors to some of the challenges from a staffing perspective at that point in time.

And I think that would give rise to some of the good questions that were asked already about what is going forward. This is a bit of a story of the current wave where we did have the ability to re-deploy volunteers from hospitals, provide supports from hospitals, because of the ramp-down in different procedures.

If we are going into the second wave where that may not be at least the first step to the response, the health human resources questions will continue to be important. I think that we have seen that a lot of great work with IPAC interventions and communication and all those supports have been a real key piece of it, but those are things that leads us to some of the thinking going forward.

And I think just because there was a slide from the last conversation about Management

Orders and even, you know, people going in voluntarily, Management Order or not, into long-term care homes from hospitals, what is also really important is also -- the identification and liability question is one thing, but there was also about the health and safety protection, and the health and safety protections not only for the staff of the long-term care home but also for the hospital employees going into the long-term care homes.

And so there was a lot of conversations and part of this is facilitated by the Emergency Order that was amended on April the 25th and a lot of the work in terms of coming up with agreements on what are those precautions, how would they be addressed, because definitely as hospitals were sending in employees to assist, they wanted to and needed to make sure that their employees were having the appropriate protections, as well as supporting the protections for the long-term care employees.

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Coke? You are on mute.

COMMISSIONER ANGELA COKE: Sorry, I just wanted to follow up a bit to understand what

might have been some of the challenges, even though you have got people volunteering, just in terms of their own health and safety, and were there issues that you had to sort out with your unions?

DAVID BROOK: Great question.

So yes, and we had a lot of dialogue with the major hospital unions, and as we have throughout the pandemic, but there were definitely points in times and the advent of the Emergency Order for facilitating directly the redeployment with employees into long-term care homes was a point of it.

They all very much were understanding of the crisis in long-term care and many of them represent workers in both long-term care as well as in hospitals.

But as much as they understood the concerns in long-term care and wanted to have the support for their members in those homes, they also wanted to make sure that people that are going into those homes from hospitals have the right protections, and there was an encouragement, as we also had an encouragement, and I think we saw materialize in how people were going from hospitals into long-term care homes, mostly on a voluntary

basis but also assurances that the right protections were being put in place and the right understanding of the linkages from, you know, who is the manager, how do you get assistance, the assurances on equipment, the assurances that the IPAC team has gone and taken a look and assessed what is necessary.

So those were all -- and that is a very important dialogue to have because it obviously -- it unsurfaced what the concerns were and how we can problem-solve along with it.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

COMMISSIONER JACK KITTS: David, I have just got two questions.

The first one is, was anyone able to quantify the impact of the single-employer directive on the long-term care homes, and did that directive also apply to hospital staff who volunteered to go into long-term care homes and then back to the hospital?

DAVID BROOK: So I haven't seen any true quantitative analysis of that. I think it is a good question to understand, and I think there is a lot of anecdotes that are out there.

So I have heard that it has had an impact and definitely in terms of -- you know, in regional -- or sorry, rural areas where there is, you know, less density in health human resources, it could have even more of a dramatic impact.

But that directive did not apply to -- so there were situations when it did not cover off movement from the hospital employees into long-term care homes, so it didn't -- that did allow for employees to move from the hospital over into long-term care home.

I think we definitely from the OHA urged everyone to be considering about the right health and safety measures and being very cautious about that, again, from the infection prevention and control perspective, but it did not apply to the hospital movement.

COMMISSIONER JACK KITTS: But you see that can mitigate the concerns about multiple sites if you have impeccable IPAC practices, and I think, you know, it is hard to do a risk/benefit analysis of that directive without knowing the unintended consequences that may have occurred.

GILLIAN KERNAGHAN: Jack, sorry, could I just add a little bit to that.

We probably had 10 to 12 homes that we worked with very actively every day for whom staffing crisis was precipitated by the single-employer directive, and more commonly the person picked the hospital to work in because of lots of reasons.

And this is when it became somewhat ridiculous, because what we then had to do when we had a staffing crisis, we went to the hospital. They sent the same staff member back technically as a hospital staff member to solve the problem in the long-term care home from whence the person who had come and chosen a single employer.

And that happened in probably six to seven homes in our region alone, where we sent the same person back who had chosen a single employer, being the hospital, we ended up sending them back to that same long-term care home as a hospital employee, and we actually precipitated the crisis.

COMMISSIONER JACK KITTS: That is fascinating.

The second question I think also builds on sort of the draining staff out of the long-term care homes is the pandemic pay was offered to all staff -- well, most frontline staff regardless of

whether they were in a long-term care home or not.

Is the second round, the recent announcement for pandemic pay, is that just limited to long-term care? Does that include all frontline workers or the same frontline workers that were in the first round?

DAVID BROOK: So great question, Jack.

So the most recent announcement is focussed on PSWs, as we understand it. We don't have all the details aside from what was announced, but there was some hourly wage increases, temporary hourly wage increases of a different magnitude, so for long-term care PSWs, but there was also some for hospital PSWs.

