

Long-Term Care COVID-19 Commission Meeting

The Honourable Merrilee Fullerton, Minister of
Long-Term Care, and Richard Steele, Deputy
Minister of Long-Term Care
on Friday, February 26, 2021



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5	MEETING OF THE LONG-TERM CARE
6	COVID-19 COMMISSION
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14	--- Held via Zoom video conference, with all
15	participants attending remotely, on the 26th day
16	of February, 2021, 10:00 a.m. to 2:00 p.m.
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1 BEFORE:

2 The Honourable Frank N. Marrocco, Commission
3 Chair

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 MINISTRY OF LONG-TERM CARE:

8 The Honourable Merrilee Fullerton, Minister of
9 Long-Term Care

10 Richard Steele, Deputy Minister of Long-Term
11 Care

12

13 COUNSEL:

14 Kristin Smith, Counsel, Ministry of
15 Health/Ministry of Long-Term Care

16 Amy Leamen, Counsel, Ministry of Health/Ministry
17 of Long-Term Care

18 Sunil Mathai, Counsel, Ministry of Attorney
19 General

20 Eric Wagner, Counsel, Ministry of Attorney
21 General

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24 Michele Valentini, Counsel, Ministry of Attorney
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1 Stephanie Figliomeni, Counsel, Ministry of
2 Health/Ministry of Long-Term Care
3 Roopa Mann, Counsel, Ministry of the Attorney
4 General
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6 Health / Ministry of Long-Term Care
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8

9 PARTICIPANTS:

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23 Care Commission Secretariat
24 Angela Walwyn, Senior Policy Analyst, Long-Term
25 Care Commission Secretariat

1 John Callaghan, Co-Lead Commission Counsel,
2 Gowling WLG

3 Lynn Mahoney, Counsel, Gowling WLG

4 Michael Finley, Counsel, Gowling WLG

5 Peter Gross, Counsel, Gowling, WLG

6 Patricia Brooks, Counsel, Gowling WLG

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8

9 ALSO PRESENT:

10 Helen Martineau, Stenographer/Transcriptionist

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1 --- Upon commencing at 10:03 a.m.

2 COMMISSION CHAIR FRANK MARROCCO:

3 Minister, and, Deputy Steele, I'll
4 take a break about every hour and 15 minutes.
5 It gives the reporter a chance to catch her
6 breath and the rest of us a brief 5 or 10
7 minutes to regroup.

8 DEPUTY MINISTER RICHARD STEELE: Okay.

9 COMMISSION CHAIR FRANK MARROCCO: So,
10 Mr. Callaghan, go ahead.

11 JOHN CALLAGHAN: Good morning,
12 Minister. Good morning, Deputy Minister. Again
13 to the Deputy Minister.

14 Before I start, I mean, as you can
15 appreciate, Minister, your Commissioners and
16 their counsel have been working these last
17 number of months trying to fulfill the terms of
18 reference that you've assigned to the
19 Commissioners.

20 We're going to today try to cover some
21 of the topics that might involve your
22 involvement and the Deputy's involvement and
23 hopefully we get through a fair number of those.

24 We've heard from Deputy Steele in the
25 past, but I wonder, Minister, you might tell us

1 a little bit about your background?

2 MINISTER MERRILEE FULLERTON: Thank
3 you. Thanks for the opportunity and thank you
4 very much to the Commissioners for all the work
5 that they've been doing over the last few months
6 and everyone involved.

7 I'm a family doctor for many, many
8 years, almost 30 years in family practice in
9 Kanata, which is just on the west side of
10 Ottawa. And I have had lots of experience
11 rural, urban, across the spectrum really, of
12 care. And I also did some Public Health. I was
13 on the Board of Health with the City of Ottawa
14 for a number of years, and actually had an
15 interest in Public Health when I was doing my
16 residency in family medicine.

17 I was able to have the opportunity to
18 help with the H1N1 outbreak back in, I guess
19 that would be 2009 or so, and working with the
20 City of Ottawa and Public Health at that time.
21 And so that was a very meaningful experience.

22 I've also been able to have some
23 training in palliative care. And for the last
24 probably 14 years have been very concerned about
25 our aging demographic, you know, the old age

1 dependency ratio, the economics of healthcare
2 and how we provide care to our most vulnerable.
3 And how, really, for the last 10 years, looking
4 seriously at long-term care and how it needs to
5 be integrated with acute care as our population
6 ages.

7 That's probably enough. So thank you
8 for the opportunity.

9 JOHN CALLAGHAN: That's helpful. And
10 on that latter part, I hope the latter part of
11 our discussion today we'll get to that.

12 Just so I'm clear, when you say you
13 were involved in H1N1, were you involved with
14 the Public Health Unit in Ottawa or were you
15 involved as a practitioner or both?

16 MINISTER MERRILEE FULLERTON: I was
17 involved as a practitioner and helping to
18 organize the physician response in conjunction
19 with Public Health in Ottawa.

20 So I was not employed by Public
21 Health, but we helped to manage the response,
22 the vaccination clinics.

23 JOHN CALLAGHAN: I'm assuming you're
24 aware, but maybe you could tell us if you had any
25 involvement in either SARS or Ebola?

1 MINISTER MERRILEE FULLERTON: Did not
2 have any involvement with Ebola, but I was
3 following the SARS situation very, very carefully
4 at the time. And obviously concerned and knowing
5 that we were overdue for a pandemic for many
6 years and leading up to today.

7 JOHN CALLAGHAN: That's very helpful.

8 So before I begin, you probably
9 appreciate that we got approximately 270 pages
10 of your notes at 11:00 o'clock last night.
11 These are basically a calendar.

12 MINISTER MERRILEE FULLERTON: Yes.

13 JOHN CALLAGHAN: And I've had my --
14 part of my team try to look at them. We haven't
15 got through them. I think the consensus is your
16 handwriting is better than your Deputy's.

17 DEPUTY MINISTER RICHARD STEELE: That's
18 not saying very much.

19 JOHN CALLAGHAN: But anyway, I thought
20 I'd tell you that. Like the rest of the
21 documents we got recently, I'm not able to fill
22 in the blanks --

23 COMMISSION CHAIR FRANK MARROCCO: Mr. C
24 allaghan, when you turn away, it's hard to hear.

25 JOHN CALLAGHAN: Then I have to get

1 closer, which makes -- I hope the Minister and
2 Deputy Minister don't think I'm leering at them,
3 but I will get closer to the mic.

4 I think you get the point. We'll try
5 and go through this and I may be able to put
6 some of the notes to you that we received last
7 night.

8 MINISTER MERRILEE FULLERTON: Certainly
9 .

10 JOHN CALLAGHAN: So, Minister, just for
11 the record, when did you become the Minister of
12 Long-Term Care?

13 MINISTER MERRILEE FULLERTON: The
14 appointment was made at the end of June, I want
15 to say the 21st, but it might have been the 22nd,
16 of 2019.

17 JOHN CALLAGHAN: And, Deputy Steele, I
18 think you told us last time you started, I'm
19 going to say, March 6 or thereabouts?

20 DEPUTY MINISTER RICHARD STEELE: Yeah,
21 March 9 of last year.

22 MINISTER MERRILEE FULLERTON: Remembers
23 it well, yeah.

24 JOHN CALLAGHAN: Minister Fullerton,
25 what was your understanding of the role of the

1 Ministry of Long-Term Care in respect of pandemic
2 preparedness?

3 MINISTER MERRILEE FULLERTON: Well, we
4 were a new ministry and were actually simply
5 staffing up at the beginning, because if you
6 really look back over the 15, 20 years, there was
7 very little done in long-term care, so there
8 wasn't much structure there. So we had to
9 create -- essentially create a ministry.

10 There was a division on inspections.
11 There was a division on capital development.
12 And so, we were staffing up during that time in
13 the Gillese Inquiry.

14 And so we were very much a shared
15 ministry or, I think the Deputy has said, like a
16 spin-out ministry that was very much attached to
17 Ministry of Health. And that the Ministry of
18 Health was doing the pandemic preparedness, the
19 co-ordination and the planning.

20 JOHN CALLAGHAN: So can I just take you
21 to the Provincial Emergency Response Plan for
22 2019. It's document G. And while that's getting
23 put up, you may be aware that in the provincial
24 hierarchy of emergency planning, certain
25 ministries are designated as responsible.

1 So, for example, in the -- in respect
2 of health and emergencies, disease, epidemics,
3 it has been stated to be the Ministry of Health
4 and Long-Term Care, which was the ministry in
5 2009. But I just want to ask you about the
6 current state of affairs.

7 So, Michael, if you can get Exhibit G
8 up, please. Or Document G, I should say.

9 So the province issued a new
10 Provincial Emergency Response Plan. If we can
11 go to page 121 of 128 and it describes the
12 responsibilities. And it says:

13 "Under OIC 1157/2009, the
14 Minister of Health and Minister of
15 Long-Term Care have been assigned the
16 responsibility for the formulation of
17 emergency plans in respect of:

18 Human health, disease, epidemics.
19 Health services during an emergency.
20 Ministry continuity of operations."

21 And then it says the:

22 "MOH/MLTC plans detail how these
23 responsibilities are met and describe
24 how the ministries manage human health
25 emergencies and ensure continued

1 access to health services regardless
2 of disruption, emergency or disaster
3 [...]."

4 Following down, it says:

5 "Co-ordination of the health
6 system with partners including: [...]
7 Long-term care facilities."

8 Do you understand it to be your
9 responsibility to do a plan under that Order in
10 Council?

11 MINISTER MERRILEE FULLERTON: This was
12 all very much a collaborative process, and I do
13 understand that we were integrated into that
14 process so, yes, we were integrated into that
15 process.

16 JOHN CALLAGHAN: Because we've heard
17 different statements made by different people who
18 had responsibilities. So you take the view that
19 you had a responsibility to provide for a plan,
20 not you, but the ministry, provide for a plan in
21 the case of pandemics?

22 MINISTER MERRILEE FULLERTON: Well,
23 certainly there was an obligation for the homes
24 to have emergency plans as well. And so from our
25 perspective with this particular outbreak and

1 pandemic, the concept was we needed to be
2 integrated with the Ministry of Health in the
3 plan. This is a hundred-year situation that we
4 had on our hands, a pandemic like this, with an
5 unknown virus, many unknowns.

6 JOHN CALLAGHAN: Well, let me just step
7 back. I'm not asking about the homes'
8 responsibility. We know they have a regulation.
9 We've heard -- we haven't heard anyone saying
10 they actually reviewed the homes' plan, but the
11 homes have a responsibility. But this is I'm
12 talking about your ministry having a
13 responsibility.

14 MINISTER MERRILEE FULLERTON: Yes, yes.

15 JOHN CALLAGHAN: You have a
16 responsibility to develop a plan.

17 MINISTER MERRILEE FULLERTON: Yes.

18 JOHN CALLAGHAN: And we've heard that
19 proper preparedness for a pandemic, or any type
20 of emergency, just doesn't involve the plans, but
21 it involves acquiring the necessary resources to
22 execute the plan. Do you agree with that?

23 MINISTER MERRILEE FULLERTON: Yes.

24 JOHN CALLAGHAN: And it also requires
25 that those who are responsible for the plan

1 simulate exercises so they're ready in the event
2 of the hundred-year pandemic. Do you agree with
3 that?

4 MINISTER MERRILEE FULLERTON: In part.
5 In part because I do think the unknowns
6 surrounding this virus, and if we go back to
7 where we were at the beginning of this, even our
8 health experts from the national level were
9 saying that the risk was low.

10 And we had been in contact with the
11 homes to understand if they felt prepared. And
12 for the most part, they did. There was one up
13 north that felt uncertain, but they said that
14 they were accustomed to dealing with influenza
15 outbreaks and they felt that they were prepared,
16 for the most part. The staffing was a concern
17 leading into this.

18 JOHN CALLAGHAN: What period of time
19 are you talking about? Because are you talking
20 about the August period? Are you talking
21 February?

22 MINISTER MERRILEE FULLERTON: Talking
23 about January, February and into March of 2020
24 when we were being told the risk was low.

25 JOHN CALLAGHAN: Were you aware that

1 the World Health Organization issued a report in
2 the fall of 2019 saying that the world wasn't
3 ready for a pandemic, governments weren't taking
4 it seriously?

5 MINISTER MERRILEE FULLERTON: I had
6 been very concerned that we were overdue for a
7 pandemic. And, as the Minister of Long-Term
8 Care, as a new ministry, and understanding that
9 Ministry of Health was setting up a plan for a
10 structure to deal with this particular event in
11 terms of the emergency management of the homes on
12 a regular basis.

13 You know, in the fall, we were very
14 concerned about capacity, the wait lists, and
15 how we were going to deal with people
16 languishing without the care they needed, you
17 know, in other locations. We needed to build
18 capacity and that was a priority.

19 JOHN CALLAGHAN: Capacity in the sense
20 that you were at about 97, 98 percent capacity of
21 the long-term care homes?

22 MINISTER MERRILEE FULLERTON: Yes.

23 JOHN CALLAGHAN: And you needed more
24 space, is that the idea? You have to answer yes
25 or no.

1 MINISTER MERRILEE FULLERTON: Oh,
2 sorry, I'll speak louder. Yes. Yes, that's the
3 case.

4 JOHN CALLAGHAN: And is that also
5 addressed, the fact that you had some 30,000 on
6 the wait list to get into long-term care?

7 MINISTER MERRILEE FULLERTON: Yes,
8 38,000. And of course with the demographics the
9 way they were, we knew that was just going to be
10 increasing, so there was a tremendous emphasis on
11 how we were going to help, not only people
12 needing care, but their families and the hallway
13 healthcare. People not getting the acute care
14 they needed. So there was tremendous pressure
15 there.

16
17 -- [TECHNICAL ISSUES]

18
19 JOHN CALLAGHAN: All right. Well,
20 maybe I'll just ask the question again.

21 So, Minister, what I'm talking about
22 is prior to this outbreak, had a plan, a
23 pandemic plan, were you aware of what the
24 provincial plan was in the event --

25 MINISTER MERRILEE FULLERTON: No, no.

1 I'll ask the Deputy if he did.

2 DEPUTY MINISTER RICHARD STEELE: No.
3 My understanding is when the ministry was
4 effectively spun out from the Ministry of Health,
5 and this was obviously before my time, but it
6 certainly would make sense to me, having been
7 involved in other circumstances where the
8 ministries are split up with a smaller one being
9 carved out of a larger one, inevitably there are
10 a series of things that ministries have and do
11 that need to be built over time.

12 So there would be a number of things
13 that would be a requirement ultimately on the
14 Ministry of Long-Term Care that wouldn't
15 necessarily have been in place for day one of
16 the creation of the ministry.

17 As the Minister noted, my
18 understanding is that through the summer and
19 fall of 2019, the ministry was essentially being
20 built. It started with one division, which
21 was -- which was -- essentially, you know, lift
22 and drop from the Ministry of Health, which was
23 the long-term care division. There was a policy
24 division being created, communications branch
25 being created, and then a significant swath of

1 shared services between -- shared functions
2 between the Ministry of Health and the Ministry
3 of Long-Term Care, which continues to this day.

4 So I think a number of things,
5 including emergency preparedness plan, pandemic
6 preparedness plan that would have been in place
7 when long-term care was sitting as a part of the
8 Ministry of Health, essentially the same -- the
9 same constructs would have carried over into the
10 creation of the new ministry.

11 So I'm not aware of there having been,
12 when I arrived, a Ministry of Health pandemic
13 response plan, yeah.

14 JOHN CALLAGHAN: So at the very end
15 there, you answered my question.

16 So, Minister, as a physician, you're
17 obviously aware of infectious diseases,
18 including viruses like corona viruses, COVID,
19 SARS, can be deadly. Are you aware of that?

20 MINISTER MERRILEE FULLERTON: Yes.

21 JOHN CALLAGHAN: And you're obviously
22 aware, from what you just said, that your
23 ministry takes care of probably the most
24 vulnerable people in our society?

25 MINISTER MERRILEE FULLERTON: Yes,

1 absolutely.

2 JOHN CALLAGHAN: And we've heard that
3 the acuity rate of residents in long-term care
4 has only gone up over the last 20 years?

5 MINISTER MERRILEE FULLERTON: Yes,
6 that's absolutely correct.

7 JOHN CALLAGHAN: Did you have an
8 appreciation from your work at H1N1 that when
9 you're dealing with a pandemic that action often
10 must be taken immediately in order to save lives?

11 MINISTER MERRILEE FULLERTON: Absolutel
12 y, absolutely.

13 JOHN CALLAGHAN: And undoubtedly you
14 would agree that saving lives, along with
15 stemming the spread of the disease, would have
16 been the most paramount concern to you and to the
17 government?

