

# **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.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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7 PRESENTERS:

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9 ONTARIO HOSPITAL ASSOCIATION:

10 Anthony Dale, President & CEO

11 Melissa Prokopy, Director of Legal Policy and  
Professional Issues

13 Gillian Kernaghan, CEO St. Joseph's Health Care  
14 Elizabeth Carlton, Vice President, Policy and  
15 Public Affairs

16 David Brook, Vice President, Labour Relations &  
17 Chief Negotiations Officer

18 Barbara Collins, CEO Humber River Hospital

19

20 PARTICIPANTS:

21

22 Alison Drummond, Assistant Deputy Minister,  
23 Long-Term Care Commission Secretariat

24 Ida Bianchi, Counsel, Long-Term Care Commission  
25 Secretariat

1 John Callaghan, Counsel, Long-Term Care Commission  
2 Secretariat

3 Lynn Mahoney, Counsel, Long-Term Care Commission  
4 Secretariat

5 Derek Lett, Policy Director, Long-Term Care  
6 Commission Secretariat

7

8 ALSO PRESENT:

9 Deana Santedicola, Stenographer/Transcriptionist

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

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

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

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

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

25 So with that introduction,

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

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

9 So with that, we are ready when you  
10 are.

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

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

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

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

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

15                  ANTHONY DALE: Thanks, Gillian. Barb?

16                  BARBARA COLLINS: I'm Barb Collins.

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

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

5 ANTHONY DALE: Elizabeth.

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

12 ANTHONY DALE: David?

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

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

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

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

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

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

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

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

25                  And then also relevant is some

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Gillian will speak to that diversity later on.

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

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

15                   Keep going, Melissa, please.

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

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

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

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

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

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

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

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

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

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

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

1 heading into the pandemic as we got deeper and  
2 deeper.

3 COMMISSIONER FRANK MARROCCO (CHAIR) :

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

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

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

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

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

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

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

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

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

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

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

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR) :

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

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

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

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

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

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

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

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

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

1       urgency.

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

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

12                   COMMISSIONER FRANK MARROCCO (CHAIR) :

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

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

1 hospital network.

2 Can you help me with that at all?

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

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

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

25 And I think the government still

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

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

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

19                   COMMISSIONER FRANK MARROCCO (CHAIR) :

20                 Okay, thanks.

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

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

1 dysfunction within our health care system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Thank you.

10 ANTHONY DALE: Gillian.

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

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

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

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

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

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

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

23                  COMMISSIONER FRANK MARROCCO (CHAIR):

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

1       2020, if you moved all of the people out that  
2       shouldn't be there, it would create 5,000 beds in  
3       the hospital?

4                     ANTHONY DALE: Yes. So there is about  
5       30,000 beds, acute and post-acute, in Ontario.  
6       About one in six are occupied by someone who, you  
7       know, has finished their time there, but through no  
8       fault of their own can't be discharged.

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

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

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

6                   And unfortunately, this is a big risk  
7 for the province, as we head into the fall and  
8 winter, because with hospitals playing so many  
9 roles in the pandemic response, running the  
10 assessment centres, the laboratories are going  
11 24/7, many hospitals, both formally and informally,  
12 continue to support long-term care. There is a  
13 backlog of surgical activity that they are trying  
14 to catch up on. There is the planned and ongoing  
15 elective activity that also still has to happen in  
16 addition to the catch-up, and then there is, of  
17 course, emergency departments and trauma and all of  
18 the things that all sorts of different kinds of  
19 hospitals do.

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

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

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

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

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

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

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

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

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

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

1 homes were full, hospitals weren't.

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

4 ANTHONY DALE: Right.

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

9 So are you aware of conversations  
10 around capacity?

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

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

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

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

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

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

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

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

8                   COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

1 region, and we can create the physical capacity.

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

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

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

23 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Okay.

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

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

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

10 We have made clear recommendations on  
11 the need for an incident management system. I have  
12 referred to this letter, but the letter on April  
13 10th about how to mobilize hospital workers to  
14 support long-term care, keep residents safe and  
15 prevent unnecessary loss of life.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 orders.

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

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Can I just stop you there for a minute.

21 MELISSA PROKOPY: Absolutely.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

16                   COMMISSIONER FRANK MARROCCO (CHAIR):  
17                   So was there some reluctance to use the  
18 authority?