And so I guess when I was looking at the story or the sequencing of events, you know, I think there probably could be some reasons why multi-movement in between multiple employers from an infection prevent and control perspective was something to seriously take a look at. But to sequence the different levers so it wouldn't have the unintended consequences or have, you know, consequences elsewhere that would exacerbate the problems, so that if there was a wage -- if people were making the decisions based on compensation

alone, to put that further up the queue in terms of the interventions as opposed to after when that directive was in place.

And in particular, you speak to the infection prevention and control measures, otherwise -- and I think that is part of the things that we are trying to take a look at, is are there safe ways to look at this. Are there other pieces. Because it has, I think we have heard -- it had an impact from a staffing perspective to be able to respond.

COMMISSIONER JACK KITTS: Yes, thank you.

BARBARA COLLINS: Jack, I would also just add the number of people because of the pay that have two or three full-time jobs when they are a PSW, and I think that is what we really learned, and then what they did was actually lose money as a result of the single-employer, and what we found is they then went to the home with the higher pay, because some homes, right, with higher hourly fee than the other, and those that were for-profit, that probably had maybe the basic amount of money and not a high percentage of full-time, you found a lot of people drained from there.

COMMISSIONER JACK KITTS: Yes. Well, thank you, Barb.

ELIZABETH CARLTON: I think with that context, we want to spend the remainder of our time really talking about those lessons learned from wave one and recommendations we might offer for wave two.

So I think in terms of lessons learned, as you can see from the slide, what we have done to date is really to reach out to a number of our hospital leaders, CEOs, and some of their staff, and those with kind of a range of relationships and experiences with long-term care during one just to canvass their views.

We asked them about kind of what would be the most difficult challenges from wave one in terms of working with long-term care homes, what they might recommend in terms of short-term solutions for government for this fall, and then we also talked about some of the longer term changes we might want to consider for -- you know, whether it is long-term care, seniors care, congregate living, what have you, but I think it is safe to say everyone is coming out of this experience realizing this is something we have to shine a

light on and look at quite carefully.

So we won't be focussing on that last question today. We are still consulting with members on that, looking at sort of what broader transformational changes might be needed, and we'll certainly provide those thoughts to the Commission in due course at a later date.

But I think we would like to now just have Barb and Gillian provide their perspectives on what they experienced with respect to those first two questions really, so maybe I'll just ask Barb, did you want to start?

BARBARA COLLINS: Yes, I will start, and I will move along fairly quickly because I guess we have about 30 minutes left and stories to be told.

So Humber River Hospital is an acute care hospital. You can see the numbers here, 140,000 emerg visits. We do 70,000 types of surgical procedures a day. We have 48 critical care beds.

When I say what we were focussed on was ramping down surgery with 200 surgeons and anaesthetists, not pleased, looking at how we were going to manage care, looking at what procedures we

would prioritize, what we were going to do in our emergency department and cancelling all elective and diagnostic procedures, that is where our focus was early on and that and preparing immensely for the huge numbers that were coming to in-patient beds in critical care probably took us in a direction that perhaps didn't have us focussing as much on long-term care, remembering that with purely acute care hospitals, other than the Ontario Health Teams where you started to do some of that just in the year prior to COVID or the year of COVID, we really relied on the regions to place patients in long-term care and did not have a great relationship with them.

Humber itself, the Wilson site, 656 beds, so lots going on there. We did have experience with long-term care. Re-activation care beds are beds at the Finch and the Church sites. Two of our old sites which are now fully opened were supposed to be demolished, and in those are a number of patients waiting to go to long-term care and simply cannot be accommodated.

We are on a little bit maybe more like a hospital or on a hospital standard, we had minor outbreaks there, but one death in one of the

hospitals. Otherwise, not the challenges that some of our nursing homes had, many of our nursing homes did not have a challenge.

We are part of the northwest Toronto HT, et cetera.

We had Management Orders for two hospitals -- for two long-term care facilities, the first one was Downsview, the second was Villa Colombo.

When COVID broke and the Ministry asked us to be involved, we immediately did set up meetings with our long-term care facility hospitals, the long-term care facility and the hospitals, and it was a twice-a-week verbal meeting. I will tell you they did not really know us. We did not know them. And who was the hospital coming to save them because it was early on in the entity.

We did then get a Management Order for Downsview on the 30th of May, but we had been in the Downsview home since the 23rd of April trying to get a Management Order and a contract in place.

We finished our formal process there on August 30th. We continued to have oversight with them, but from April 23rd, we did our first review.

And what does that look like? Hospitals were asked to go and do a virtual review with the long-term care home on how they were doing with their infection control, their PPE, their staffing, et cetera.

So they don't necessarily know us. They are in control of their own homes. All nine in our community are pretty well private -- they are all private business. And so, you know, didn't know us and wasn't sure what we were doing there, trying to look around, and I understood that a lot.

At the Downsview home, there were three of our nine homes that did not do well, and I do want to say I am here to tell you the story of the ones that did not do well. The others did very well, and other than us helping them with PPE and giving them some tools to work with and now having a great community of practice that we have set up, they were fine, and they managed well, and they are fearful that it will be their turn this next round, and we are working very closely with them.