18 MINISTER MERRILEE FULLERTON: Absolutel
19 y, yes.

20 JOHN CALLAGHAN: And I take it that
21 you're aware of the precautionary principle?

22 MINISTER MERRILEE FULLERTON: Yes.

23 JOHN CALLAGHAN: And you agree that it
24 means that one ought to take the precautionary
25 measures, even when evidence and informed

1 decision making is not possible due to the lack
2 of data or the uncertainty of an evolving event?

3 MINISTER MERRILEE FULLERTON: Yes.

4 JOHN CALLAGHAN: This would mean taking
5 timely steps that are proportionate to the
6 threat, correct?

7 MINISTER MERRILEE FULLERTON: Yes. And
8 I would add in there that this was a relatively
9 unknown virus and the science at the beginning
10 was not clear in many areas. And so we were
11 listening very carefully to quite a few experts.
12 And our Chief Medical Officer of Health, the
13 Associate Chief Medical Officer of Health, we
14 were listening and taking the advice of the
15 experts.

16 JOHN CALLAGHAN: It's interesting
17 because I think when we get to the notes, I think
18 you were ahead of the Chief Medical Officer of
19 Health in many respects, from your notes anyway.

20 And as you say, there was much to be
21 done when you took over long-term care. We
22 are -- you had an aging infrastructure, we just
23 talked about it. Effectively no new beds since
24 about 2011?

25 MINISTER MERRILEE FULLERTON: Between

1 2011 and 2018, I think there were 611 beds, but
2 the aging infrastructure of homes built in the
3 1970s not redeveloped.

4 JOHN CALLAGHAN: And then when you went
5 into the pandemic, there was already a commitment
6 by your government to build about 15,000 beds.

7 MINISTER MERRILEE FULLERTON: 15,000,
8 yes.

9 JOHN CALLAGHAN: One five.

10 MINISTER MERRILEE FULLERTON: Yes, 15,
11 one five.

12 JOHN CALLAGHAN: Right. And redevelop
13 another 15.

14 MINISTER MERRILEE FULLERTON: Yes.
15 15,000 beds in 5 years and 30,000 new beds in 10
16 years.

17 JOHN CALLAGHAN: And as you talked
18 about, you also -- you also had a staffing issue
19 to deal with. You called a crisis. We'll talk
20 about that a little later.

21 So the Premier has said that long-term
22 care is broken. Are there other factors, other
23 than the ones we've just mentioned, that would
24 cause the Premier, to your knowledge, to say the
25 system was broken?

1 MINISTER MERRILEE FULLERTON: Well, it
2 was definitely the staffing, definitely the age
3 of the homes, the lack of new capacity. And I
4 would also add, it was the lack of integration
5 between the acute care sector and the long-term
6 care sector, as well as how the community numbers
7 were rising, so an aging demographic.

8 And I kept saying for many years, Why
9 isn't someone doing something about this? And
10 that's eventually why I came to politics.

11 JOHN CALLAGHAN: And so at the time
12 when the pandemic happens, the Ministry of
13 Long-Term Care doesn't have a plan and it's fair
14 to say that it has, what the Premier calls "a
15 broken system". Is that correct?

16 MINISTER MERRILEE FULLERTON: We had a
17 broken system and we were very much integrated
18 with health at that time. And over the span of
19 the year that, you know, we've been -- year and a
20 bit we've been in existence, we were able to
21 begin to build a ministry that was going to deal
22 with these long-standing issues. But we were
23 very much attached, you know, an appendage
24 ministry is sort of the way it was.

25 So we were dependent on the Ministry

1 of Health for staff, for many of the resources
2 that we were attempting to use during the
3 pandemic and before. So very much dependent on
4 the Ministry of Health.

5 JOHN CALLAGHAN: So as you can
6 appreciate, we've interviewed a significant
7 amount of people.

8 MINISTER MERRILEE FULLERTON: Yes.

9 JOHN CALLAGHAN: And we met with the
10 Ontario Nurses Association, who you met with in
11 February. If you turn up tab 31.

12 MINISTER MERRILEE FULLERTON: Pardon
13 me?

14 JOHN CALLAGHAN: Tab 31, Michael.

15 So this is a meeting that appears to
16 have happened in February and the notes -- this
17 is the notes that you had for the agenda and it
18 says on the next page, go down a little further
19 Michael:

20 "The risk to long-term care homes
21 is low since residents can be screened
22 during the admission and readmission
23 process. It is unlikely that
24 long-term care home residents will
25 have travel history to China."

1 Now, we heard from ONA, and they
2 said -- if you can pull it up at tab 33? I'm
3 afraid I don't always have the transcripts. And
4 this is what we were told. If we can get up 33,
5 please?

6 MICHAEL FINLEY: Just having some
7 Internet lag here. Can you see it now?

8 JOHN CALLAGHAN: Yes, page 76.
9 It says:

10 "We have rarely met with the
11 Ministry of Long-Term Care. We did
12 meet with Minister Fullerton in the
13 middle of February, but that was to
14 discuss the staffing study. And
15 during that meeting, when we raised
16 issues of COVID with her, herself, as
17 well as her staff, were unprepared and
18 didn't have responses to our questions
19 about the readiness of long-term care
20 to protect against COVID."

21 Was that the situation for long-term
22 care in the middle of February?

23 MINISTER MERRILEE FULLERTON: Certainly
24 we were aware and there was planning that was
25 beginning through the Ministry of Health. There

1 were guidelines issued to our long-term care
2 homes.

3 I think -- I think the context of
4 COVID, as it evolved, the asymptomatic spread,
5 the inability for the Public Health measures to
6 be effective in asymptomatic spread was a major
7 issue.

8 And if I -- if I look at the readiness
9 of long-term care, certainly, as you've pointed
10 out, we were 98, 99 percent capacity and also
11 helping the hospitals at that time because they
12 were concerned about making sure that there was
13 space available for COVID patients, so we were
14 assisting there. And the staffing issues. So
15 these were long-standing issues that we were
16 looking to shore up.

17 And in terms of the readiness, the
18 Ministry of Health started issuing guidance to
19 long-term care, I believe, in January and
20 February.

21 JOHN CALLAGHAN: And then she goes on
22 to say:

23 "Following that, ONA and the
24 other unions repeatedly raised
25 concerns about long-term care, and by

1 mid-March, the government was advised
2 about our concerns with PPE supply in
3 long-term care. And one of the issues
4 we raised was why are long-term care
5 staff working in multiple facilities?
6 "One of the recommendations from the
7 SARS inquiry and Justice Campbell was
8 that health care workers needed to
9 minimize the number of workplaces they
10 worked in, and we were asking the very
11 same thing about the lessons learned
12 from SARS and how they were going to
13 apply that to COVID."

14 MINISTER MERRILEE FULLERTON: Yes.

15 JOHN CALLAGHAN: So throughout this
16 period, they're raising concerns, correct?

17 MINISTER MERRILEE FULLERTON: Well,
18 yes, certainly. And I think there was -- we were
19 all concerned. And if we look at the staffing,
20 really the neglect of the sector for many, many
21 years. And as I told you earlier, we were very
22 aware of the staffing, the crisis as we came in
23 to the new ministry and also speaking to the
24 sector.

25 And that was something that we were --

1 and made sure, when Justice Gillese did her
2 recommendations, that we added PSWs to a
3 recommendation that she made because we knew it
4 needed to be addressed as soon as possible.

5 JOHN CALLAGHAN: But here she's talking
6 about specific concerns relating to PPE and staff
7 working at more than one location. So they
8 raised that with you in mid-March, as she said,
9 correct?

10 MINISTER MERRILEE FULLERTON: Yeah, and
11 I will go back to the precarious nature of the
12 staff in terms of the homes. And if we, you
13 know, fast forward to March 22nd when we -- when
14 the Chief Medical Officer of Health made the
15 recommendation about one site only, and it was a
16 strong recommendation, and understanding the
17 precarious nature of the staffing at that point,
18 there was concern that one site only would tip
19 some of our homes into staffing collapse.

20 And so, you know, that precautionary
21 principle requires us to understand what could
22 happen and mitigate. So that's why it was
23 strongly recommended and not mandated.

24 And also at that time, there was risk,
25 or lack of understanding, shall we say, about

1 the community spread and we were beginning to
2 understand the magnitude of the community
3 spread.

4 JOHN CALLAGHAN: So we'll come back to
5 the single site a little bit later, but I just
6 want to take you to what the Ontario Hospital
7 Association said. And this is at tab 35.

8 They say at page 18, so tab 35,
9 page 18. So it says at the bottom:

10 "And I think that in a nutshell
11 reflects the challenge that faced
12 long-term care in the early stages of
13 the pandemic. By creating a kind of
14 separate, stand-alone, tiny Ministry
15 that really is just the inspectorate,
16 plus some specialized policy and
17 funding expertise, I don't think it
18 will have -- I don't think history
19 will judge the decision last summer --
20 a year ago last summer to create a
21 stand-alone long-term care ministry as
22 having been a wise one.

23 "I think that its separation from the
24 Ministry of Health has created systemic
25 kind of silos and barriers to integrated

1 thinking for the response, and you will
2 see in a moment some of the
3 communications and actions we took after
4 we realized that long-term care was
5 not -- the needs of long-term care and
6 the need for speed and substantive
7 planning and preparation for the
8 pandemic response, once we realized that
9 those were not being met, we chose to
10 act and undertake some actions to
11 address that."

12 Now, do you agree with the Ontario
13 Hospital Association that you were siloed from
14 the Ministry of Health and, as a tiny ministry,
15 you couldn't be all that effective?

16 MINISTER MERRILEE FULLERTON: I
17 would -- I mean there's a lot in there. I agree
18 with some of it. I agree that we were dependent
19 on the Ministry of Health. So in that respect we
20 were part of the Ministry of Health because of
21 the nature of the shared staff, the shared
22 expertise. And ultimately the ministry -- but
23 the ministry being created was -- is a way to put
24 a lens on the long-standing neglect.

25 It was the Ministry of Health and

1 Long-Term Care for many years, many, many years.
2 And so it is in the process of creating a
3 separate ministry that we can actually address
4 the issues.

5 Do we still have to work with the
6 Ministry of Health? Do we need to work with
7 other ministries? Absolutely. So I disagree
8 with the concept of siloing. And I disagree
9 with the concept that he raises in terms of, you
10 know, that this created a barrier.

11 What the creation of the Ministry of
12 Long-Term Care demonstrated is that there was a
13 ton of work, a whole lot of work. The magnitude
14 of the work needed to be done for long-term care
15 is huge, and this was the beginning. And we
16 were very much tied to the Ministry of Health;
17 and that in itself posed problems.

18 JOHN CALLAGHAN: Let me just take
19 you -- maybe this is one of those problems. Tab
20 36, this is an email from Mr. Hains, your Chief
21 of Staff, to Mr. Steele. And it's in March 31st
22 and it says -- he's attaching a briefing and he
23 says:

24 "This came through MCGS", which I
25 think is the Ministry of Government

1 Services, "I am sure we didn't see it.
2 But can we please use all channels. I
3 will do so with my colleagues to
4 ensure that long-term care is
5 recognized as an equal partner with
6 hospitals, especially as it relates to
7 PPE. The part on page 7 is
8 particularly frustrating which says
9 that PPE has been deployed to
10 hospitals and correctional facilities.
11 This was done with LTC partners on the
12 line. We are too often the forgotten
13 partner."

14 Was that the feeling at that time?
15 That you were the forgotten partner?

16 MINISTER MERRILEE FULLERTON: The
17 voice, yes, at that time that was the feeling.
18 And the voice of long-term care has long been
19 neglected. And I've been paying attention for at
20 least 15 years in this sector. So in the midst
21 of a crisis like this our voices needed to be
22 larger, and having the Ministry of Long-Term Care
23 was a step towards that.

24 JOHN CALLAGHAN: Then I'll show you
25 document 37, which in fact is actually you

1 perhaps voicing that in a real-time manner. And
2 this -- it's a small issue dealing with guidance
3 testing. And you're saying:

4 "Just wondering why Ministry of
5 Health is issuing, reissuing the
6 guidelines without MLTC. I understand
7 MOH is the lead, but MLTC must be part
8 of this communication to our own
9 sector."

10 So you're asserting that new voice, as
11 it were. Is that what's going on?

12 MINISTER MERRILEE FULLERTON: Yes. I
13 believe that we needed to be communicating with
14 the sector or we would lose trust, but I also
15 understood the efforts to collaborate with the
16 Ministry of Health as the lead.

17 So I understand in a crisis, you can't
18 have multiple leaders because the communication
19 gets garbled. And so I understood the necessity
20 of having the Ministry of Health as the lead,
21 but I believe very strongly that our -- the
22 trust in our ministry would be put at risk if we
23 weren't able to communicate with our sector.

24 JOHN CALLAGHAN: Right. And just so
25 you know, I mean, I'll -- we heard from one of

1 the municipalities who operates long-term care
2 and they said they got 450 different directions,
3 memorandum --

4 MINISTER MERRILEE FULLERTON: Yeah.

5 JOHN CALLAGHAN: -- during that period.

6 MINISTER MERRILEE FULLERTON: Yes.

7 JOHN CALLAGHAN: Was it ever a concern
8 of yours that there were too many people
9 communicating with your sector and there wasn't a
10 central point of contact?

11 MINISTER MERRILEE FULLERTON: I
12 think -- it was a concern and we did hear that
13 and we were working to streamline things as much
14 as possible, in the context of a very fluid
15 situation. And, you know, we were working around
16 the clock constantly to try to keep up as we
17 understood new realities and just trying to use
18 every ability that we could to provide the proper
19 advice to the homes.

20 JOHN CALLAGHAN: So we have had an
21 opportunity --

22 MINISTER MERRILEE FULLERTON: Deputy,
23 did you want to speak?

24 DEPUTY MINISTER RICHARD STEELE: If I
25 could add, if that's okay?

1 Just to reinforce, I think we were and
2 have been and continue to be very aware of that
3 concern of just how much information is being
4 pushed out.

5 As the Minister notes the challenges,
6 the situation's evolving very rapidly. A
7 preferred model, for example, would have been to
8 provide weekly bulletins of here's all the
9 things you need to know. That's certainly
10 something I've done in previous situations.

11 The challenge was it was frequently a
12 requirement to get information out the day it
13 became available. So we did get into very, very
14 frequent updates and absolutely understood that
15 that was challenging. We tried to address that
16 if anything was particularly complex, we would
17 organize supplementary ways of explaining the
18 information. There would be webinars, there
19 would be calls with the sector.

20 So we tried to address it and tried to
21 mitigate it, but it does remain a significant
22 challenge.

23 JOHN CALLAGHAN: One of the things that
24 struck us when we look at the documents is
25 clearly who's responsible to communicate what

1 advice. So we would have the Chief Medical
2 Officer of Health that would write a memorandum.
3 There would then be emails from yourself, Deputy,
4 from Assistant Deputy Ministers. There was
5 emails from the command tables. And it wasn't
6 always clear to us, when we looked at it, who had
7 the handle on what level of communication.

8 Did you have a clear understanding of
9 who was responsible to communicate what
10 information to your sector?

11 MINISTER MERRILEE FULLERTON: The
12 communications that we were eventually putting
13 out, because as I said originally all
14 communications regarding COVID were to come out
15 of the Ministry of Health, things were moving so
16 rapidly. We were moving fast. COVID was moving
17 faster and so we were looking after the areas
18 that we believed would be of most significant
19 assistance to the homes.

20 And that was, again, done through the
21 several layers with the Chief Medical Officer of
22 Health and co-ordinated as best we could, but
23 there was a sense of urgency to get information
24 to the homes as the situation changed.

25 DEPUTY MINISTER RICHARD STEELE: We did

1 try to ensure -- if I could, we did try to ensure
2 that while the source of the advice might come
3 from different places or the -- could be, as you
4 say, a Deputy's memo, a Minister's directive from
5 the Chief Medical Officer of Health, it could
6 come from multiple sources, but we tried to
7 ensure it was all channeled through one
8 communication channel in the end, which was the
9 portal that the homes could access, ltchomes.net.

10 So whatever it was, the practice was
11 to ensure that it was posted there so that it
12 was one place where the homes could see all of
13 the requirements and directives that were coming
14 up.

15 JOHN CALLAGHAN: And if we could just
16 go to your notes, and again, if somebody can pull
17 this for me? This is February 5th, 2020. So if
18 you go down. If you go down and I think we're
19 reading your handwriting correctly.

20 MINISTER MERRILEE FULLERTON: Sorry,
21 about that. Doctor's handwriting.

22 JOHN CALLAGHAN: I can assure you, we
23 won't have many of the Deputy's notes up.

24 But this one says "mentioned
25 asymptomatic spread". So were you discussing

1 asymptomatic spread by February 5th?