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

25                   I suspect Barb, because she has been

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

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

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

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

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

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

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

9                   COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

21                  MELISSA PROKOPY: Uhm-hmm.

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

11 ANTHONY DALE: There was.

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

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

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

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

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

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

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

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

18                  COMMISSIONER FRANK MARROCCO (CHAIR) :

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

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

5                   ANTHONY DALE: With this --

6                   MELISSA PROKOPY: Do you want to add  
7 something there?

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

13                  COMMISSIONER FRANK MARROCCO (CHAIR):

14                  Go ahead. I'll stop asking questions.

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

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

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

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

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

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

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

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

24                  DAVID BROOK: Thanks, Melissa.

25                  So on the slide, this next slide here,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Commissioner Coke? You are on mute.

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

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

5 DAVID BROOK: Great question.

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

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

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

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

20                   COMMISSIONER JACK KITTS: That is  
21 fascinating.

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

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

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

7                     DAVID BROOK: So great question, Jack.

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

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

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

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

12                  COMMISSIONER JACK KITTS: Yes, thank  
13 you.

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

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

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

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

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

1 light on and look at quite carefully.

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

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

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

17 So Humber River Hospital is an acute  
18 care hospital. You can see the numbers here,  
19 140,000 emerg visits. We do 70,000 types of  
20 surgical procedures a day. We have 48 critical  
21 care beds.

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

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

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

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

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

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

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

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

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

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

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

6 So they don't necessarily know us.

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

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

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

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

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

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

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

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

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

23 Next slide.

24 I do want to be fair to --

25 COMMISSIONER JACK KITTS: Barbara, can

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

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

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

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

10 BARBARA COLLINS: Right.

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

13 BARBARA COLLINS: Yes.

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

16 BARBARA COLLINS: Right.

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

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

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

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

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

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

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

25                  BARBARA COLLINS: They are.

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

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

6                   COMMISSIONER JACK KITTS: Thank you.  
7 Thank you.

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

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

1                   Next slide.

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

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

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

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

25                  And they have taught us a whole lot

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

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

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

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

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

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

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

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

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

1                   BARBARA COLLINS: Yes, I agree.

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

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

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

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

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

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

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

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

1 together and look at things.

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

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

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

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

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

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

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

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

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

16 I would say the acuity of patients has  
17 changed over the years, and perhaps we have not  
18 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

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

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

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

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

1 whether they are having specific problems or not.

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

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

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

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

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

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

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

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 Commissioner Coke?

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

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

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

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

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

1                   GILLIAN KERNAGHAN: Off mute.

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

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

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

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

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

4                   [Court Reporter intervenes  
5 for clarification.]

6                   So we see about a million outpatient  
7 and outreach visits every year. We train over  
8 3,000 students and are very distributed. Our  
9 furthest location -- actually we have a clinic in  
10 Toronto, and so we are very distributed across the  
11 region, so we have staff all over southwestern  
12 Ontario.

13                  So you'll see the numbers there.

14                  Next slide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Some of the biggest challenges were the  
13 behavioural supports. We had one home that had a  
14 wanderer that was positive, and we were told by the  
15 Ministry of Long-Term Care that we couldn't sedate  
16 the person to minimize the risk to other residents,  
17 even though we had a whole plan in place with the  
18 psychogeriatric supports to look at how could we  
19 safely manage all the non-medication interventions;  
20 if they didn't work, the psychogeriatric alongside  
21 the home and manage that behaviour if need be with  
22 medication. We were told that was inappropriate.  
23 And so we had continued outbreak in a home because  
24 we couldn't get support to look at some of those  
25 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,

1 even if they are in outbreak.

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

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

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

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 There is a question from Commissioner  
23 Kitts.

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

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

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

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

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

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

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

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

1 or PPE.

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR) :

13 Jack, I think you are on mute.

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

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

1 as needed.

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

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

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

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

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

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

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

25                   COMMISSIONER JACK KITTS: Thank you,

1 Gillian.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, thank you very much,

4 Dr. Kernaghan. I wrongly assumed -- I didn't mean  
5 to cut you off. Were you at the end of what you  
6 were saying or was --

7 GILLIAN KERNAGHAN: I am happy to be  
8 done.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Well, thank you all very much. We'll  
11 probably be back to you, if that is okay.

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

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

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

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

1 closely.

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

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

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

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

25 ANTHONY DALE: Well, at the heart of it

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

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

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

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

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

1 opportunity.

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

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

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

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

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

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

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

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

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

5 So that is really our closing comment.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

25 -- Adjourned at 4:12 p.m.

1                   REPORTER'S CERTIFICATE  
2

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

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

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

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

13  
14  
15  
16                  Dated this 6th day of October, 2020.  
17

18                    
19

20  
21                  

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22                  NEESONS, A VERITEXT COMPANY  
23                  PER:     DEANA SANTEDICOLA, RPR, CRR, CSR  
24  
25

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