The Downsview home was a different story, and suffice to say that when we got in there on the 23rd of April, their physicians had left the home. They were doing largely virtual visits or

not at all. They were down 60 percent of their staff because of the single employer, but also because of a number of people that were sick and a number who were not sick but were terrified.

And aside from that, not only was there the single employer rule that was implemented, we limited visiting, and one of the things we found in Downsview is that in fact 50 families came twice a day to that home to feed the patients. And so I think we did the single-employer, and we did the families and caregivers cannot visit right around the same time and not realizing that those family members had become part of the care of the patient.

So we had significant challenges there. I will say of the Downsview home that another home in our community, Hawthorn, the Army was in, and I have shared a number of experiences with the Army, and we saw many of those same things in Downsview home. Four of our physicians moved in there and stayed until the -- really from the 23rd of April until the end of June when they could put sufficient practice in and recovered many, many patients, but there was still a lot of death.

And some of that was food and water, and if your condition has deteriorated as a result

of food and water challenges, you probably cannot fight COVID. And I tell you that story because Villa Colombo was a different story. We went into Villa Colombo, which is a not-for-profit but has a charitable arm for which the charity sends 2 to $3 million a year for them to provide more, and although they had COVID a little bit later in the disease entity than our Downsview home did, Villa Colombo had patients that were well fed, well looked after, well cared for, despite a shortage of staffing. They spent a fortune on agency. And I think those patients were in better health to battle COVID and many of them did battle it.

So I think that there is two different stories here at the end of the day. Both of them are private corporations, and in April when we wanted to, you know, move in -- the Downsview home is owned by a corporation who live in Nova Scotia. They have one home in Ontario and their head office is in Nova Scotia, so they had very little recognition of the challenges that were going on in the home.

Next slide.

I do want to be fair to --

COMMISSIONER JACK KITTS: Barbara, can

I interrupt you for a second? Go back to the previous slide. Let me see if I understand.

So you have 11 long-term care homes in your catchment area; is that correct?

BARBARA COLLINS: If I consider Finch and Church long-term care, yes.

COMMISSIONER JACK KITTS: Okay. And you say that with Downsview you needed -- you had to have a Mandatory Management Order?

BARBARA COLLINS: Right.

COMMISSIONER JACK KITTS: And you are going to provide oversight until November 30th?

BARBARA COLLINS: Yes.

COMMISSIONER JACK KITTS: And with Villa Colombo, it is a Voluntary Management Order.

BARBARA COLLINS: Right.

COMMISSIONER JACK KITTS: And you are going to provide oversight until November 30th.

BARBARA COLLINS: Right, and I -- can I just do one thing on the voluntary? After a few Mandatory Orders went out, homes that were asked to go into a Management Order really knew they were either going to do it voluntarily or they were going to get an MO from the Ministry, so the second round, it was a little easier to do an MO.

COMMISSIONER JACK KITTS: Great. Thanks. But the other nine, you have a formal partnership with.

BARBARA COLLINS: We have -- yes, more or less formal because the region has asked us to meet with them regularly. So they are part of our OHT, but all of them we meet with regularly.

COMMISSIONER JACK KITTS: So is that oversight, or do you have a formal partnership with Downsview or Villa Colombo?

BARBARA COLLINS: We have a formal -- so probably I should have categorized that as informal. We have a group. We have what we call a community of practice for long-term care, and they come to the table happily every two weeks, and if they have any challenges or problems, we go in and help them, and we bring all of them together to communicate with each other. We share information, but it is less formal than a Management Order.

COMMISSIONER JACK KITTS: So for the rest of the pandemic and into the future, you will be as much an umbrella for at least nine long-term care facilities? Like you have got hospitals and long-term care working well in your area.

BARBARA COLLINS: They are.

COMMISSIONER JACK KITTS: And that bodes well for wave two in your --

BARBARA COLLINS: Yes. In my opinion, it does because we have been able to build those relationships.

COMMISSIONER JACK KITTS: Thank you. Thank you.

BARBARA COLLINS: Why is it so important is the next slide. Northwest Toronto has the highest incidence, along with Peel and Mississauga, the highest incidence, the highest positivity rate for COVID.

You can see the circled area here. That is in peak of wave one. You can see how intense the COVID disease was here. Our community are the frontline workers. They are the bus drivers, the Uber drivers, the grocery store workers, and they live in multigenerational families, in very small and crowded environments in many cases. We are just a demographic population health parameter challenged community. So we did see a lot of COVID, to be fair to the homes. It was difficult to avoid, and it is still a bit difficult to avoid in wave two. We still have a high positivity rate.

Next slide.

So what was our experience? So right now where we are at with the homes, I will say, is a coordinated response supporting the long-term care homes in managing COVID cases outbreaks, and we have assigned resource people to them. Whether we are in a Management Order or we are not, they know who their contact person is here.

We have a standardized approach to providing support. We have a document that all of our homes fill out, helping us understand their data, and I will show you that in a few pages.