2 MINISTER MERRILEE FULLERTON: I was
3 concerned about it because I'd been following
4 what was happening around the world and I had
5 heard that in some anecdotal cases, and of course
6 I wasn't the scientist, I'm not the Chief Medical
7 Officer of Health, I'm not a public health
8 expert, I was concerned about this.

9 But, again, there was a lot of
10 different opinions and a lot of different
11 experts differing on this, but it is something
12 that I had read and heard about.

13 JOHN CALLAGHAN: So by February 5th,
14 were you concerned then, given the frailty of
15 your population in long-term care, of COVID
16 entering long-term care?

17 MINISTER MERRILEE FULLERTON: I was
18 concerned that we needed to understand the
19 transmission of this virus. So I was
20 obviously -- I mean, yes, I was obviously
21 concerned about the vulnerability of long-term
22 care residents, the immunosenescence, the fact
23 that they don't demonstrate symptoms. I was very
24 concerned.

25 JOHN CALLAGHAN: And we've talked to

1 others, Minister, and one of the Commissioner's
2 questions, which I'll ask, is when did that dawn
3 on you? I mean, we've heard people talk about
4 the Diamond Princess; we've heard people talk
5 about the outbreak in Washington State in the
6 long-term care home. But can you sort of
7 pinpoint when -- I mean, your note is one of the
8 earlier ones we've seen, to be frank, but when it
9 actually coalesced in your mind?

10 MINISTER MERRILEE FULLERTON: Well, I
11 had suspicions early on only -- well, because I'm
12 a family doctor and spent many years dealing with
13 the elderly, and even if they get a urinary tract
14 infection, they may not present with typical
15 symptoms and so you always have to be watching.
16 If they present with very vague symptoms, if it
17 could be something else. That's for that segment
18 of the population.

19 But the concept at this time still was
20 that people would be screened adequately coming
21 into the home. And these were anecdotal that I
22 was hearing. There was no massive research that
23 had been done at this point, but I was concerned
24 it could be different from influenza.

25 But I'm not the expert. And I

1 recognize that at times people can overstep, so
2 that was -- I needed to listen to the experts
3 and the science and I was -- I was trying to
4 wear my -- not my doctor or Public Health hat,
5 because that's not the role I had.

6 JOHN CALLAGHAN: Well, I mean, it
7 sounds like you had a fair bit of information in
8 terms of intuitively, because you ended up being
9 right.

10 But if we can go to March 12th in your
11 notes. Now, this is after that meeting of ONA.
12 So I want to juxtapose that for both the record
13 and for yourself.

14 If you go down, it talks about
15 COVID-19 filming. And if we've made out your
16 handwriting correctly, it says, "Refused to say
17 the risk is low", and it circles "COVID-19".

18 We saw in the note in February that
19 that was the messaging. Had you changed your
20 view about the messaging by March 12th?

21 MINISTER MERRILEE FULLERTON: Well, in
22 terms of my thinking at that time, I was very
23 concerned about doing a video that would show or
24 tell people that the risk was low, even though
25 that was what health experts and the health

1 leaders in Canada were saying. I did not want to
2 make a video indicating that.

3 In the notes with ONA, I don't believe
4 that I ever said that. That was -- those were
5 notes that were -- that were in, provided to me,
6 but I don't believe I ever said that.

7 So, you know, I also believed that we
8 should be locking down in our long-term care
9 homes as soon as possible and that was very
10 important I believed.

11 JOHN CALLAGHAN: And so were you of
12 that view as of March 12th?

13 MINISTER MERRILEE FULLERTON: Yes.

14 JOHN CALLAGHAN: And when would you
15 have become of that view? As to -- would it have
16 been a week before, two weeks before?

17 MINISTER MERRILEE FULLERTON: Specifica
18 lly about locking down?

19 JOHN CALLAGHAN: Well, yes, I mean,
20 that's a fairly drastic measure. So when would
21 you have been of that view?

22 MINISTER MERRILEE FULLERTON: It would
23 have been leading into that time. Again, I'm not
24 the scientist. I'm a family doctor. I'm not the
25 Chief Medical Officer of Health. And there was a

1 lot of -- a lot of priority put on listening to
2 the experts. Listening to the people that
3 were -- that was their role, that was their job.
4 That they -- that's what they did full time. And
5 to listen to them, they were the experts.

6 I don't know if the Deputy wants to
7 add anything there?

8 DEPUTY MINISTER RICHARD STEELE: No. I
9 would agree with -- I think it was certainly --
10 this would have been the first week that I was --
11 that I was in the Deputy role and it was
12 certainly that was the week that the ministry, in
13 again, in co-ordination with the Ministry of
14 Health, with the Chief Medical Officer of Health,
15 started to implement a number of measures. So
16 active screening for visitors and staff was
17 implemented around about the middle of that week
18 and a prohibition on all but essential visitors
19 would have been implemented at the end of that
20 week, so the timing would make sense.

21 MINISTER MERRILEE FULLERTON: It was
22 very close, yeah.

23 JOHN CALLAGHAN: So just on that point
24 so I have it clear. The ministry has a number of
25 tools at its disposal, and that's my phrase, not

1 anybody else's, in order to compel compliance
2 with homes. And I'll just -- they have -- you
3 have regulatory authorities under your Act, is
4 that correct, Deputy? This is a better Deputy
5 question.

6 DEPUTY MINISTER RICHARD STEELE: Yes,
7 absolutely. Under the Long-Term Care Homes Act,
8 yes.

9 JOHN CALLAGHAN: And you have the power
10 to provide guidance and directives, which we've
11 seen plenty of, right?

12 DEPUTY MINISTER RICHARD STEELE: Yes.

13 JOHN CALLAGHAN: And you have powers
14 under your contracts with the homes?

15 DEPUTY MINISTER RICHARD STEELE: Right.

16 JOHN CALLAGHAN: In other words, there
17 are contractual provisions. And then you have
18 the power of financial incentives, which you used
19 to the tune of about a half a billion dollars
20 during the outbreak, correct?

21 DEPUTY MINISTER RICHARD STEELE: Yes,
22 ultimately significantly more. I think, on the
23 financial side, ultimately about \$1.3 billion
24 but, yes, your point is correct.

25 JOHN CALLAGHAN: So those are part of

1 the powers and then the other powers is the Chief
2 Medical Officer of Health has powers, correct?

3 DEPUTY MINISTER RICHARD STEELE: Correc
4 t.

5 JOHN CALLAGHAN: The emergency
6 legislation directs certain people to have
7 powers, correct?

8 DEPUTY MINISTER RICHARD STEELE: Correc
9 t. Once the state of emergency was declared,
10 then that became another route or another tool
11 that could be used to provide direction through
12 emergency orders.

13 JOHN CALLAGHAN: And then, of course,
14 Cabinet, being Cabinet, has the powers that
15 Cabinet ordinarily has, correct?

16 DEPUTY MINISTER RICHARD STEELE: Correc
17 t.

18 JOHN CALLAGHAN: I want to go back to
19 what -- to what the Minister was talking about
20 because a single site has been an issue that we
21 explored. I just want to first take you to
22 something that Dr. David Walker wrote.

23 And I don't know, Minister, do you
24 know David Walker at Queen's University?

25 MINISTER MERRILEE FULLERTON: I'm

1 familiar with the name. I don't think we've ever
2 met, but I'm familiar with the name.

3 JOHN CALLAGHAN: Just to bring you up
4 to speed, he wrote a report after SARS, probably
5 not as well-known as Archie Campbell's report,
6 but certainly a good read. And I just want to --
7 I don't know if we have it there.

8 So this is what he said. This is in
9 2004 or 2005, maybe earlier, but this after
10 SARS, and he says under "Staffing Strategies:

11 "SARS shed a spotlight upon a
12 problem that has existed in the health
13 profession, particularly in nursing
14 for the past decade. The use of a
15 high proportion of staff that is
16 employed casually, rather than on a
17 full-time or "regular part-time"
18 basis. Full time and regular part
19 time work usually involves a
20 relatively fixed schedule, an agreed
21 number of hours. But casualization
22 involves a systemic replacement of
23 full-time and part time staff with
24 staff employed on an ad hoc way basis.
25 As stated in one submission to the

1 panel a move towards a much higher
2 ratio of full-time permanent staff,
3 part-time casual staff work at
4 multiple sites and may contribute to
5 the spread of the disease.

6 "The panel heard that the problem of
7 casualization is most severe in
8 long-term care and community care
9 sectors but remains a concern across all
10 sectors of care. Those employed on a
11 casual basis tend to work at multiple
12 sites raising the spectre of healthcare
13 workers transmitting the disease.

14 Although there was no definitive
15 incident of such transmission during
16 SARS, many submissions to the panel
17 expressed concern that it could easily
18 have happened and the risks are too
19 high."

20 So I take it you would agree that in
21 long-term care today, the incidence of part-time
22 and casual work amongst, particularly PSWs, is
23 considerable? It's greater than 50 percent at
24 least, correct?

25 MINISTER MERRILEE FULLERTON: Agreed,

1 yes.

2 JOHN CALLAGHAN: And so what Dr. Walker
3 and his committee seems to be pointing to is the
4 problem that existed in SARS, and which also you
5 were considering COVID, that is that part-time
6 employees going to more than one home may be
7 carrying disease with them as they go from home
8 to home, correct?

9 MINISTER MERRILEE FULLERTON: Or --
10 yes, or coming from the community, which is in
11 this scenario where the asymptomatic spread could
12 have also been a risk.

13 JOHN CALLAGHAN: Right. And we'll see
14 in a moment, but you obviously were alive to
15 asymptomatic spread in February. I'm going to
16 take you in a moment to a Cabinet submission
17 where you definitively identified asymptomatic
18 spread in April. But that would be a concern,
19 right? That due to asymptomatic spread, that
20 they may unknowingly come to work and spread
21 COVID to the long-term care residents, correct?

22 MINISTER MERRILEE FULLERTON: And
23 that's -- yes, correct. And that's why we needed
24 the testing so badly.

25 JOHN CALLAGHAN: Right. And -- and the

1 situation is this, we know that on March 22nd,
2 the Chief Medical Officer of Health issued his
3 Section 77 Order, and whatever you think about
4 it, and there's different views as to the
5 effectiveness of the wording in it, it was deemed
6 not to be effective enough, correct?

7 MINISTER MERRILEE FULLERTON: Yes.
8 However, there was the risk of the precarious
9 staffing that we had. And there was, as I
10 mentioned earlier, there was great concern that
11 by limiting staff to one location only that we
12 would tip some of the homes into collapse. And
13 that's what we heard also from some of the sector
14 that we'd spoken to and some of the
15 representative organizations. And because of the
16 nature of the staffing crisis preceding COVID, we
17 felt that that was a real risk.

18 JOHN CALLAGHAN: But --

19 DEPUTY MINISTER RICHARD STEELE: Could
20 I just, if I may, could I just add one comment
21 just in response to the point around the
22 effectiveness of the initial directive or the
23 initial recommendation from the Chief Medical
24 Officer of Health around single site?

25 I don't think it would be accurate to

1 say it was not effective. Certainly it was not
2 a hundred percent effective because it wasn't an
3 absolute requirement. In talking to long-term
4 care home operators in the period between the
5 initial recommendation from Dr. Williams and
6 when we moved to the kind of mandatory nature of
7 it, it was clear that many were moving forward
8 to implement the single-site recommendation.

9 So, yes, ultimately it became
10 mandatory and that of course finished the job,
11 so to speak, but it is important to note that
12 many homes moved on the recommendation in -- at
13 the end of March. And indeed, some may well
14 have made that decision voluntarily themselves
15 even earlier.

16 MINISTER MERRILEE FULLERTON: Yes.

17 JOHN CALLAGHAN: If we can go to
18 tab 110? And this is an email, Deputy, from you
19 on April 2nd.

20 SUNIL MATHAI: Mr. Callaghan, before we
21 go on, I think the Minister wanted to add
22 something. I'm not sure.

23 MINISTER MERRILEE FULLERTON: Thank
24 you.

25 I think we really had to understand

1 many factors. There were multiple factors at
2 play here. And at first glance, you know, if
3 you're not in tune with the sector, you might
4 say, you know, having staff work at multiple
5 sites was spreading COVID. And, you know,
6 without the testing at that -- early on, we
7 couldn't be sure of that. But there was
8 community spread and Dr. Vera Etches in Ottawa
9 was calling a community spread.

10 And so we had to have some
11 understanding of what was in the community as
12 well. And I believe that our limited testing
13 early on did not identify the level of community
14 spread that was there.

15 So I believe that staff were bringing
16 it in unknowingly. They're the heroes in this
17 and I'm not laying any blame whatsoever on them.
18 They were doing heroic work, but the problem was
19 it was in the community and it was coming into
20 the homes.

21 So whether they worked in multiple
22 sites or not, it was coming into the homes and
23 that was pretty clear when we looked at the
24 testing results.

25 JOHN CALLAGHAN: So, well, let's just

1 see what the Deputy said on April 2nd. If we can
2 go down, the Deputy writes. Go down please,
3 Michael.

4 You're writing Dr. Williams and you
5 say:

6 "One point that is striking is
7 that the number of instances where
8 infection has been introduced,
9 apparently, through a staff member."

10 So by April 2nd, even though there is
11 no scientific proof, it seems that both the
12 Minister and the Deputy Minister are of the
13 belief that staff members are, through
14 asymptomatic spread, introducing COVID to
15 long-term care, is that fair?

16 MINISTER MERRILEE FULLERTON: What is
17 the date on that one?

18 JOHN CALLAGHAN: April 2nd.

19 MINISTER MERRILEE FULLERTON: April 2nd
20 . We were starting to be very concerned at how
21 it was getting in. We knew that the residents
22 weren't travelling typically. Some of them might
23 have been admitted from elsewhere, but they
24 weren't travelling. So we were concerned about
25 this and it was beginning, you know, the

1 evolution of the understanding of the spread of
2 this virus was evolving.

3 DEPUTY MINISTER RICHARD STEELE: From
4 my perspective, I would say what I was outlining
5 there was not necessarily a belief. Again, I'm
6 not a medical expert or a scientist, but
7 certainly a concern and just, anecdotally, kind
8 of connecting the dots.

9 Screening had been in place. Staff
10 were getting screened and yet we were seeing --
11 we were seeing homes go into outbreak. So
12 clearly something was happening and we were
13 concerned.

14 COMMISSION CHAIR FRANK MARROCCO: Mr. C
15 allaghan, if I can interrupt for a minute.

16 Deputy, it doesn't -- it sounds a
17 little stronger than a belief. You say:

18 "One point that is striking is
19 the number of instances where
20 infection has been introduced,
21 apparently, through a staff member."

22 That sounds -- it certainly sounds
23 like you're down -- you're further down the road
24 than just having a belief.

25 DEPUTY MINISTER RICHARD STEELE: I

1 mean, that's fair. I think that was an
2 observation of -- that's a statement of what we
3 were seeing, absolutely.

4 As to the science around -- did that
5 mean there was asymptomatic spread or what?
6 Obviously, I don't know that for sure. All I'm
7 responding to is what we were seeing in terms of
8 outbreaks happening and how they could be
9 happening, given that we didn't have visitors
10 anymore and we did have active screening in
11 place for a period of time by then.

12 JOHN CALLAGHAN: So the email goes on
13 and I was going to applaud you, Deputy, because
14 you hit the trifecta of issues with Directive 3.
15 If we go down a little further, it says:

16 "Directive 3 introduced enhanced
17 active screening for staff, including
18 twice daily temperature checks, but I
19 think we may wish further measure to
20 reduce risk of staff introducing
21 infection."

22 If you go down to the last bullet
23 point.

24 "Further support for limiting
25 staff working multiple locations. Our

1 assessment is we may not be able to go
2 much further in terms of directing
3 this. We will be assessing what else
4 we can do to incent the right
5 behaviour (this is obviously a piece
6 we can lead)."

7 So by this time, you're actively
8 looking to strengthen that directive, correct?

9 MINISTER MERRILEE FULLERTON: Yes.

10 DEPUTY MINISTER RICHARD STEELE: Correc
11 t. And to the Minister's point, the challenge
12 here in that period between the initial
13 recommendation and when the -- I will say when
14 the initial recommendation was being developed
15 and the discussions were happening around how far
16 could that go. Could it be an absolute
17 requirement? The sense was under the HPPA that
18 the Chief Medical Officer of Health was not in a
19 position to make it an absolute requirement.

20 In addition, as the Minister has
21 noted, there were a set of concerns as to if we
22 went straight away and immediately to a
23 mandatory requirement, what would be the impact
24 on an already precarious staffing situation?

25 Again, as we were having these

1 conversations with the sector around, you know,
2 what was happening, what were they doing? For
3 those that were implementing based on the
4 recommendation, what were the impact? We were
5 certainly hearing that it was challenging. Many
6 were managing, but it was very challenging.
7 They were losing staff from long-term care.
8 Like, if staff had to make a choice, you've got
9 to pick, long-term care? Acute care? Many were
10 picking acute care. So we were trying to -- we
11 were trying to balance that.