And we share all of our best practices, twice weekly huddles with the long-term care home champions, administrative leadership and our IPAC leads, to be sure that we are okay. So this is where it has evolved to.

We share directives. We share Ministry of Health. I share the slides I use for my town hall, I make available to our long-term care homes so they can use them for their town halls, and we go in once a week to each of those homes and do an IPAC audit to compare it against their data and do some retraining if we need to.

And they have taught us a whole lot

about long-term care. I will not say that that has not been the case as well. We look at long-term care homes as acute hospitals, and they look at them as people's residence, and it is important for us to have remembered that.

I will go over a few of our reflections. So is that the first one? Yes. We were advised to complete virtual assessments, and I will say not only were hospitals completing virtual assessments, but the physicians caring for patients were completing virtual assessments, and the inspections branch of the Ministry of Long-Term Care were completing visual inspections -- virtual inspections.

And virtual has its place, but it doesn't tell the whole story, and it was -- long-term care homes of course were reluctant to allow these hospitals they didn't know to attend, what are you doing here, maybe you are going to end up bringing me COVID, never mind helping me prevent COVID, and it took awhile to get in.

I will say that I don't think the medical directors did anything that they weren't advised to do. They switched to virtual visits. Many of them are older, semiretired physicians who

take on the long-term care homes. The challenge with that is a combination of not having enough staff to do that virtual visit with them and them not being aware of the condition of their patients.

Very different story between the three of our homes that did poorly. The physicians at Villa Colombo stayed. They stayed on site, and they did not do virtual visits, and although they had as many people affected with disease, a little bit later than Downsview, they had very few deaths, they managed their patients very quickly. They sought hospital health if they needed to.

ANTHONY DALE: Barb, can I add one quick tiny thing from the provincial side?

Just on your comments on virtual, it was pretty clear at the March 21st meeting with the Ministry of Long-Term Care that they were planning on relying very, very heavily on virtual as the kind of anchor of the response, so that was made clear at that meeting, but as you can hear from what Barb is saying, it turns out to have been inadequate.

But there was a choice made to focus on that systemically for certainly, I guess, at least three to four weeks.

BARBARA COLLINS: Yes, I agree.

IPAC processes. So remember, long-term care homes wash their hands, and they focus on caring for patients, but they do not do that in a pandemic like hospitals do. It is not a focus on how you mask, on how you gown, on how you glove, because these are residents' homes.

So that was quite a difference that took some time to train and teach people on. You weren't teaching people on hand washing, they knew that, but masking, gowning, and gloving, and dealing with isolation was a different thing.

There was problems with access to PPE, and remember, all hospitals had that problem too, but we had huge purchasing departments that could do some bulk purchasing for us and homes did not. We ended up and still to this day, if they are short of anything, we just send it to them, because at the end of the day, it is one big bill.

The whole issue around testing and Public Health's role and the communication, I think enough has been said about that, but we certainly sometimes took five to seven days to test a resident who was positive. Remember, these people are elderly. They are wandering. This is their

home. And if you don't know they are positive, and they are not showing very many symptoms, you probably do not have them under control quickly enough.

Us, in our hospital attitude, said, Well, it is really easy, just make an isolation ward and put all the COVID patients over there, and to this day, I'm still a proponent of that, and the long-term care homes remind me that that's the patient's home, not their bedroom, not just a room we have assigned them. So that was a challenge for us to understand.

Isolation routines, there was also a variety of messages around whether you isolated or did not.

Ministry of Inspections Branch I will speak to. Their visits are infrequent to the homes. They were most often virtual, and they are not terribly collaborative, and I don't know whether they are -- I do believe there would be more merit to them being a little bit more collaborative. The inspector goes around, and it feels -- and I have been at part of them -- that it is a bit punitive in nature. I would love to see a planned, more organized visit where the teams go

together and look at things.

And then the Mandatory and Voluntary Management Order process. It was five weeks from the time we first knew Downsview was in trouble until we could get to actually having an order, and I feel that there was challenges during that period of time for the home. Had we moved quicker, perhaps they would have benefitted.

And I think in retrospect they know that, but I tell you, when you call the owner of a private home who doesn't know you as anybody and only thinks you are the CEO of the big grand hospital, they are not listening to you, and you can understand that, and I understand where they are coming from. They were very surprised in Nova Scotia when I told them about the problems they were having in their home because what is their resource? The Inspections Branch has said everything is okay, and our Executive Director has told us everything is okay.

So it is a bit of surprise and shock on their part.

And there were difficult conversations, and now we are very good friends, and we do things together now.

So leadership roles, focus and strength, you know, I will only say that the Executive Director of the home carries a lot of weight, carries a lot of requirements between that person and the Director of Nursing. There are not medical advisory committees, there are not formal quality committees of the Board in many of the homes or anything like that, so it really goes to the strength and ability of the Executive Director and how much they communicate with staff and how much goes on in terms of setting standards.

Communications I feel is a challenge. Formal reporting between the caregivers is probably not necessary when it is somebody's home, but when you get into a situation like COVID and the illness we saw there, it is very important to have that going on, and we had to implement that in all of our homes.

I will say that as many staff were off because they were sick as they were because they were afraid. Their colleagues were dying. Their colleagues were picking up COVID. Their colleagues were very, very sick in many cases, and they were scared, and we could get people back to work in fairly large numbers once we started holding town

halls, and we held them along with the Executive Directors. We didn't exclude them from it, and we keep those going to this date.

Communication between the physicians and communication with the families, in the interests of time, I won't go into it, but a very similar story. People get scared in pandemics and you need to be sure they have information.

Policy and procedure development and adherence, I think even when there are policies, there were adherence issues. That has become the nature in long-term care in many cases, and it is not wrong. They are people's homes. They are not acute care hospitals. They were dealing with an acute illness.

I would say the acuity of patients has changed over the years, and perhaps we have not recognized that.

Environmental services, lacking of service, people afraid and left, and because it is people's homes, they have a massive amount of personal items in their home. We have a lady with 280 plants on a wall in her room, right? You have pictures on dressers and pictures and trinkets, and when you are short of housekeepers, and you are

trying to prevent a pandemic spread, we in the hospital would say get rid of all that junk, and the long-term care providers would say those are their valuables and that is their home. So learnings for both of us there.

We did talk about the single-employer, and then isolation units not developed in long-term care because they are homes, and I would still challenge that might be one we want to consider.

I only leave for your information a chart that each of our homes now willingly fills out. It goes through a plethora of information around their staffing, their PPE, who requires testing, who is sick, who is not. This is an example of one of our dashboards. All nine of our homes fill them out now, and we share that information collectively with each other, allowing us to keep an eye on whether things are failing or getting better.

Next slide is really about managing wave two and most of that I have talked about or you have heard about. There is only one other thing we put in the next slide, and that is that we have developed a triggering mechanism for all nine of our homes based on how we will intervene on

whether they are having specific problems or not.

Next slide is the trigger document, which is really a red, green, yellow. It is based on staffing, patients that are sick, the activity we know of our homes, and then we grade each home each week collectively with the home as to which of those red, yellow or green blocks they are in, and there are defined activities we will do and how involved we will be if they have a challenge.

And what we did with our homes -- and it will be in the package for you to look at -- is really look at what percentage of patients got sick, because remember in round one, not all of them got COVID. There is many who can get it in round two as there were in round one, and that is our reason for looking at it.

The same thing with staff. There is still a lot of staff in long-term care that could get sick a second time, and that is why we have to be careful.

COMMISSIONER JACK KITTS: Barb, could I just ask, are there infrastructure or other barriers that keep you awake at night in terms of having wave two be less -- or being able to mitigate wave two more than wave one? Are you

going to have more Downsviews and Villa Colombos in wave two, or do you think you have gotten around that?

BARBARA COLLINS: Jack, what I hope is that we will know sooner if we have got a problem because of our template. I still think you can have the problem. PPE is solved and the work around IPAC is solved and that is going to go a great deal.

Remember, nobody was coming into the homes but staff. Not all of the staff got infected in the homes, and so at the end of the day, it is just like a hospital. The break in protocol is really what drives you to be spreading the disease, and I think that that's something that I worry about all the time.

COMMISSIONER JACK KITTS: Thank you. Thank you. That was excellent.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

COMMISSIONER ANGELA COKE: Just the system that you have described in terms of how you are managing with your catchment of homes, is this what is happening with other hospitals? Is this just the particular approach that you have taken?

BARBARA COLLINS: I think it is the particular approach we have taken. Gillian will talk about what she is doing. We do have some hospitals reaching out and saying can we have your chart, but I just believe you have got to be data-driven.

I believe we modelled and data-drove ourselves around acute care, and we didn't do the same thing around long-term care, and there are those who will disagree with me because it is people's homes, but if we don't track the data and do our own modelling, we won't know where our risks are.

ANTHONY DALE: That is a very good question for Ontario Health because I believe that all five regions are closely monitoring and have cascaded down the monitoring function that Barb has described. But we don't know from an OHA vantage point if it is uniform across the whole province, and as Barb said, there is plenty of engagement among and in between the members right now to prepare for what could be another, you know, busy fall and winter in second wave.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kernaghan? You are on mute.

GILLIAN KERNAGHAN: Off mute.

So St. Joseph's Health Care London -- go to the next slide, please -- is a multi-hospital site. We have four specialty hospitals across our geography, not all in London, and we also run a long-term care centre.

So my experience in long-term care is, when I was in family practice, I was a long-term care physician for many years. When I moved into hospital leadership, I have been involved with the hospitals that have always had a long-term care home associated with it and became CEO 10 years ago, and we have close to a 400 bed long-term facility as part of our multi-site corporation.

I also have personal experience. My husband developed early Alzheimer's and is a resident in long-term care, so I come at it from three different angles as to the perspective of long-term care.

When the COVID was first established, I was asked to take a leadership role for our region, so it was our old LHIN geography, and that goes from Lake Erie all the way up to Tobermory. So we have 24 hospitals, and we have a large number of individuals involved in the region.