12 As time went on, it did seem like by
13 offering full-time work with the additional
14 funding that we were providing, many homes
15 seemed to be able to at least somewhat mitigate
16 the impact of single-site.

17 We were asked to look again as to how
18 far can we go? Can we make this -- can we make
19 this mandatory? What would it look like? What
20 would it take? And we then started looking at
21 the other tools that could be used under the
22 state of emergency, under the emergency
23 management tools, and that's where we ultimately
24 landed. Is that, yes, we could make it
25 mandatory. We needed to provide some transition

1 time so the people could work through the
2 staffing issues, but that we could do it.

3 JOHN CALLAGHAN: So when we talked to,
4 I believe it was Ms. Hope, her principal concern
5 were labour law considerations as it related to
6 stopping employees from working in more than one
7 home.

8 MINISTER MERRILEE FULLERTON: If -- if
9 I can add quickly, you know, it was also we'd
10 been concerned about the wellbeing of the staff.
11 Their income. And we wanted to make sure we
12 could soften the edges of this so we gave them
13 some time, but ultimately we did not want to see
14 staff being financially impacted by not being
15 able to work as they were before.

16 So there was -- there were many
17 considerations. There was a lot of different
18 factors that were overlaid here.

19 DEPUTY MINISTER RICHARD STEELE: The
20 point that you raise from Ms. Hope, absolutely it
21 was a factor too, kind of constitutionally what
22 could we actually do in telling people where they
23 could and couldn't work?

24 JOHN CALLAGHAN: So let me ask you,
25 given what we read from Dr. Walker from 2003, '4,

1 '5, whatever it was, and given the quality of
2 senior managers that you have in long-term care,
3 do you think if they sat back in a simulation of
4 a pandemic they would have been able to figure
5 this issue out, that this was going to be a
6 problem and resolve these difficult issues before
7 it actually happened? Do you think that would be
8 likely?

9 DEPUTY MINISTER RICHARD STEELE: A
10 hypothetical question. If you're running a
11 detailed simulation of a pandemic that involved
12 asymptomatic spread as one of its features, then
13 that might be somewhere you got to. There's a
14 whole bunch of ifs in there, though.

15 The shorter answer is, even with your
16 really good planning, a lot of time spent on
17 contingency planning, I don't know if that would
18 have fallen out and become a plan.

19 JOHN CALLAGHAN: You don't think
20 anybody would have bothered to pick up
21 Dr. Walker's document, read it, recognized that
22 long-term care, as the Minister says, was in
23 crisis in staffing, and identified that they
24 would transmit the disease from home to home in
25 the part-time setting? You don't think they

1 would have been able to come up with that
2 conclusion had they turned their mind to it
3 before COVID? I'm surprised.

4 MINISTER MERRILEE FULLERTON: You would
5 have to simulate the level of community spread
6 because, you know, if we think of tuberculosis,
7 something that is not in the community at least,
8 you know, not in Toronto, it may be in other
9 areas, but certainly the community spread was a
10 factor here.

11 And so, how would you be able to tell
12 whether it was coming in from the community
13 directly into the long-term care home or whether
14 it was going home to home or whether one
15 trajectory was more significant than another?
16 There's a number of different complexities here.

17 I'm saying this is a complex system
18 and you do one thing over here and something
19 else happens over here and it's not always
20 intuitive.

21 And so we would have to simulate the
22 community spread to understand and we would have
23 had to know the testing results. And we would
24 have had to have widespread testing to know the
25 level of community spread, but there were people

1 calling the community spread at that time.

2 So I definitely think that offering --
3 making sure that workers in long-term care have
4 opportunity to work in one location if they
5 wish, to work full-time if they wish, is
6 important. We would also need to understand
7 what would attract them to the sector. So I
8 think there's a number of things at play here.

9 JOHN CALLAGHAN: So I guess I'm still a
10 little baffled here. Doctor, you, or Minister,
11 you, by February had postulated asymptomatic
12 spread.

13 MINISTER MERRILEE FULLERTON: Yes.

14 JOHN CALLAGHAN: We have heard -- we've
15 heard here that there is a significant
16 statistical reality of people who are sick who
17 continue to go to work no matter what. And I
18 cannot imagine that your staff, had they been
19 asked to simulate any type of pandemic, would not
20 have come up with the notion that long-term care
21 employees who work part-time, as Dr. Walker
22 postulated way back when, would take the disease
23 from home to home. You don't accept that if
24 you -- because it makes it sound like if we plan,
25 something as simple as that can't be found.

1 MINISTER MERRILEE FULLERTON: I'm
2 agreeing that it is possible. I'm also saying
3 that the community spread directly from the
4 community into the home. So the one location
5 only may not have stopped the spread.

6 And in fact, if you look at the
7 staffing study that was done by our expert
8 panel, they do point to the one-site-only as a
9 contributor to the staffing challenges.

10 And so you would have to understand
11 the level of community spread. If there's not a
12 lot in the community and only a few people have
13 it and they're going from home to home, then
14 clearly that would be a major problem. If it's
15 coming in from the community directly into a
16 single home without multiple homes, it will
17 still be coming in.

18 So anything that we can do to improve
19 the staffing and stabilize the staffing will be
20 of help going forward. Our problem, at the
21 time, was the issue surrounding the
22 precariousness of our staffing.

23 DEPUTY MINISTER RICHARD STEELE: I'm
24 not sure that a planning exercise -- just to add.
25 I'm not sure that a planning exercise would have

1 fundamentally resolved the tradeoff here. As
2 with so many decisions through COVID, there's not
3 a clear -- there's not a clear, you know, all of
4 the benefit is on one side of the decision. So
5 there's a set of tradeoffs which ultimately are
6 always going to be situationally specific that
7 have to get worked out in the moment, and no
8 planning exercise can resolve those tradeoffs in
9 advance. They could -- it could maybe highlight
10 here's an issue that we need to be ready to think
11 about, but ultimately the tradeoffs are going to
12 have to be worked out in the context of the
13 specific situation and the facts at that time.

14 MINISTER MERRILEE FULLERTON: And I
15 would like to believe that it would. But I'm a
16 critical thinker and I believe in this scenario
17 that we were dealing with, it was more
18 complicated than that.

19 And I think, as I mentioned before, we
20 need to be looking at many solutions and one
21 location of work is one of them. But it is --
22 there's a number of factors at play here that
23 make it a complex situation.

24 JOHN CALLAGHAN: So you can appreciate,
25 though, the issues identified at least by

1 March 22nd by the Chief Medical Officer of
2 Health, who is -- we now have the Deputy on
3 April 2nd raising alarm bells, as it were.

4 Minister, you go to Cabinet on
5 April 15th and you describe this as an issue
6 that is caused by asymptomatic spread. I can
7 take you to that in a second, if you wish.

8 But it's not till, I believe,
9 April 22nd, if I got the date right, that that
10 order comes into effect.

11 In that time Revera, for example, in
12 their report says 97 percent of those who were
13 infected and died of COVID had happened in the
14 first wave. They'd been infected by that time.

15 And so what I -- you know, the
16 Commission has asked to provide prescriptions as
17 to how to stop this going forward and I'm afraid
18 I'm not hearing a lot of prescriptions here
19 because right now even planning, like from
20 March 22nd to April 26th, the staffing situation
21 did not change in Ontario. You did not get more
22 staff and yet we considered it, considered it,
23 considered it, and changed only at the very last
24 minute, as some would say, on April 22nd, after
25 so many people had been infected and died.

1 That's the concern. So I'm wondering
2 what the prescription would be to stop this from
3 happening again?

4 MINISTER MERRILEE FULLERTON: And I
5 appreciate, you know, the perspective you're
6 putting there.

7 You know, going back to the time that
8 we were dealing with, you know, because we don't
9 have the benefit of hindsight -- we didn't have
10 the benefit of hindsight at that time. And
11 looking at the staffing situation, you know, we
12 were making sure that we were doing everything
13 to try to stabilize the staffing by making sure
14 that we got PPE just in time, even though there
15 was a shortage of PPE. Making sure that we were
16 addressing the support and the leadership and
17 the IPAC. This was an ongoing effort to make
18 sure that local resources were brought to bear.

19 Given the circumstances of COVID and
20 the fear in the community, we were challenged to
21 attract people to the sector during that. We
22 did put in -- implement changes later, once the
23 first wave was settling, and we spent many
24 months addressing a plan for the fall.

25 But there was ongoing efforts in the

1 first wave to marshal support from the hospital,
2 from the matching portals, from the retired
3 sector, from -- with the RMAO portal, with the
4 federal portal. Making sure that we worked with
5 the Ontario PSW Association, or OPSWA, for any
6 retired PSWs that could be brought in. So we
7 were putting out everything possible to shore up
8 the staff.

9 And I go back to the study done by the
10 expert panel that we had initiated before the
11 outbreaks began. And, you know, they do mention
12 the staffing location of one site contributed to
13 the staffing shortages. And I'm -- going by
14 their expert opinion.

15 So, again, a complex system with many
16 factors, with many things happening and all
17 happening very quickly. So many people working
18 very hard to address this issue and --

19 DEPUTY MINISTER RICHARD STEELE: I
20 think your question is a very fair one and as the
21 Minister is talking, thinking about is there
22 something that could have been done that would
23 have got us to that final decision sooner?

24 And off the top of my head, it's not
25 obvious to me what that would be. We were

1 weighing the factors. We were weighing the
2 implications, which were challenging. We moved
3 quickly to put in place -- to put this in place
4 to the degree that we felt was kind of
5 immediately obviously beneficial, which was
6 providing strong recommendation. And then
7 providing the financial support to the sector
8 and the encouragement that they should be moving
9 to offer full-time work to support single-site
10 working.

11 We know that had a significant impact.
12 We don't unfortunately, any of us that I'm aware
13 of, have data to tell us, you know, how far did
14 that get us versus the ultimate mandatory
15 nature. I don't think we have the data to tell
16 us that.

17 I don't -- it's a very fair question
18 and I think it's worth thinking about, but it's
19 not immediately obvious to me what that -- what
20 that solution would be that would enable us,
21 again under what would likely be a different set
22 of circumstances next time, that would enable us
23 to make that decision and reach that ultimate
24 decision faster.

25 JOHN CALLAGHAN: Michael, if you could

1 put that document back up?

2 Well, on that issue, with respect
3 to -- to paying. You provided money that
4 allowed homes, if they chose, to supplement so
5 that they could hire someone full time, correct?

6 DEPUTY MINISTER RICHARD STEELE: Correc
7 t.

8 JOHN CALLAGHAN: But you provided no
9 money to those people that lost employment on the
10 other side?

11 DEPUTY MINISTER RICHARD STEELE: We did
12 not, but of course, again, we're working in a
13 bigger system here. The federal government
14 certainly was through CERB. So there were --
15 there were -- and the Ministry of Long-Term Care
16 is obviously not in the income support benefits
17 business. The federal government is and other
18 parts of the provincial government, to some
19 degree, are too. But ultimately, there were
20 financial supports available if somebody did, in
21 fact, lose hours.

22 JOHN CALLAGHAN: But if they worked
23 part time, more than 10 hours, they wouldn't
24 qualify for CERB, yet they wouldn't be able to
25 work at another long-term care, correct?

1 DEPUTY MINISTER RICHARD STEELE: Sorry,
2 can you just go through that scenario again?

3 JOHN CALLAGHAN: My understanding is
4 that in order to obtain the federal benefit, you
5 couldn't work more than 10 hours. So these
6 part-time employees who were working part time
7 and their employer chose not to make them full
8 time, did they continue to work part time or did
9 they leave and collect CERB, because they would
10 exceed the limit by which you could obtain CERB?
11 Do you have any information on that?

12 DEPUTY MINISTER RICHARD STEELE: I
13 don't. But, again, keep in mind what we were
14 trying to do was incent the employers to provide
15 more hours where employees wanted to work them.
16 That was the whole point of what we were trying
17 to do. If the employee didn't want to work more
18 hours, that's not something that we could
19 obviously force them to do.

20 JOHN CALLAGHAN: No, but I thought you
21 were incenting to keep PSWs in the field
22 because of the shortage, not to incent employers
23 necessarily, but to incent PSWs.

24 DEPUTY MINISTER RICHARD STEELE: We're
25 trying -- with that particular measure, what

1 we're trying to do is say to employers as you
2 move to single site, one of your solutions is
3 obviously going to be, if you've got staff now
4 that are choosing, right, they're now going to be
5 working -- they can't work two places, they're
6 working for you, if you can, make them full-time
7 and we'll provide the funding to do that. So
8 that as you lose some staff part-time, because
9 they go somewhere else, you can replace that with
10 more full-time staff.

11 Ultimately, of course, it's beneficial
12 to the employees, but we're trying to create a
13 mechanism through which employers could in
14 response to single-site recommendation, could
15 actually make more staff full time.

16 MINISTER MERRILEE FULLERTON: And if I
17 may add, back in those days at the end of March,
18 you know, April, there was, again, so much going
19 on. We were just trying every possible mechanism
20 that we could implement in a reasonable way, in a
21 timely way, to shore the staffing up.

22 And when I read the expert panel's
23 report, their staffing study report, I thought
24 it was very instructive and very insightful.
25 But there was a lot of fear from the staff at

1 the time because of, you know, uncertainty and
2 people were afraid.

3 JOHN CALLAGHAN: I'm still back at the
4 Deputy's comment. I don't quite understand it.
5 If we have a pool of people working part time at
6 various places and one becomes full time, it
7 would seem to me that you lay someone part time
8 in the pool of PSWs. And I'm not sure exactly
9 how it is you solve the problem because now two
10 part-time people become one full-time person, and
11 what happens to the other part-time person? Do
12 they have to go work some place else?

13 DEPUTY MINISTER RICHARD STEELE: If I
14 can clarify the way this scenario was playing
15 out. You had a hundred -- I mean, this isn't the
16 way it was because everybody obviously had a mix
17 of full-time and part-time.

18 But for the sake of clarifying the
19 argument, let me make it simplified. You've got
20 a hundred part-time staff. Those hundred staff
21 are spending half of their time working at your
22 long-term care home and half of their time
23 working at the neighbourhood acute care
24 hospital. Now they can't do that. They've got
25 to pick. And it's the staff person that's

1 picking, it's not the employer, it's the staff
2 person that's deciding I'm going to choose the
3 hospital; I'm going to choose the long-term care
4 home. So they've got to choose.

5 The total number of staff required is
6 the same. Like, everybody needs those hours.
7 In fact, everybody actually needs more hours, as
8 we know.

9 So the staff are -- the staff are
10 picking, the long-term care home's going to lose
11 some of those part-time staff because they're
12 going over to the hospital. Similarly, the
13 hospital may lose some of the part-time staff
14 going to the long-term care home. The whole
15 point here is you're going -- in a vastly
16 simplified world, you're switching from a
17 hundred part-time staff to 50 full-time staff.
18 And that's all we were trying to say because the
19 reality is, of course, the math is never going
20 to be that neat. And we all understood the
21 staffing precarity and challenges that existed
22 in long-term care.

23 Our point of view was if you end up
24 being able to increase your hours by offering
25 more people full-time staff, that's great. Some

1 of it will just be, you know, you're going to
2 end up with one full-time versus some part-time,
3 but if you end up with you've got a part-time
4 person who hasn't got work somewhere else and
5 you've got an opportunity to make them full-time
6 and have more hours in the home, do that and
7 we'll pay for it.

8 JOHN CALLAGHAN: And just going back,
9 how big were the labour concerns requiring a
10 mandatory order?

11 COMMISSION CHAIR FRANK MARROCCO: Mr.
12 Callaghan, at some point I did want to have a
13 break, so let me know.

14 JOHN CALLAGHAN: I'll just ask this one
15 question then. Because I'm just curious as to
16 why you needed an emergency order then? I had
17 understood the emergency order was to deal with
18 the labour component. That is that you were
19 going to tell people they couldn't work at one
20 spot.

21 DEPUTY MINISTER RICHARD STEELE: You'd
22 have to -- to be honest, you'd have to ask -- I'd
23 have to ask the legal folks as to why it was felt
24 that that order couldn't be made under the HPPA.
25 That was the advice we got was that the HPPA was

1 not -- it would -- it didn't have the power to
2 require this kind of -- this kind of requirement
3 on a mandatory basis. Obviously, the Chief
4 Medical Officer of Health had the power to make a
5 strong recommendation, but I believe the -- my
6 recollection is the legal advice we got was under
7 the HPPA, it couldn't be mandatory, and that
8 that's why -- and as to why it would be legally
9 more feasible under the EMCPA versus the HPPA, I
10 can't comment on that, but that's my recollection
11 of the advice we got.