So if you look at St. Joe's -- just go to the next slide -- I'll give you a bit of a perspective of who we are. We see --

[Court Reporter intervenes for clarification.]

So we see about a million outpatient and outreach visits every year. We train over 3,000 students and are very distributed. Our furthest location -- actually we have a clinic in Toronto, and so we are very distributed across the region, so we have staff all over southwestern Ontario.

So you'll see the numbers there.

Next slide.

At a regional level, we have 77 long-term care homes and 8 residential hospices. One of our first outbreaks actually was in a hospice.

I was asked to take on looking at long-term care in our region, and so we do have within our region, in each of what we call our sub-regions, which is those five that you see there, they have long-term care communities of practice, and they are flag groups where they get together as long-term care homes. So we leverage

the Chair of each of those and put together a regional leadership group for long-term care and a regional lead for hospice, along with a medical director from long-term care, a geriatrician, and some psychogeriatric support.

If you remember back to the beginning of the pandemic, there was an ethical framework that had been drafted that said that long-term care homes would not be allowed to -- if the hospitals became overwhelmed would not be allowed to transfer their patients into long-term care because their chance of survival was very, very low.

So our initial focus was how do we create increased capacity in long-term care to manage if COVID hit them hard, and so we worked with the homes to say what do you need. We put a regional psychogeriatric on-call system in place, a regional palliative care on-call system in place across our large geography, and a large -- and a regional geriatric on-call system so that the Medical Directors had some support if they needed to care in place.

We worked with the homes to make sure that they had up-to-date plans of care so they knew what the desire was of their residents should they

actually become ill. So we were being respectful of the choices that individual residents wanted to make as far as their care plans.

We then set up -- when it became evident that long-term care was going to be challenged, they were challenged to get PPE, and we worked with them to get that. Sometimes it was donated supplies we sent to hospices that had come from dentists' offices and different places, but it is the only place we could find it, and we sent it off to them if we needed to to make sure they had that.

But when we realized we needed to put more of a system in place, we worked with the home and community care quality team that was part of our historical LHIN, and they set up a process where they called every home and every retirement home and every hospice every two weeks to sort out IPAC, staffing, and PPE.

We set up one number to call in the region. So if a home had any concerns, they had one number to call in our region and to access the team. And then I, as the regional lead, along with the community lead, who is also a family doc, and Public Health, we met every day to look at the

homes that needed support to make sure they got the support they needed, and we really -- we debriefed with all of them. So we have more than 77 retirement homes in our region.

And so we set up a process where they were being monitored regularly, and they could either self-indicate they were having concerns. Public Health if they had concerns about a home would put them into our system, and if an inspector was having any concerns, they could put them into our system either from the Retirement Home Association or the long-term care inspectors.

That then triggered more frequent calls and contacts with the home, and if a home looked like it was starting to get increased numbers, we had a red, green, yellow process across all of Ontario Health West, not just in our region, and we monitored every home that was either yellow or red, although green homes still got a phone call every two weeks, and then we escalated.

So if a home looked like they were heading into trouble, we actually met with the home, and we assigned a partner, a hospital partner at that time, and the hospitals then became part of that daily meeting, along with the Medical Director

of the home, became part of those daily meetings until they got out of trouble.

We only had one home where we really had some problems. We couldn't sort of preventively prevent some of the spread, and we were concerned, so we did a -- we didn't really have the authority to do it, but we did a we need to meet the owner, thank you very much, not the Executive Director, and basically said to the owner -- we may have called their bluff a bit -- that if you don't start taking this more seriously, we will have to recommend a Management Order.

And it was interesting how they actually took on that -- took that very seriously and actually put a much more detailed HR plan. We required them to come forward with their HR plan if they needed help. We coordinated with the service provider organizations, LHIN staff or hospital staff, to meet their needs as far as staffing.

And we knew ahead of time if next week it looked like they were going to be in trouble, we were working to get them staff in advance of when they were truly in crisis.

So we very much had a preventive approach, and we had data. We had the data

spreadsheet for the 77 homes. We looked at every single day when the homes were in the midst of wave one, and the three of us as regional leads met with the home and community care team every day to look at what were the issues.

Some of the key issues in the homes were the long turn around times for laboratories. Some of them were 10 and 12 days to get the lab results back for patients and for staff, which was nigh unto useless to be honest, as far as managing what they needed to manage.

Some of the biggest challenges were the behavioural supports. We had one home that had a wanderer that was positive, and we were told by the Ministry of Long-Term Care that we couldn't sedate the person to minimize the risk to other residents, even though we had a whole plan in place with the psychogeriatric supports to look at how could we safely manage all the non-medication interventions; if they didn't work, the psychogeriatric alongside the home and manage that behaviour if need be with medication. We were told that was inappropriate. And so we had continued outbreak in a home because we couldn't get support to look at some of those innovative ways of providing support.

I have mentioned the single employer policy that caused some real troubles in some of our homes, probably 10 to 12 of our homes that precipitated the crisis. We had one home that had 17 to 19 staff quit the minute there was a first case in their home. You can imagine that precipitated a staffing crisis.