12 JOHN CALLAGHAN: So there is an order
13 that was issued on March 23rd that allowed
14 employees to work amongst various locations owned
15 by one owner. So basically the chains could
16 move, at their will, employees from place to
17 place. You are familiar with that order?

18 DEPUTY MINISTER RICHARD STEELE: Yup.

19 JOHN CALLAGHAN: In that order, it
20 specifically refers to the risk of labour action
21 because of it and yet the emergency order was
22 passed. And what I had understood is they were
23 trying to work out those issues in order to get
24 the single site.

25 And given what we talked about with

1 the Minister earlier about the need for speed
2 when people are going to die, how much of this
3 delay was as a result of trying to work out the
4 labour issues at the -- at the risk of people
5 dying while people worked in more than one home?

6 DEPUTY MINISTER RICHARD STEELE: Honest
7 ly, I do not recall, is the truth of it. My
8 recollection is in that period between the end of
9 March and when the EMCPA order was finally made,
10 there are -- there were a bunch of considerations
11 being played through that we've covered off in
12 this conversation, which one was the predominant,
13 how exactly the sequencing of where would we
14 focus when on which day in those conversations, I
15 honestly do not recall.

16 All of these things were factors that
17 were being worked through. That much I recall.

18 MINISTER MERRILEE FULLERTON: And if I
19 may add in, we were working furiously. Were we
20 able to get everything perfect? Clearly we
21 couldn't. And, you know, we were trying to work
22 in COVID speed, in COVID time, but COVID moved so
23 fast, our processes weren't instantaneous and
24 obviously people died.

25 JOHN CALLAGHAN: I think people

1 appreciate that. I will stop there,
2 Commissioner, and rejoin with this document when
3 we get back.

4 SUNIL MATHAI: Commissioner, just one
5 thing in terms of the timing for your breaks.
6 Minister Fullerton has a caucus meeting that she
7 must attend shortly at two o'clock, I believe.
8 So that we do have that hard stop and I don't
9 know how that's going to factor in when you think
10 breaks should be taken, but I did want to
11 identify that for you.

12 COMMISSION CHAIR FRANK MARROCCO: Well,
13 I'm going to just take 10 minutes now and
14 probably 10 minutes an hour and 15 minutes from
15 now and we'll just go straight through till two
16 o'clock in that case. So why don't we say 20 to
17 12 we'll come back.

18 And I would just remind the Minister
19 and the Deputy, it's probably not necessary.
20 You might want to make sure your microphones are
21 muted, though, in case you're having any
22 conversations during the break.

23 MINISTER MERRILEE FULLERTON: Thank
24 you, Commissioner.

25 DEPUTY MINISTER RICHARD STEELE: Thank

1 you.

2 -- RECESSED AT 11:28 A.M.

3 -- RESUMED AT 11:40 A.M. --

4 COMMISSION CHAIR FRANK MARROCCO: I
5 think we're ready. Mr. Callaghan.

6 JOHN CALLAGHAN: Thank you.

7 So, Deputy, you write this letter on
8 April 2nd, and you write to the Chief Medical
9 Officer of Health and you say:

10 "Should we in fact be considering
11 broader use of PPE by staff, in
12 particular broader use of surgical
13 masks? As discussed yesterday, if we
14 are not in a position to recommend
15 usage at all times, is there a
16 risk-based approach to extend usage
17 beyond current direction?"

18 So by this time we know that the
19 Toronto LHINS had ordered that not only the
20 hospitals, but the long-term care homes that
21 they're responsible, that they would go to
22 universal masking. Were you aware of that by
23 the time you wrote this email?

24 DEPUTY MINISTER RICHARD STEELE: I saw
25 the document you provided. I don't know if I was

1 aware of that specific document. I was certainly
2 aware that by that time there was, you know,
3 conversation and thinking amongst -- amongst some
4 that we should be considering universal masking,
5 yes.

6 JOHN CALLAGHAN: So we've heard that
7 the stock pile of the province was -- had been
8 destroyed and not replenished, and we heard from
9 the Minister of Health how she was working
10 diligently to secure PPE frankly all over the
11 world.

12 Was that -- is that the comment -- is
13 that what that means when you say:

14 "[...] are in a position to
15 recommend usage."

16 That there was a concern with respect
17 to the quantity of PPE available?

18 DEPUTY MINISTER RICHARD STEELE: I
19 don't recall that linkage, no. I think -- you
20 know, my recollection was that -- and this would
21 really be something to ask Dr. Williams because
22 you may -- you probably already did.

23 JOHN CALLAGHAN: We did.

24 DEPUTY MINISTER RICHARD STEELE: It was
25 around, at what point was the evidence pointing

1 to the need for universal masking? There's no
2 question that in parallel there were lots of
3 conversations happening about PPE and was there
4 enough PPE. But I don't recall an explicit
5 linkage as we were thinking through -- as this
6 conversation was playing out around universal
7 masking that led -- I guess a few days after this
8 email, it did lead to that requirement being
9 added as a directive.

10 I don't recall that the -- the general
11 concern that existed around PPE being a factor
12 in making that decision. Certainly once that
13 decision was made, I believe it was the
14 following week, it was, you know, really
15 important to ensure that our homes could in fact
16 get access to masks to be in compliance.

17 So lots of conversations with the
18 Ministry of Health, with the Ministry Emergency
19 Operation Centre who were kind of running the
20 provincial stockpile and handling the
21 distribution to be assured that in fact if homes
22 had an emergency request for surgical masks in
23 particular, but other PPE as well, that those --
24 that those needs could be met.

25 JOHN CALLAGHAN: So Revera told us, and

1 I take it -- sorry, let me start by this. I take
2 it from your answer that the actual delivery of
3 this product was not really in the hands of your
4 ministry but other ministries in government,
5 correct?

6 DEPUTY MINISTER RICHARD STEELE:

7 Delivery of PPE?

8 JOHN CALLAGHAN: Right.

9 DEPUTY MINISTER RICHARD STEELE:

10 Correct.

11 JOHN CALLAGHAN: Right, because we
12 heard from Revera that it took another week after
13 the mandatory order for them to get one-day
14 turnaround, on the PPE which caused some
15 consideration -- considerable angst -- I don't
16 know exactly how they put it -- but in other
17 words, there wasn't sufficient to get immediate
18 turnaround. Was that your understanding is as
19 Rivera has told us?

20 DEPUTY MINISTER RICHARD STEELE: I'd
21 have to go back and look at -- we are getting
22 pretty specific on dates. I'd have to go back
23 and look at the dates. I do recall heading into
24 the Easter weekend, and I think we were all
25 concerned around, you know, supply and access

1 through the Easter weekend of PPE. I recall
2 asking, because we were having a conversation
3 with the sector and we wanted to give them an
4 assurance that if they had an emergency request
5 it could be through the Easter weekend. And I
6 received confirmation that yes, there would be
7 sufficient for emergency requests. And keep in
8 mind that doesn't mean everything everybody may
9 want; they are not going to get a month's worth
10 of supply. It would be a limited amount of
11 supply, but that emergency requests could be met.

12 Now, I will say we were also aware
13 that there were at times process issues through
14 -- you know, because the process was, initially
15 there would be a Regional ask, could the needs
16 be met Regionally before an escalation to the
17 provincial warehouse? So it may be -- I don't
18 know, but it may be that what Revera was
19 alluding to was some of those process challenges
20 and actually getting the shipments quickly.

21 JOHN CALLAGHAN: The last issue you
22 touch on in this letter is testing constraints
23 and we've heard from the Ministry of Health about
24 labs and I know that is not your responsibility.

25 But one issue we have heard that falls

1 presumably into your responsibility, and I
2 appreciate you're both relatively new, was when
3 the hospitals went into long-term care home,
4 they were, we heard a number of times,
5 absolutely floored by the lack of technology.

6 Some talked about testing results
7 coming back by mail; some talked about fax
8 machines. I don't think we had anybody talk
9 about a desktop return of test results.

10 We heard that the delay in test
11 results -- not just because of that but because
12 of the labs too, so just to be clear -- resulted
13 in -- and I'm sure you heard the same thing,
14 test results coming back in five days, seven
15 days, and we heard from the hospitals that had
16 they got the test results and been told
17 expeditiously within a day they could have got
18 in there and saved lives.

19 That's a big wind up, but the question
20 is: Are you aware -- is it true that basically
21 the technology in these homes barely covers the
22 last century as it relates to the transmission
23 of test results? Are you aware of that?

24 DEPUTY MINISTER RICHARD STEELE: I
25 would certainly have some awareness of that. I

1 would say still work to be done, but the reality
2 is, just to paint a slightly different picture,
3 is most homes in fact do have access to OLIS,
4 electronically. I believe around about two
5 thirds of homes have access to OLIS. That is
6 continuing work that is happening to move homes
7 to access OLIS. That is an ongoing piece of work
8 that Ontario Health is continuing to follow
9 through.

10 I believe by the end of this fiscal
11 year, for example, it will be closer to
12 80 percent of homes having access to electronic
13 test results.

14 So you're absolutely right. There are
15 homes -- there were homes and there are homes
16 that did not have electronic access, and I would
17 have to agree with you that it would make sense
18 for all homes to have electronic access, yes.

19 JOHN CALLAGHAN: Well, I say that only
20 because perhaps we examined some of the worst hit
21 homes and maybe they were them that didn't have
22 OLIS, but the Commissioners could take it that
23 the ministry has that in hand and it's going to
24 roll out OLIS across the board?

25 DEPUTY MINISTER RICHARD STEELE: We

1 would absolutely be continuing to -- that would
2 be work we're doing with Ontario Health, but,
3 yes, we would see it as important to make sure
4 that all homes have electronic access.

5 JOHN CALLAGHAN: During the course of
6 the first wave at least, we heard from Dr. Kyle,
7 who was the chief -- or the local Medical Officer
8 of Health in Durham and how he had to deal with
9 Orchard Villa. And he said that he and Lakeridge
10 didn't get any direction from the Ministry of
11 Long-term Care and little direction from
12 elsewhere and they had to come up with a
13 solution. So he issued an order under section
14 29.2 of the HPPA. Are you aware of that?

15 DEPUTY MINISTER RICHARD STEELE: Yes.

16 JOHN CALLAGHAN: So, and now, and I
17 recognize you weren't there, Deputy, but I take
18 it as far as you're aware there was no plan at
19 the ministry as to what to do if a home had an
20 uncontrolled outbreak and needed to have
21 assistance of a hospital at that time? This was
22 new, I take it?

23 DEPUTY MINISTER RICHARD STEELE: I
24 think that certainly in the -- under the
25 legislation and this is a power that certainly is

1 regularly, not every day but regularly used, is
2 there are powers to appoint alternative managers
3 to run a home, either through what's called a
4 mandatory management order, which is where the
5 ministry will order, will order a third-party
6 manager is brought in or alternatively through
7 what we would call a voluntary management
8 contract which is where we would, you know,
9 perhaps encourage the home, or the home may,
10 themselves, seek to bring in a third party, a
11 third-party manager to assist them.

12 So those powers existed, you know, in
13 a nonpandemic context. They were certainly
14 used. Early on in the -- earlier on in March,
15 for example, when the home in Bobcaygeon, Pine
16 Crest went into outbreak we contemplated the use
17 of a management order or a management contract
18 to support that home. In the end, in that
19 particular case, the -- we didn't need to go
20 down the voluntary management contract or MMO
21 route because the -- the licensee, with some
22 urging from us, chose to bring in some
23 third-party assistance so we didn't need to go
24 down that route.

25 So there is certainly the mechanisms

1 through which third parties could be appointed.
2 Typically historically, they wouldn't have been
3 hospitals; they would have been private
4 management companies like Extendicare and like
5 some of the others, Universal Care.

6 One of the challenges we certainly
7 faced initially beyond the first couple of weeks
8 was the -- the management companies that we
9 would typically have turned to to assist a home
10 that was facing challenges were themselves, of
11 course, facing significant challenges. So in
12 the case of Orchard Villa, which is a home
13 that's licensed by Southbridge, in fact
14 Extendicare was the manager of that home. So
15 clearly not a situation where we could call an
16 Extendicare to come and support the management.

17 So the process of hospital partners
18 taking over management was a -- was a new
19 construct that I would say all of the players
20 had to actually work through what was the right
21 tool to make that happen, what did the hospitals
22 need, what authority did they need? How would
23 that actually happen?

24 And what you will see is from the
25 period through kind of late April through May,

1 we were working with hospitals who under the
2 action plan that had been put in place the
3 previous week, around the middle of April, we
4 were certainly trying to get hospitals deployed
5 to assist homes in various capacities, IPAC,
6 health human resources, leadership.

7 Around about the same time as Dr. Kyle
8 was putting in place his order for Orchard
9 Villa, we actually issued a Minister's Directive
10 that provided broad authority for -- or broad
11 direction for homes to essentially take
12 assistance and take direction from hospitals and
13 indeed others in managing outbreaks.

14 To the --

15 JOHN CALLAGHAN: Can I ask on that?

16 DEPUTY MINISTER RICHARD STEELE: Yes.

17 JOHN CALLAGHAN: Before you leave,
18 sorry, so if I can just put a document in before
19 you -- you went over a point that I want to make
20 sure I understand, because I don't think we've
21 had evidence on this before.

22 But there is the -- I think it's
23 document M, Michael, which is the May 12th Order
24 that I think that the Deputy is speaking of.

25 MICHAEL FINLEY: It may be document F,

1 John. Is this the Order?

2 JOHN CALLAGHAN: Okay, well there you
3 go. I've got the wrong note. Is this what
4 you're referring, to doctor? Doctor -- Deputy?

5 DEPUTY MINISTER RICHARD STEELE: I'm
6 definitely not a doctor. No, I don't believe so.

7 JOHN CALLAGHAN: If you go down, let's
8 just see what it says. If I can go down, it
9 talks about -- stop there.

10 It talks about the regulations and the
11 Emergency Management Act and it goes further
12 down. If you take it down a little bit,
13 Michael, please.

14 And it talks about using:

15 "The Director is authorized to
16 make an order under section 156.1 with
17 respect to a long-term care home if at
18 least one resident or staff member in
19 the long-term care home has tested
20 positive."

21 I had thought that was the section.
22 And I was going to ask you, given the power in
23 the Act, why does this emergency order of
24 May 12th exist?

25 DEPUTY MINISTER RICHARD STEELE: Sure.

1 So just to clarify, this isn't the document I was
2 referring to. This is something different. So
3 maybe I can just step back, if you will indulge
4 me for two minutes, on the powers we have and
5 some of the challenges with exercising those
6 powers which certainly was relevant to the
7 Orchard Villa situation and likely relevant to
8 some others and again, various -- various
9 documents that will demonstrate the levers we
10 were trying to pull to address those things.

11 So the fundamental challenge in an
12 outbreak situation with the powers that we had,
13 and it's not -- it didn't make the powers of no
14 use, but it was just a consideration as to, you
15 know, which authorities and which powers get
16 used when, is it does take a little bit of time
17 to work through a management order and
18 particularly prior to the emergency regulation
19 that you just put up on the screen here, it
20 takes a little bit of time to work through a
21 management order, not too much. But more to the
22 point, because the outcome of that management
23 order is the appointment of a manager under
24 contract, there actually has to be a contract
25 worked through.

1 Now that can happen relatively quickly
2 because under -- particularly under an MMO,
3 we're mandating, we're saying we need this
4 contract in place in 24 or 48 hours. But there
5 is a bit of work to do. It does involve -- no
6 offence, but it involves the lawyers working
7 through a contract, in these situations the
8 licensee and the hospital.

9 And while the licensee, again, was
10 under an obligation to just get it done, the
11 hospitals also had to -- had a perspective on
12 wanting to review the contracts, understandably,
13 that they were entering into.

14 So the bottom line is that the whole
15 construct of mandatory management orders and
16 management contracts are really designed for a
17 regular business timeline. Typically my
18 understanding is that in a nonCOVID world, these
19 things could take weeks to put in place. We
20 were getting them in place in 48 to 72 hours so
21 the team was working very, very hard to make
22 that happen, but what they didn't give you was a
23 tool to provide immediate, immediate
24 supplementary authority to a hospital to step
25 in.

1 And that's --

2 JOHN CALLAGHAN: That's this order
3 here?

4 DEPUTY MINISTER RICHARD STEELE: Sorry?

5 JOHN CALLAGHAN: That's what this order
6 here?

7 DEPUTY MINISTER RICHARD STEELE: Yes
8 and no. So what -- so let me explain this order
9 and then a couple of other things.

10 Under the regular mandatory management
11 order, the Director has to have quite specific
12 grounds in order to make the order. There has
13 to be a full inspection. That has to get, you
14 know, essentially written up in some form and
15 then we can issue the order, and it has to be
16 defensible against appeal.

17 The objective of this particular order
18 was to make that process extremely simple, to
19 issue a mandatory management order. Basically
20 if you have got a case of COVID, we can issue an
21 MMO.

22 So it was really around making the
23 issuance of an MMO simpler. Still doesn't
24 address the issue that you have to get a
25 management contract in place.

1 JOHN CALLAGHAN: I don't want to take
2 too much time.

3 DEPUTY MINISTER RICHARD STEELE: Okay.

4 JOHN CALLAGHAN: I appreciate -- I was
5 more trying to get the --

6 MINISTER MERRILEE FULLERTON: May I add
7 something?

8 COMMISSION CHAIR FRANK MARROCCO:
9 Sorry, is that --

10 MINISTER MERRILEE FULLERTON: It's
11 Minister Fullerton.

12 COMMISSION CHAIR FRANK MARROCCO:
13 Certainly. What's the question?

14 MINISTER MERRILEE FULLERTON: Well,
15 just to say that it was speed. When we looked at
16 the case with Dr. Kyle and what Public Health
17 could do, whoever can do it fastest. And if -- a
18 pre-existing relationship with the hospital we
19 found to be very helpful.

20 And that's what we endeavoured to do
21 as we went on, and I believe one of your interim
22 recommendations was along those lines and that
23 has turned out be very, very helpful. So thank
24 you.

25 DEPUTY MINISTER RICHARD STEELE: What

1 sometimes --

2 COMMISSION CHAIR FRANK MARROCCO: Well
3 go ahead, Deputy.

4 DEPUTY MINISTER RICHARD STEELE: No, I
5 was just -- really then how that played out on
6 the ground ultimately is what happened in a
7 number of circumstances where a hospital felt
8 strongly that they needed the authority -- they
9 needed some additional authority with a home to
10 step in is, what we would sometimes do is have
11 the local Medical Officer of Health issue a
12 Public Health directive, and then we would
13 subsequently back-stop that with a management
14 contract for a more extended period.

15 So, for example, as we went into Wave
16 2, some of the homes in Ottawa, that was the
17 approach that we used is starting -- starting
18 with a -- with an order from the local Medical
19 Officer of Health and then moving it across to a
20 management contract. So you have got the speed,
21 but then you have got the structure of a
22 management contract back-stopping that over
23 time.

24 COMMISSION CHAIR FRANK MARROCCO:
25 Mr. Callaghan, are you going to pursue this

1 further or are you going on to another --

2 JOHN CALLAGHAN: I'm just going to ask
3 one more question on a different topic.

4 So if we could just put up the
5 Minister's notes of April 17th, please? We're
6 on Orchard Villa, so I should ask you this,
7 because it has been a consideration asked by
8 others.

9 On April 17th in your notes, you say
10 in your notes -- it may not be too clear -- that
11 you identify the military -- perhaps you can
12 read that for us, Minister. "Military plan
13 needed".

14 DEPUTY MINISTER RICHARD STEELE: You
15 were cutting out there, Mr. Callaghan.

16 MINISTER MERRILEE FULLERTON: I can.
17 "Military plan needed, get them in within 24-48
18 hours."

19 Unfortunately it's cut off because of
20 the way it's presented here. 48 hours because
21 homes -- I think it says, it started to say
22 "spiral". Maybe go back to where it was.
23 "Homes spiral down quickly".

24 JOHN CALLAGHAN: And we've had people
25 come to us and ask why the military didn't come

1 in 24 to 48 hours after -- after about this time
2 actually, because of the crisis. So they don't
3 actually come in, I think, until like the 26th or
4 28th of April, something like that.

5 MINISTER MERRILEE FULLERTON: Twenty-ei
6 ghth. 28th when they were fully. There was
7 reconnaissance before that, but fully coming in
8 with staff on the 28th, yes.

9 JOHN CALLAGHAN: But your hope is that
10 they would be coming in later and I take it it
11 just took time? Is that the idea?

12 MINISTER MERRILEE FULLERTON: My -- you
13 know we had started to contemplate the military
14 earlier, and my concern was with the speed that
15 COVID hit these homes. I would talk to medical
16 colleagues that were medical directors in these
17 homes and they would say, you know, Monday we
18 were fine, by midweek things were not so good,
19 and by the end of the week it was a war zone.

20 And I was very concerned that we were
21 seeing more critical staffing shortages, and I
22 believed that we needed a military plan that
23 could be activated quickly within 24 to 48 hours
24 so. So that's what my note is here.

25 So we had -- there had been initiated

1 plans. I was not privy to that, but there were
2 plans initiated, I was told. But the reality
3 was that I think in hindsight the military was
4 more suited to a flood, a disaster, something
5 that had already happened.

6 COVID was COVID time. And for them to
7 come in, they -- they really needed to come in
8 within 24 to 48 hours and that's not how they
9 function. And we called the military, I believe
10 the request was sent in around the 22nd of
11 April, but they didn't get in with staff until
12 the 28th. And they were deployed elsewhere as
13 well, so they weren't just Ontario's military;
14 they're all of Canada's military.

15 JOHN CALLAGHAN: And this was part of
16 the -- or a result of, in part, the staffing
17 crisis that you talk about, the inability to have
18 a surge capacity in the system, that type of
19 thing?

20 MINISTER MERRILEE FULLERTON: And our
21 one site only. When we went to the one site only
22 and I go back to the expert panel and their
23 staffing study, you know, they called that. They
24 identified that as one of the problems.

25 And so we were -- we were seeing more

1 critical homes with critical staffing shortages,
2 and we were deploying as many measures as we
3 possibly could. And we began discussions around
4 the middle of -- the middle of April about
5 military. And when the decision was made it
6 still took them a week, almost a week to get in.
7 And it's the speed. It's the speed.

8 COMMISSION CHAIR FRANK MARROCCO: Just
9 if I can just follow-up, the staffing shortage
10 is, in part, as we've been talking about, made
11 worse by the -- or aggravated or however you want
12 to say it, by the single site policy there, both
13 having a negative -- the staff concern plus the
14 policy of both pushing your total complement of
15 staff down. They are reinforcing each other.

16 Was there any thought given to
17 advising the homes to consider hiring the
18 essential caregivers as employees?

19 MINISTER MERRILEE FULLERTON: Yeah,
20 we -- I was really -- at this time there was just
21 so much concern. Again, the testing that really
22 wasn't ramped up and how would we safely allow
23 the essential caregivers in?

24 And the -- you can see towards May
25 we're getting -- I'm getting anxious because I

1 really believe there is a role. I believe there
2 is a role for them, and we wanted them to make
3 sure they had training in infection and
4 prevention control and the donning and the
5 doffing. Because I really did believe that they
6 would be a support for the homes.

7 But there was reluctance to bring in
8 more people because of the risk to them and then
9 the community spread. Again, I think if we
10 could have had rapid tests to be able to
11 identify them coming into the homes, we would
12 have been in a different scenario. But we were
13 following the advice of the Chief Medical
14 Officer and our experts in Public Health.

15 And some areas, even into the fall,
16 there was discrepancies over, from the Medical
17 Officers of Health saying, no, we don't want the
18 essential caregivers going in. We were from the
19 ministry level, from my opinion and my deputy's
20 opinion, that they were potentially going to be
21 very helpful, and yet we didn't pursue it.

22 COMMISSION CHAIR FRANK MARROCCO: And
23 if they're employees, if they're employees then
24 presumably they can come in.

25 DEPUTY MINISTER RICHARD STEELE: Can

1 I --

2 COMMISSION CHAIR FRANK MARROCCO: Just
3 a minute. The reluctance to employ them or --
4 wasn't coming from the Ministry of Long-Term
5 Care; it was coming from the chief -- it was
6 coming from elsewhere, including the Chief
7 Medical Officer of Health; is that right?

8 MINISTER MERRILEE FULLERTON: I would
9 say the reluctance was coming from elsewhere in
10 terms of getting them into the homes.

11 DEPUTY MINISTER RICHARD STEELE: If I
12 could maybe just to clarify a little bit and
13 distinguish between essential caregivers as
14 visitors and --

15 COMMISSION CHAIR FRANK MARROCCO: No,
16 no, I wasn't speaking of them as visitors.

17 DEPUTY MINISTER RICHARD STEELE: I know
18 and that's where --

19 COMMISSION CHAIR FRANK MARROCCO: I was
20 speaking of them as employees.

21 DEPUTY MINISTER RICHARD STEELE: That's
22 where I'm trying to draw the distinction. So
23 lots of conversations around essential caregivers
24 as visitors and that played out through the
25 course of the year; and then essential caregivers

1 as potential employees, which I think is the
2 point you are making.

3 We had provided back in March
4 significant flexibility, regulatory flexibility
5 to homes to hire -- to hire beyond the group of
6 people they would normally hire. And there's
7 certainly not -- now, I don't recall exactly
8 when these conversations happened, but there
9 absolutely was consideration to, could essential
10 caregivers, even though they weren't able to
11 come in as visitors, could homes contemplate
12 hiring them as staff? Obviously not as
13 registered qualified staff, but given the
14 flexibility that we provided, could they be
15 hired as, you know, providing supplementary
16 support? And absolutely they could.

17 So it was contemplated. I don't
18 recall exactly when those conversations were
19 happening, but, again, to be clear it was in the
20 context of them being employed staff versus
21 visitors.

22 COMMISSION CHAIR FRANK MARROCCO: I
23 wasn't speaking of when it was contemplated. My
24 question was whether there had been a
25 communication to the homes that they might

1 consider this option. And I took it from the
2 Minister's answer that the communication didn't
3 take place because there was a reluctance
4 elsewhere to having essential or family members
5 on site.

6 Maybe I misunderstood but that's what
7 I took the answer. Is that -- did I understand
8 you correctly, Minister Fullerton, or did I not?

9 MINISTER MERRILEE FULLERTON: Yes, yes.
10 There was concerns by others about the risk to
11 the homes of bringing in -- of COVID through
12 others, and that's why we were following the
13 advice of the Chief Medical Officer of Health. I
14 was very eager to get caregivers back into the
15 homes, because I believe it was well-being and
16 emotional well-being.

17 However, others understood differently
18 and had their reasons for understanding the
19 risks that they did, and so it was left.

20 COMMISSION CHAIR FRANK MARROCCO:
21 Mr. Callaghan, I don't want to go on too long but
22 I do have a question unrelated to this so if I'm
23 changing the subject --

24 JOHN CALLAGHAN: I was going to move
25 into another topic anyway.

1 COMMISSION CHAIR FRANK MARROCCO: All
2 right. Minister, you referenced your experience
3 with long-term care and the fact that it predated
4 really your interest -- or your appearance in
5 politics. And that prompts this question: Why
6 do you think long-term care has been ignored or
7 minimized in terms of the healthcare --
8 healthcare I was going to say "industry" but it's
9 not an industry, but in terms of healthcare
10 policy?

11 We've experienced -- we've heard the
12 same thing, and it's difficult for me anyway
13 because, one, almost everybody has a loved one
14 that they can't care for any more. That's
15 something -- an experience that would be very
16 common to a lot of people.

17 And secondly, quite frankly, whether
18 you're young or not, there's going to come a day
19 when you might be in one of those facilities.
20 And so I'm wondering what your view is as to
21 why, despite those factors, long-term care seems
22 to be a secondary consideration?

23 MINISTER MERRILEE FULLERTON: Certainly
24 . So, you know, I came to politics, as you
25 mentioned, my father needed long-term care,

1 excuse me.

2 COMMISSION CHAIR FRANK MARROCCO: We
3 can take a break for a minute, if you like.

4 MINISTER MERRILEE FULLERTON: I'm okay.
5 And so you have -- my mother was a caregiver.
6 And you see caregiver burnout. And then you see
7 the families needing to come together to help and
8 the toll that it takes on families trying to
9 manage like that.

10 And so, you know, I retired from
11 medicine to drive my mom to see my dad -- just
12 give me ten seconds.

13 COMMISSION CHAIR FRANK MARROCCO:
14 While you're taking the time -- I understand that
15 experience.

16 MINISTER MERRILEE FULLERTON: I think
17 what happens is -- and this is just my opinion,
18 so if you are just asking my opinion, I'll give
19 it.

20 COMMISSION CHAIR FRANK MARROCCO:
21 That's what I was asking for.

22 MINISTER MERRILEE FULLERTON: Is that
23 you have an acute care sector that gets
24 tremendous attention, the fundraising that goes
25 on, the tools that they have. It's in the

1 papers; it's in people's minds. And they are
2 aware of that.

3 And then I did, you know, my training.
4 I know what it was like 35 years ago. Long-term
5 care was a place that you sent people to. It
6 wasn't a place that the acute care sector really
7 had an understanding of.

8 And I think if something good comes
9 out of this, it will be that the acute care
10 sector understands the importance of long-term
11 care, not only to all Ontarians, but to its own
12 health as an acute care sector.

13 And so long-term care, it must be a
14 prominent piece of integration with the overall
15 healthcare system. And we need many solutions.
16 And I think also people -- it's hard for people
17 to look at something that makes them perhaps
18 sad. It is the last years of life that people
19 get into long-term care, especially now because
20 you're waiting on a wait list for so long. So
21 it's the last year and a half, maybe two years
22 of your life that you're getting in. At that
23 point 66 to 81 percent of our residents in
24 long-term care have dementia, and families have
25 tried. They have tried and they can't do it.

1 COMMISSION CHAIR FRANK MARROCCO: And
2 there's guilt there too, I think, because you
3 feel you're letting somebody down that looked
4 after you, especially if it's a parent.

5 Anyway, can I -- at the risk of going
6 on too long, I'll just ask one other question.

7 MINISTER MERRILEE FULLERTON: Certainly
8 .

9 COMMISSION CHAIR FRANK MARROCCO: And I
10 do want to leave it to Mr. Callaghan.

11 But if I can turn the tables a bit,
12 you created us to make recommendations, but
13 since you're here, let me ask you the question.
14 If there was one recommendation that we could
15 make that would address or help address this
16 attitude towards long-term care, but based more
17 on your experience than the fact that you're the
18 minister, do you have a thought about what that
19 might be?

20 MINISTER MERRILEE FULLERTON: Yes, yes,
21 I've had a long time to think about this and I
22 really think that we -- in Scotland they start
23 training -- when medical students start, they
24 begin to get experience in long-term care. And
25 I've often thought we need a medical residency in

1 long-term care. We have the geriatric aspect of
2 it, geriatricians, but there is not very many of
3 them either. And so we need to be able to
4 connect the long-term care sector with the acute
5 care sector in terms of the experiential learning
6 that our residents and doctors and specialists
7 will understand the level of frailty.

8 And I think it creates a more
9 compassionate medical work force to understand
10 what is happening in another space. When that
11 resident or when that patient leaves the
12 hospital, it's just not that they're gone from
13 the acute care bed that they -- that the welfare
14 and the well-being of that individual that has
15 left the acute care sector needs to be attended
16 to.

17 And so we see people coming back as
18 alternate level of care patients to hospital.

19 And so the better job that we do in
20 terms of understanding how we support our
21 residents in long-term care, who are, you know,
22 the level of acuity -- I spoke to some people
23 who said that the level of acuity they are
24 seeing in long-term care is higher than some of
25 the ALC patients they are seeing in hospital.

1 So we need to marry -- and I'm sorry I'm going
2 on here now, but I could go on. So thank you.

3 COMMISSION CHAIR FRANK MARROCCO: No,
4 no. Actually it's extremely helpful. Please
5 don't -- and now I'm going to ask one other
6 question and Mr. Callaghan can't stop me because
7 I'm the chair and I guess I think all my
8 questions are really important.

9 But it's this: Given the increased
10 level of acuity, I think was your word, in terms
11 of staffing, do you not think that that should
12 reflect itself in the skills of the staffing
13 mix? That instead of looking for less -- not
14 looking for, but instead of trying to solve a
15 staffing problem with less qualified people,
16 part of addressing the problem may be to go to
17 more qualified people?

18 MINISTER MERRILEE FULLERTON: And I see
19 where you're going and I agree. There is a
20 balance. And over the last ten years what we've
21 seen is a real push in long-term care to have
22 less medical intervention, to have more a
23 home-like environment, and the concept of futile
24 care.

25 And yet the acuity of the residents

1 and the medical understanding that is required
2 of the staff, it's something that we can
3 address, I believe, by having more training for
4 the personal support workers, having stronger
5 leadership, medical leadership in the homes.
6 And that's something that we heard very early on
7 when we were consulting with the sector is to be
8 able to train and provide a level of confidence
9 for the personal support workers who are in
10 there to give them a sense of pride in what
11 they're doing, and to be able to have a stronger
12 training program, micro credentialing,
13 experience in dementia care.