We have a number of smaller homes in our region, and that was our biggest -- one of our biggest challenges.

But I do think that really doing the proactive approach to care. What am I worried about in wave two? The hospitals were at 65 percent occupancy during wave one. The hospitals are running between 80 to 90 to 100 percent occupancy now, and when we look for where there might be supports in place, there aren't many.

So the strategies that we are looking at is looking at a principle-based agreement between two employers to share staff. We think that will help some.

We have looked at -- we have developed a definition of an essential caregiver and what training they would be required to really support their loved one in a safe way during a pandemic,

even if they are in outbreak.

We have looked at how do we continue to retain volunteers, particularly around things like screening, and helping with some of the non-essential tasks, and we do have a model in place to look at emergency support workers to support the PSWs that the Ministry has now indicated some funding for, and one of our partners is working with Georgian College to create a model where somebody is an emergency support worker, that they can use their work time as placement to get them towards a PSW designation.

So trying to be creative and creating some solutions to move that forward.

But we met -- as long-term care, we met two or three times a week as a whole region and shared policies, shared innovations, and we did a formal evaluation of wave one as a group and have put that into a document as to what we learned in wave one to teach us for wave two.

COMMISSIONER FRANK MARROCCO (CHAIR):

There is a question from Commissioner Kitts.

COMMISSIONER JACK KITTS: Gillian, so the St. Joseph's Health Care collaborative support,

you mentioned the group that was getting together. So can you just describe for me again the leadership that supported these 77 long-term care homes, and I think Barb mentioned hers was communities of practice in an Ontario Health team. Is this an Ontario Health team, or is this separate from that?

GILLIAN KERNAGHAN: No, so the five regions are likely to become Ontario Health Teams but only one of them was actually an Ontario Health Teams, but for many, many years, there have been communities of practice in our region called FLAG groups - and I can't remember what "FLAG" stands for - where the long-term care operators get together and they share information and share strategies.

We leveraged those relationships. And So in Ontario Health West, each of the prior LHIN boundaries were assigned a triad, so there was a hospital triad lead, a non-hospital triad lead, and a Public Health triad lead.

So the 12 of us became the leadership for Ontario Health West.

I ended up taking on both the hospital leadership and long-term care leadership for

various circumstances, and so we leveraged these FLAG groups to actually bring them into our regional leadership group. So I met with the long-term care leadership group two or three times a week to start with to make sure we were driving policies, make sure they had all the information that they needed, sort of what Barb talked about, made sure they had all the directives, they understood how to interpret them. If they had questions, we escalated it up to Ontario Health to make get clarification for the directives.

So it became a place of two-way dialogue, and then when the homes started to get into trouble, it was the triad from the region. So me as the hospital lead, Cathy Volts [phonetic], who was the non-hospital lead, and Chris Mackie, who was the public health lead for the region, we met with the home community care team every day to brainstorm how we would support the homes so that they could then continue, and we did that based on a database spreadsheet where we had all the retirement homes, all the long-term care homes, and all the hospices listed, and they were either red, green or yellow, and we knew exactly why they were red or why they were yellow based on staffing, IPAC

or PPE.

And if they needed support for IPAC, we either sent Public Health Ontario, a Public Health unit or a hospital IPAC person in to support them. We just leveraged the resources that we could find to make sure they got the supports they needed.

The same with staffing, we just leveraged the resources we could find through agencies, through the LHIN, through hospitals, to get them the staffing they needed literally shift by shift.

COMMISSIONER FRANK MARROCCO (CHAIR): Jack, I think you are on mute.

COMMISSIONER JACK KITTS: Oh, I'm sorry. So leveraging the hospitals in wave two, is that going to be a big problem versus wave one?

GILLIAN KERNAGHAN: It is. We didn't have to use hospital staff very often, to be honest, Jack. We were able to, through the service provider organizations and some LHIN staff, provide a lot of the support, but there were hospitals -- there were probably six hospitals across the region. We have 12 hospital corporations across the region. So probably six ended up sending some staff into long-term care homes and to fill shifts

as needed.

Am I worried about HHR going into wave two? Yes, I am, because we have -- the long-term care homes staff are tired. They had their vacations cancelled all summer. They all worked overtime in order to make sure people were cared for. So they have not had a wave one or wave two. They have had a continuous wave of working extraordinary hours in order to keep the residents safe.

COMMISSIONER JACK KITTS: But the hospitals will still be able to provide IPAC support or IPAC education, learning, and also the data, the data analytics and stuff? Will the hospital be able to still do everything but staffing it?

GILLIAN KERNAGHAN: The hospital is not doing the data analytics. We have leveraged the LHIN data support to do all of that, Jack, so that is all done by the home community care for all 77 homes. So the data is all produced.

What we are going to do in wave two, Jack, is that we have now had -- we have assigned a dedicated Home and Community Care Director to each of the sub-regions. Then we have triads in each of

the sub-regions. So we have a hospital lead, a primary care physician, and a community services lead in each of the sub-regions.