14 And we're really looking at the ways
15 that we can not only support the education and
16 training of the PSWs, but how we integrate
17 and, in a more continuum and more continuous
18 way, the medical care. And out of this as well
19 has come the concept of the virtual connection
20 with primary care, with specialists. And I
21 think that is something, although we don't want
22 to medicalize long-term care and we want to have
23 people live in dignity and respectful of their
24 wishes and not put them through things that they
25 don't want to go through, we do have to give the

1 people working in those scenarios the support
2 and the training that allows them to feel
3 confident and supported. And then they can
4 support the residents.

5 COMMISSION CHAIR FRANK MARROCCO:
6 Thank you.

7 MINISTER MERRILEE FULLERTON: Thank
8 you.

9 COMMISSION CHAIR FRANK MARROCCO: Go
10 ahead, Mr. Callaghan.

11 JOHN CALLAGHAN: I was going to ask,
12 you recently started an initiative that would
13 allow for the decanting of long-term care home
14 residents Minister, and it came out in January.
15 And we heard that decanting of COVID-positive
16 patients and those exposed to COVID patients to
17 different places, positive to hospitals and COVID
18 elsewhere in Hong Kong resulted in very few
19 deaths.

20 And I was wondering why did it take
21 until January for you to really get to a
22 decanting plan?

23 MINISTER MERRILEE FULLERTON: So I had
24 watched -- thank you -- so I had watched what was
25 happening elsewhere and looking at Italy that had

1 COVID-positive hospitals and COVID-negative
2 hospitals and I thought we could potentially
3 looking at decanting. And so I raised that when
4 I got to the Command Table probably early April,
5 thinking that that would be a solution.

6 But the issue was where would they go?
7 Where would we move them to? And then we spoke
8 to the Ethics Table, because it is their home
9 and residents in long-term care, they are not
10 widgets. They are not things to be moved around
11 at the will of somebody. They have rights.
12 They have constitutional rights and this was
13 reinforced by the Ethics Table.

14 And so what I had asked is, you know,
15 if we have an outbreak that is severe, can we
16 move the COVID-negative residents somewhere? Or
17 if it's early, can we move the positive
18 residents out? But there were a number of
19 factors, including, you know, the testing that
20 we needed to identify and the timing that it
21 took to do the testing.

22 And so we did decant some homes and --
23 early and then what happened was that it had
24 already spread in the home and so it didn't
25 accomplish anything.

1 But there would also be staffing
2 issues. So how do we move staff?

3 Now it is a long-winded answer, but
4 there were many things that we considered in
5 terms of the ethics, in terms of the staffing,
6 in terms of the testing. And ultimately, you
7 know, we had learned from the experience of the
8 Windsor field hospital, and that was on my radar
9 very early.

10 So we couldn't get it done in the
11 first wave, but we were working to get something
12 like this in the second wave. And yet we were
13 in a different scenario with the hospitals,
14 because now they were ramping up their services.
15 And so they didn't necessarily have the staff to
16 assist with that.

17 So it was finding the right location,
18 honouring the rights of the residents, and the
19 time it would even take to contact Power of
20 Attorney. So it was a complicated process. And
21 you know, I'm proud of the Specialized Care
22 Centre for doing what we did there and I also
23 thank you for your interim recommendation on
24 that.

25 JOHN CALLAGHAN: I just want to make

1 sure -- because we don't misconstrue your letter
2 on decanting which you sent us. And I take it
3 you recognize that decanting is outside the --
4 real decanting is really outside the ability of
5 one individual home, right? It requires the
6 Province to provide the facility.

7 MINISTER MERRILEE FULLERTON: And that
8 was one of the original questions that, when we
9 raised it early in the first wave, is: Where
10 would they go? Ultimately it also depended on
11 the clinical acumen of both the Public Health,
12 Medical Officer of Health, the hospital that
13 would be involved with the home, the medical
14 director of the home, the nursing staff in terms
15 of understanding the clinical situation in the
16 home. Our ministry is not suited to do that. We
17 are at a distance, and inspectors have some
18 training but they are not -- they are not
19 medical.

20 And so, you know, that was a flaw, I
21 would say, in -- or missing link that we needed
22 to understand the clinical aspect and someone
23 needed to be able to determine that.

24 JOHN CALLAGHAN: So I don't think
25 anybody is quibbling at all with your idea that a

1 home's residents wishes has to be considered and
2 obviously it's not just the person with COVID but
3 the impact on those without COVID.

4 We've heard evidence that well-meaning
5 homes moved COVID asymptomatic patients around
6 the home and managed to infect everybody in the
7 home quite innocently.

8 But is it your intention in the event
9 that we have another pandemic to have a plan in
10 place before that pandemic to address that type
11 of issue?

12 MINISTER MERRILEE FULLERTON: Yes, and
13 there was -- you know, we have to learn from the
14 Specialized Care Centre. They will be providing
15 us with a report. I know there's also lessons to
16 be learned from the Windsor field hospital and
17 very positive. So we just have to understand how
18 we can get our partners to work with us to
19 accomplish it.

20 JOHN CALLAGHAN: When we move to the
21 preparation for Wave 2, one of the things we were
22 told is that the ministry did a survey, Minister,
23 of homes as to their status of readiness and that
24 it was given to the Ontario health teams, but
25 then it never seemed to make it to the field.

1 And one home, Sunnycrest was the one
2 we heard about, was considered under high risk
3 and yet nobody seemed to go in, inspectors
4 hadn't gone in. The local Medical Officer of
5 Health was not asked to go in. Do you know why
6 that happened?

7 DEPUTY MINISTER RICHARD STEELE: I can
8 speak to that.

9 MINISTER MERRILEE FULLERTON: I'll ask
10 the Deputy.

11 DEPUTY MINISTER RICHARD STEELE: So the
12 assessment that was done in the summer, the
13 preparedness assessments done in the summer, a
14 joint exercise between the ministry and Ontario
15 Health as part of our Wave 2 planning, done
16 relatively quickly as we were putting in place
17 some of the other elements of the Wave 2 plan,
18 looking to take the opportunity through the
19 summer to have homes think about your learnings
20 from Wave 1 and plan for Wave 2 and ensure they
21 had the partnerships in place for Wave 2.

22 So it was fundamentally constructed as
23 a self-assessment exercise, working with the
24 LHINS and working with, where possible, hospital
25 partners as well. It was not intended -- maybe

1 it should have been, but it was not intended as
2 a kind of an audit tool. It was intended as a
3 kind of capacity building, self-assessment
4 preparedness tool.

5 The results of those preparedness
6 assessments, my understanding they certainly
7 were available locally. In terms of who
8 precisely got them in each area that's a fair
9 question.

10 And you know, maybe there should have
11 been a more structured process around who was
12 getting that information. I think we kind of
13 left it to the regions to manage that and maybe
14 the ministry could have or should have provided
15 more direction around sharing who precisely that
16 information should have been shared with.

17 I think in terms of -- well, I'll stop
18 there.

19 JOHN CALLAGHAN: And so the other one
20 that we came across when we talked to -- about
21 some of those homes were your inspection group.
22 And we were told that from December 2009 to
23 October 2020 their budget for inspectors was
24 essentially frozen. We were told that an
25 increase of inspectors was provided in October of

1 2020, but it takes nine months to train an
2 inspector.

3 And so I was wondering, Minister, why
4 would it take so long to increase the complement
5 of inspectors during a pandemic?

6 MINISTER MERRILEE FULLERTON: Well, as
7 you can understand during outbreaks in homes that
8 it -- there was an attempt to reach out to, I
9 believe, retired inspectors and others. There
10 may not be as much -- I'm speculating because I
11 don't have the facts on why there weren't a lot
12 of people coming forward to fill those roles.

13 But to say that, again, there's a
14 concept that the inspectors played a role that,
15 in COVID that would have turned around some of
16 these homes very quickly. And I present the
17 reality that on day 1, you know, you could have
18 an inspector in the home, and they would see no
19 compliance issues, which has happened. And then
20 a few days later the home is in massive
21 outbreak.

22 And so the inspection is a snapshot in
23 time. So in terms of getting more inspectors, I
24 believe very strongly we have to address the
25 inspection system, that we need to have a

1 resident-centered system, that we need to have
2 an understanding of the reality in those homes
3 in a meaningful way that puts the resident at
4 the center.

5 And some of the compliance orders that
6 are issued are things like, well, you know, the
7 resident was served their dessert before their
8 dinner. Maybe in that person's last year of
9 life getting the dessert first was something
10 that they wanted. And would it make a
11 difference for them? It may have stimulated
12 their appetite.

13 So the compliance that is structured,
14 it needs to be more meaningful. And I think we
15 can do a better job in terms of the inspectors
16 being able to support our homes so that we can
17 actually surface what the problems are. And if
18 we can do that, then they're not going to get
19 shoved under the rug.

20 So there has to be a review of how the
21 inspectors, how they do it, what they do. And
22 it's got to be putting the resident at the
23 center.

24 JOHN CALLAGHAN: So the reason why I
25 asked is we heard from at least one home, they

1 had an outbreak in April of 2020; there was no
2 inspection. They had an outbreak on
3 October 20th, October 2020, no inspection. They
4 had an outbreak in November 2020, no inspection.
5 They then had a major outbreak from December 2020
6 through January of this year, 14 residents died.
7 And by the time they came and visited -- the
8 inspector responsible came and met with us, we
9 asked him like in all these times why didn't you
10 go in to that home? And he said they just didn't
11 have the resources.

12 And I don't know how that happens, one
13 of your managers can come and tell us he doesn't
14 have the resources for inspections during a
15 pandemic.

16 MINISTER MERRILEE FULLERTON: I'll let
17 the Deputy comment on that. I just want to
18 mention one point about the outbreaks.

19 So, again, when you hear the word
20 "outbreak", there is a tendency to think that
21 there is cases within the home. And we lowered
22 the threshold of outbreak definition to make
23 it -- it could be a staff member self isolating
24 at home. So they may have picked it up in the
25 community but through our testing it showed up

1 positive. They never went into the home and
2 there is not a single resident in the home.

3 And I know that there is a lot of
4 confusion and there has been that every outbreak
5 looks as dramatic and severe. So that
6 threshold, we did that purposefully to be able
7 to get Public Health units activated right away.

8 So I just want to clarify that point
9 because it does seem to be a point of confusion
10 and I will let the Deputy speak to it.

11 DEPUTY MINISTER RICHARD STEELE: Yes, a
12 couple of things mostly just to echo the
13 Minister's comments around -- I don't think there
14 is any question that we need to take a pretty
15 end-to-end look at quality, quality assurance.
16 What is the role of inspection in quality
17 assurance?

18 Right now the inspectors, they're
19 operating under the current legislative
20 framework, and I just want to be clear that
21 whatever we're saying is not a criticism of the
22 individual inspectors; it is that we need to
23 look at the structure they are working in.

24 They are a few things. We continue to
25 look at the risk prioritization through which we

1 were deploying and allocating inspectors
2 throughout the pandemic frankly and continue
3 to -- continue to adjust how we were doing that.
4 Absolutely.

5 Significant COVID outbreaks were
6 significant risk factors, and we would be
7 deployed inspectors starting in May. Once we
8 actually got inspectors back out into the field
9 again, we were deploying inspectors to
10 significant outbreaks of concern.

11 It is important to note that that's
12 not the only thing -- COVID wasn't the only
13 thing that the inspectors had on their plate.
14 There is all of the regular business, the 80,000
15 long-term care residents and the various, you
16 know, critical incidents and complaints that
17 will come in. That business also still
18 continued, and we needed to have some of that --
19 we needed to have those issues being responded
20 to as well. COVID is -- COVID was not, is not
21 the only threat to residents. It is a major
22 threat as we know because of the terrible loss
23 of life that happened, but it wasn't the only
24 threat.

25 So it was always something we had to

1 balance. In terms of which -- in terms of which
2 homes did we prioritize getting inspectors to
3 once an outbreak was underway? To some degree,
4 through our kind of rapid response and incident
5 management process, there would certainly be an
6 assessment of who else was on the ground. Was
7 the home being well supported? Was there a
8 hospital partner deployed? Was Public Health
9 deployed?

10 We would certainly be -- there would
11 be a higher priority of deploying inspectors
12 into a home where we were less convinced that
13 there were already lots of eyes on the home and
14 loots of boots on the ground.

15 So there was always -- particularly
16 through the fall, there was a bit of a -- a
17 judgment and tradeoff as to how best could
18 inspectors be deployed, where would they have
19 the most incremental impact relative to the
20 other partners?

21 We did -- as I think you have got in
22 your list of documents, we did kind of -- you
23 know, reframe that risk prioritization to have
24 inspectors go out quickly to any outbreak home
25 in January. That was a continued evolution of

1 our thinking around risk management. But it's,
2 again, really important to note that that
3 doesn't imply that COVID outbreaks were not
4 considered a risk factor earlier.

5 In fact in the Playbook that we
6 developed as part of our Wave 2 planning in the
7 summer, deploying inspectors again to higher
8 risk homes was part of that plan.

9 So that was happening as we headed
10 into Wave 2.

11 JOHN CALLAGHAN: You can appreciate,
12 even with all that, that it's relatively cold
13 comfort to the families of residents that died --

14 DEPUTY MINISTER RICHARD STEELE: I
15 totally understand. I think we're all -- we all
16 live with that every day.

17 JOHN CALLAGHAN: I know you do. The
18 Minister asked us to go find out what went on.
19 I'm telling you what went on and these families
20 have asked -- I'm going to read to you when we
21 get there some of the families' comments. The
22 Commission has heard a whole lot about the
23 anguish of families.

24 So just to go back to what the --
25 Minister, what you said, there had been a change

1 in the inspection policy where they looked at
2 critical incidents and there really wasn't a
3 universal assessment.

4 And we heard from one of your senior
5 inspection people about, you know, you had to
6 focus on the incident you were there for and if
7 you saw other things, unless they were raised to
8 a level 4, I believe it was, they weren't to
9 deviate from what they were there for and
10 probably all done for good reason.

11 But am I to understand from what
12 you're saying that that philosophy, in your
13 mind, has to change? That you have to now look
14 at the larger issue for the benefit of the
15 residents?

16 MINISTER MERRILEE FULLERTON: I think
17 it always has to be about the residents. And we
18 have a situation where the safety and the
19 well-being, that is the priority. And so we need
20 to understand how the inspection system can do
21 that. And we have to understand how it does it
22 in normal times, and also in a scenario of COVID.
23 Because if it's not COVID there may be something
24 else.

25 And we absolutely have to understand

1 how our inspectors actually integrate with
2 others as well. Because there were Public
3 Health inspectors; there were labour inspectors;
4 and understanding the roles and the clear
5 delineation and clarity of those roles is also
6 important. So I would agree.

7 JOHN CALLAGHAN: So we heard from a
8 number of the hospitals that went in and most
9 were quite surprised and in fact shocked at the
10 level of IPAC ability of the homes. Some -- and
11 I invite you to read the UHN transcript, the
12 Lakeridge transcripts, talked about the inability
13 of the staff to clean properly, that there wasn't
14 terminal cleaning done properly and people were
15 shifted from one room to another and perhaps got
16 COVID.

17 And the comment that came back was
18 that they didn't think that the inspectors
19 actually knew what to look for. And for
20 example, we talked to Public Health Ontario who
21 said that they never trained your inspectors.
22 We've heard from others who said that perhaps
23 the Public Health unit should be doing the IPAC
24 and the -- that type of inspection.

25 But what is your view as to how and

1 who should be doing IPAC and environmental
2 inspections particularly?

3 MINISTER MERRILEE FULLERTON: Thank
4 you. I think of the role of Public Health and
5 there ought to be a stronger Public Health
6 integration. That is my opinion.

7 And exactly how that would look,
8 because infection prevention and control on a
9 regular basis during normal times is one thing;
10 it is a very different scenario with COVID, and,
11 again, early on understanding the science behind
12 it.

13 So there would have to be a
14 co-ordinated effort through Public Health to
15 have an understanding of long-term care and, of
16 course, that's why we reduced the outbreak
17 definition to one so that they could get in
18 there at the earliest possible time.

19 I think this has to be considered, the
20 role of Public Health in long-term care. And
21 we've seen the importance of them during COVID
22 and at other times, but we have to have the
23 level of training. That's why we put out the
24 dollars, the \$30 million for the IPAC training
25 and for the -- hire IPAC staff and also have

1 created the IPAC hubs with the Ministry of
2 Health to make sure that that expertise was
3 available.

4 But ultimately it needs to be
5 reinforced. So it speaks to system-wide
6 integration of long-term care. But again, I
7 come back to the important part that it is
8 someone's home. Long-term care is not a
9 hospital. And I don't think people want it to
10 become a hospital. That's my general feeling of
11 listening very carefully to various advocates
12 over the last ten years.

13 JOHN CALLAGHAN: Just so we're clear,
14 you'll agree that IPAC is particularly important
15 in -- and cleaning in a home where influenza
16 outbreaks are routine?