They now have the home and community care support that will call all the homes in their sub-region, and they will link with that triad to leverage the resources in their more local community in order to find the resources they need to keep the congregate setting stable.

So this isn't just for long-term care. It is for long-term care, retirement homes or any other congregate setting. So we will set up a parallel triad leadership model in each of the sub-regions because they know the people in their sub-region and know how to leverage the resources, but they now have a dedicated home and community care person that they will have that two-way relationship with who will call all their homes and give them a spreadsheet regularly of how their homes are doing, and then they'll work together. So we have taken it from being the whole region to actually dividing it into five for wave two because we think that we'll be able to leverage the local resources better as we focus into wave two.

COMMISSIONER JACK KITTS: Thank you,

Gillian.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much, Dr. Kernaghan. I wrongly assumed -- I didn't mean to cut you off. Were you at the end of what you were saying or was --

GILLIAN KERNAGHAN: I am happy to be done.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you all very much. We'll probably be back to you, if that is okay.

The other request I should have made is you have a website. We would like to put a link from your website to ours, so that if any of your members want to find out what we are up to, they can quite easily find us. If that is okay, we would appreciate that.

ANTHONY DALE: We would be very happy to assist in any way that would be useful to you.

You know, I think Gillian and Barb covered off a huge amount of the practices and solutions that their organizations and partners put in place.

We have at the end of our deck two things that we would encourage you to review quite

closely.

One set is really findings from the intensive interviews with an even broader range of hospital leaders to give you a kind of industry sense of key themes.

And the second is some quite specific observations on wave two, which is of course here.

And our core message to you is that there has to be -- the hospital sector remains completely open and willing and has been through this pandemic to supporting long-term care.

A great deal of discretion should be left in their hands about how to create and maintain very productive and constructive working relationships, and it is that innovation that is very important.

There is some other more specific things that follow, but if it is okay, we would like to make one final statement.

COMMISSIONER FRANK MARROCCO (CHAIR):

It is quite all right, and if there is something there that you want to point out to us, don't feel unduly constrained. Please show it to us or tell us, but go right ahead.

ANTHONY DALE: Well, at the heart of it

lies what I have just tried to quickly summarize, which is that it is clear that there is already ongoing linkages and relationships and partnerships between hospitals and long-term care, and the secret to success right across the whole membership is, you know, mutual respect and collaboration as an approach.

And it is also clear, I hope you see even from right today, that no single approach can be universally applied in a province this big and this diverse.

And that is really we think the secret to successfully protecting residents through wave two.

And it also goes without saying that this is more than just hospitals, but it is also about collaboration and partnerships and shared approaches with other partners, particularly from the community.

And when things do go wrong -- and, unfortunately, it is fair to assert that that is likely in some instances -- what is essential from a provincial management point of view is a coordinated and standardized process that allows for very rapid escalation at the earliest

opportunity.

And we do recommend that explicit criteria and thresholds be established to guide and direct the escalation of different levels of support when it is needed, because as you can see, all of this has been done organically and through goodwill and a desire at all times to protect our residents, but like the province's pandemic response and the use of public health measures now, we do not know at this moment what criteria is guiding many decisions related to escalating or changing significant measures of any kind.

Staffing shortages, as the members have said, remains a very significant issue, particularly in long-term care, so we do recommend a thoughtful re-evaluation of the universal application of the single-employer policy. It may be that, as I think Jack was alluding to, that where conditions can be made safe and appropriate, that an alternative policy could be implemented.

It is clear -- and I think the government has addressed some of these pieces in its long-term care strategy announcement of last week, but there does need to be specific funding targeted to long-term care homes, certainly for the

duration at a minimum of the pandemic, to enhance the number of hours that health care workers can work to support the homes.

Long-term care homes will need ongoing support with access to PPE, and of course the huge insight and learning and a very sad one from the first wave was the role of family caregivers in wave two. Allowance and support must be made to allow properly trained and involved family caregivers to be active in their family member's care.

So some of that has been touched on with the province's new strategy.

And really the final thing we would like to emphasize is that the key to really the whole pandemic response is mitigating and greatly reducing the community spread of COVID-19, and certainly from the perspective of the OHA, we are seeing very little action on the part of the Government of Ontario to adjust and change its public health measures to bend down the curve of growth.

We are seeing disturbing and alarming trends already when it comes to the number of outbreaks in long-term care facilities and other

indicators, and we really implore you to use any measures within your power as a Commission to encourage the government to respond as quickly as possible.

So that is really our closing comment.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, thank you very much. I just want to finish my note there.

Thank you very much. This is very, very helpful to us, and we really do appreciate the time and effort that went into the presentation, and I hope you didn't find it too hurried. You gave us an awful lot of information to absorb, and we will have some work to do to do that.

But it is very helpful, and as I said, we probably will be back, and certainly if it occurs to you that there is something that we might say in an interim report that you think is important, don't hesitate to communicate that to us, and we would be happy to consider it, and we'll try to be as thoughtful in our consideration as you were in your presentation.

So thank you all very much, and good-bye for now.

-- Adjourned at 4:12 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 6th day of October, 2020.

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