17 MINISTER MERRILEE FULLERTON: I
18 absolutely agree. IPAC is a foundation. It's a
19 foundation and as we learn more about COVID and
20 how it is transmitted, then have more research
21 and data on that we may have to do more.

22 JOHN CALLAGHAN: You talked about the
23 \$20 million to hire IPAC specialists, and I'm not
24 sure I understand what the actual -- what you
25 actually intended to accomplish. Because that is

1 about \$30,000 a home. An IPAC specialist I think
2 runs, as I understand it, about -- with benefits
3 about 120,000 and you can correct me if you have
4 different numbers. It would leave one IPAC
5 specialist for about 285 residents, which is well
6 above the recommendation.

7 So that \$20 million doesn't solve the
8 IPAC leadership problem, which frankly we've
9 heard was quite persistent throughout the
10 industry.

11 So what were you accomplishing,
12 Minister, by that amount of money?

13 MINISTER MERRILEE FULLERTON: It was
14 really to create a person who had additional
15 training in that -- in IPAC so that that would be
16 an IPAC lead in the home and that's why also the
17 hubs were created so that that level of expertise
18 could be shared.

19 It is actually not that easy to get
20 infection prevention and control experts, so
21 this was a way to solve that problem at the same
22 time recognizing the importance of it, and I'll
23 ask the Deputy to ...

24 DEPUTY MINISTER RICHARD STEELE: Yeah,
25 I just wanted to add that one of the pieces of

1 advice we got precisely because there is -- there
2 is, at this point, a pretty finite IPAC expertise
3 out there. It was not to try and solve this in
4 isolation in long-term care.

5 So we were very much thinking about
6 what can we do in long-term care to create --
7 within the long-term care system to create some
8 supplementary capacity but very much in the
9 context of what was seen as a broader effort
10 through the hubs that were being implemented
11 through the Ministry of Health and Ontario
12 Health to provide a locus of IPAC expertise that
13 various settings, including long-term care,
14 including retirement homes, including other
15 congregate settings, could be drawing on given
16 the limited supply.

17 The intent of what we were doing in
18 long-term care in the immediate term was to
19 create at least some supplementary capacity to
20 support that. Certainly not intended to be the
21 be-all and end-all solution to IPAC with the \$30
22 million.

23 JOHN CALLAGHAN: You need to increase
24 the envelope to the homes to make sure they all
25 had highly trained IPAC people? Is that what

1 you've saying that's what will have to happen?

2 DEPUTY MINISTER RICHARD STEELE: I
3 think ultimately we will need to land on -- and
4 just looking at some of the various testimony
5 you've heard and various conversations I've had
6 with various people too, I think there's a few
7 different perspectives that we'll need to kind of
8 land on the right path is: Do you try to build
9 out more capacity in the long-term care sector?
10 My view is that we should. Or do you rely on --
11 do you rely on that capacity sitting somewhere
12 else in the hospitals to draw on? I personally
13 think it's probably both.

14 I do think the capacity needs to be
15 strengthened in the long-term care sector itself
16 would be my view and, yes, that will require
17 funding to accomplish that.

18 JOHN CALLAGHAN: So Minister you asked
19 your Commissioners to look into the situation
20 with staff, and so what I want to do is give you
21 a sense of some of the information and evidence
22 we've heard from staff and get your reaction. So
23 I'll read a few that we've got.

24 So here is one:

25 "I left the other day and I came

1 home and I said, it is like a war
2 zone. I have no idea what's going on.
3 Very, very mixed messaging and I feel
4 horrible because my background is
5 health and safety, I should know this,
6 right? [...] We should know what
7 we're doing by now. We're in a mess."

8 And that was from someone who met with
9 the Commissioners on January 28th. Here is
10 another one:

11 "Infection control. How can you
12 do infection control with four people
13 in a room? We know what needs to be
14 done, but we cannot physically do it.
15 There's no plan. There was absolutely
16 no plan for infection control when
17 this hit. Blew me away."

18 That was someone who we met with them
19 again on January 28th.

20 "How many PSWs, how many
21 healthcare workers have to give up
22 their lives because we can't get it
23 together? I don't think we have to
24 be -- we shouldn't have to die in
25 order to do our jobs. So there has to

1 be a workable, workable isolation
2 plan."

3 Another January 28th.

4 "Don't just brag, Oh, you're our
5 frontline workers. You're the best
6 people. No, show it, prove it."

7 Here is another one.

8 "The management team were nowhere
9 to be found. They're just staying in
10 their office, not coming out, not
11 helping to feed. Not helping. Not
12 giving any proper directive. It was
13 just so, I mean, chaotic and a mess.
14 [...] But they chose -- in a fight or
15 flight situation, they close the
16 flight and left the staff with no
17 safety no security, no PPE. They had
18 to be reported for them to bring
19 proper PPE to give the staff. People
20 were getting sick. It was so sad."

21 We heard that on February 11:

22 "I worked on a COVID-positive
23 unit. I ended up walking out the one
24 day from work. At the start of my
25 shift several staff members and I went

1 to our DOC. We begged her for N95s
2 and she said, 'No, you will not be
3 getting them. They are for hospital
4 workers not for us.' And at this
5 point there was so much fear and
6 anxiety. And I have a family I have
7 to protect too. And I feel very
8 guilty about what I did.

9 And the next day the DOC had
10 us -- made us come in her office. And
11 she showed me all the PPE that she
12 locked up and she told me that none of
13 us would be getting any of it."
14 We heard that on February 11th.

15 "Other changes that should have
16 been implemented would be things
17 coming down from government as
18 apparently a lot of these rules are
19 coming down from government. They
20 seem to occur on a Friday at around
21 4:00.

22 And when we try to ask questions
23 by our managers we get told, 'Oh well,
24 it could wait until Monday.' And
25 we're getting told to follow these

1 directions when we have questions for
2 the weekend. So we don't know if
3 we're doing it right, if we're doing
4 it wrong, or what."

5 We heard that on February 11th.

6 What do we do about the disarray and
7 the lack of leadership in some of these homes,
8 Minister?

9 MINISTER MERRILEE FULLERTON: I
10 referenced that a little bit earlier. And first
11 of all, I just want to acknowledge the stories
12 and the experience of the people that were really
13 holding the line in the long-term care homes.
14 And we have called it a war against COVID.

15 And certainly some people who have
16 gone through wars, they are upset by that
17 analogy but you can see to these people it
18 really was a war for them.

19 But when we look at the leadership, it
20 was the homes that held had the medical
21 leadership that stayed and held the front line
22 with the staff.

23 In homes where the leadership did not
24 stay or was sick themselves in some cases, they
25 had a much harder time. So we need the

1 leadership and the accountability, and I believe
2 that we should have leadership training for
3 long-term care homes. And I believe that we
4 ought to be looking at how do we -- how do we
5 look at the medical directorship of the homes?
6 And it's also the directors of care for nursing
7 as well.

8 So this has to be a stronger piece.
9 There is no doubt in my mind. And I think how
10 we do that is create a training programs, again
11 integrating the acute care sector so we have
12 people experienced in long-term care and have an
13 understanding of it, but provide them with the
14 training programs and supports that will help
15 them be effective.

16 And to the point where you also made
17 reference to, you know, like the crowding. You
18 know, we have to redevelop and that's what we've
19 been working furiously to do, to add new spaces.
20 There is no doubt that the congestion played a
21 role. And I'll ask the Deputy.

22 DEPUTY MINISTER RICHARD STEELE: Nothin
23 g really to add. You said it, Minister.

24 COMMISSION CHAIR FRANK MARROCCO: Just
25 before you leave that, do you have a view about

1 where the obligation of the home owner or
2 operator starts and ends in terms of this
3 process? It struck me that virtually everybody
4 who comes here, even the private sector owners
5 want to tell us what the government should do,
6 and that's fine.

7 But do you think perhaps there is an
8 absence of accountability on the ownership and
9 operators of these homes that there's -- it's
10 too -- everyone's too quick to assume that the
11 first line of defence is the government as
12 opposed to perhaps the last line of defence?

13 MINISTER MERRILEE FULLERTON: Well,
14 every home operator has an obligation to the
15 residents of a safe place to live, and that is
16 their duty. So the obligation is there.

17 However, COVID is just unseen. We've
18 never had something like this in a hundred years
19 And so the question then becomes, the things
20 that were pre-existing, the congestion in the
21 home, this staffing crisis, the years of neglect
22 of the sector and really long-term care was
23 where you sent people from acute care after
24 their families couldn't manage them any more.

25 It has to be an understanding that the

1 homes obviously do have an obligation. I
2 believe many of them were overwhelmed, that the
3 leadership was overwhelmed in the home, that the
4 directors of care simply couldn't cope. And so
5 what we need do is create the environment with
6 which people can work and maintain the safety
7 for the residents. That requires getting,
8 gradually getting rid of the 1970s buildings.
9 If I could do that, I would do it instantly.
10 Unfortunately that takes time.

11 We need to build more community
12 programs where people can be in their homes for
13 longer. In terms of the responsibility of the
14 operator, they already have the responsibility.
15 And yet they could not, in some instances,
16 achieve it under the circumstances.

17 So we have to put the environment in
18 place to allow them to succeed but to hold them
19 accountable in those conditions. I don't think
20 it's fair to expect a home that applied or a
21 chain that applied numerous times to rebuild and
22 was turned down and couldn't build.

23 So there is a -- there is -- it is
24 their responsibility, but I think government
25 also has a responsibility to create the

1 conditions whereby homes can get rebuilt and
2 staff can be hired. And that's what we're
3 doing.

4 JOHN CALLAGHAN: I should say,
5 Minister, the lack of leadership issue, we heard
6 it from big chains, from mom-and-pop shops.
7 Like, it didn't seem to come from just one
8 quarter. So is there something wrong with the
9 way we fund staffing such that they don't have
10 enough to have real leaders on the ground?

11 MINISTER MERRILEE FULLERTON: I go back
12 to the staffing study. So to your question I
13 would say it's a combination of things, not just
14 one thing. Funding is most likely part of it.
15 However, if we go back to the staffing study and
16 they described attracting the right people. So
17 you need people that care. You need people that
18 want to be there for the right reasons, but also
19 you need to retain them. So funding is part of
20 that.

21 So I do agree that funding needs to be
22 better and that is something that we've been
23 working very hard to achieve, but it's also the
24 conditions of the homes.

25 And when you go into some of the homes

1 built in 1970, they need to be redeveloped. And
2 we want to give people pride in where they work.
3 But it needs to be the right people and so a
4 process by which we attract people to the sector
5 needs multiple approaches.

6 JOHN CALLAGHAN: That is a good
7 jumping-off point to the issue of staffing. You
8 yourself have described it as a crisis. So let's
9 just delve in and see the extent of the problem.

10 And these numbers come from, I think,
11 a number of sources, including your staffing
12 study, that there are about a hundred thousand
13 PSWs in the healthcare system, about
14 50 percent work in long-term care. So there is
15 about 50,000. Is that your understanding?

16 MINISTER MERRILEE FULLERTON: Yes, yes.

17 JOHN CALLAGHAN: And that there is
18 believed to be a 25 percent attrition every year,
19 correct? That's the information that we have in
20 the staffing study.

21 MINISTER MERRILEE FULLERTON: And
22 roughly, during a program to train PSWs, half
23 of them would leave before the program is
24 finished and the other half that would graduate,
25 half of them would leave before two years, yes.

1 JOHN CALLAGHAN: Right. So I have seen
2 different numbers of how many graduate, but
3 somewhere between 7 or 8,000, some say 70 to
4 7400, so with the information you just gave us
5 about those who don't either ever practice or
6 leave shortly thereafter, I think it's 40 per
7 cent, you are at a net migration of PSWs in the
8 system, correct?

9 MINISTER MERRILEE FULLERTON: Yes.

10 JOHN CALLAGHAN: Right. And that's the
11 problem you have -- inherited is not the right
12 word, but that's the one you came upon in June of
13 2019?

14 MINISTER MERRILEE FULLERTON: Right.

15 JOHN CALLAGHAN: And the information we
16 read is that the shortage of PSWs, even at the
17 beginning of COVID, was about 6,000, about half
18 of which, 3,000, would have -- should have been
19 going to long-term care. Is that about right?

20 MINISTER MERRILEE FULLERTON: Yes,
21 that's correct.

22 JOHN CALLAGHAN: So at this point in
23 time you have this type of attrition. Now, we've
24 looked at some of the documents and between Wave
25 1 and Wave 2, we did not see a great uptick in

1 PSWs, is that correct? Am I right on that?

2 MINISTER MERRILEE FULLERTON: Correct.

3 JOHN CALLAGHAN: Right. And Quebec
4 introduced their 10,000 PSWs and we've heard
5 different numbers. On the radio the other day I
6 think I heard they had 8100. You just yesterday
7 introduced a similar type of program. Can you
8 tell me why you didn't introduce that type of
9 program in the summer like Quebec?

10 MINISTER MERRILEE FULLERTON: There is
11 a couple of different clarifications needed
12 there. So in Quebec what they were doing is
13 training orderlies. So they weren't training
14 PSWs; they were training orderlies. They put
15 out the call for 10,000. I don't believe they
16 got 10,000. I believe they got around half of
17 that, roughly, and then they had attrition. So
18 they weren't able to retain them either.

19 So that's just to clarify that piece
20 of it.

21 JOHN CALLAGHAN: Thank you, that's
22 helpful.

23 MINISTER MERRILEE FULLERTON: Yes. So
24 in terms of what -- we were looking in terms of
25 the staffing. We were looking at the staffing

1 study done by the expert panel to inform us. And
2 we added in the PSWs because Justice Gillese,
3 that wasn't part of her recommendation coming
4 from the inquiry, the public inquiry, but we
5 added them in because we felt it was so
6 important.

7 What we did in the interim was really
8 shore up our homes with, again, being able to be
9 flexible in the deployment from other sectors
10 with matching portals, with federal portals,
11 with the lists that were provided by the nursing
12 organizations and creating the flexibility
13 through emergency orders and regulatory changes,
14 because, you know, a lot of things come back to
15 local. If you can find the solutions locally,
16 they will stay.

17 And to implement the local solutions,
18 it's also more expedient we discovered as well.
19 But we did that because we chose a slightly
20 different path than Quebec. Quebec's situation
21 was worse than ours. I know that hadn't always
22 come out, but they needed many, many more.

23 But to be able to train people and
24 then retain them and get them to go into
25 COVID-outbreak homes, we were -- with the

1 attrition we were seeing already, it didn't seem
2 likely that that would be the way forward.

3 So over the summer, and actually as
4 soon as we came out of the first wave, we began
5 to look at how we would train. And this had to
6 be co-ordinated with Ministry of Health, because
7 what you do in one area can affect another. And
8 so this was a -- again, this was part of what we
9 share with the Ministry of Health. And so this
10 was a co-ordinated effort in order to create the
11 numbers that we needed.

12 So in short, there were emergency
13 requirements to get people into those homes
14 which we took and the stabilization and then the
15 longer-term plan. And we were doing all of
16 those pretty much at the same time.

17 DEPUTY MINISTER RICHARD STEELE: I'm
18 just wondering if I could add a couple of points
19 to what the Minister said there, because I think
20 they are important to the issue, again that
21 Quebec comparison and the logic of what we're
22 trying to accomplish in Ontario and the impact on
23 staffing levels.

24 One of the -- one of the conversations
25 we were having with the sector through the

1 course of the summer in preparation for Wave 2
2 we have exactly this issue of resident aids,
3 which is what -- which is what we call them
4 here, and what's your -- what was needed for
5 homes to bring them in in volume. We certainly
6 did go down the path of providing a provincial
7 solution for that. That's what became the
8 Ontario Work Force Reserve for Seniors that was
9 launched in the fall to recruit people and get
10 them some basic training, very comparable to
11 what Quebec was doing, basic on-line training
12 and then deploy them.

13 What we heard from the homes though,
14 was in addition to that, when we asked them what
15 do you really need from us for you to be able to
16 hire resident aids? The bottom line was money.
17 And they actually were able to hire resident
18 aids as long as they had the funding. So a
19 significant part of our focus was in fact to
20 ensure that they had that additional funding
21 available through the Prevention Containment
22 Funding which we extended and increased into the
23 fall.

24 And if you analyze how homes have
25 spent that money, around two thirds of it has

1 gone on staffing. So that was a key element.

2 To the Minister's point, absolutely we
3 tried to do programming centrally to support,
4 but we didn't, you know -- we didn't rely solely
5 on that. We did also rely on what the homes
6 could do themselves if we provided them the
7 regulatory flexibility and the funding as the
8 Minister's noted.

9 I think another point that is
10 important to note in terms of the staffing
11 picture that's evolved over the course of the
12 year is, as we've tried to work to address the
13 crowding issue in ward rooms and as homes have
14 implemented the direction that Chief Medical
15 Officer of Health provided around not admitting
16 into ward rooms, three- and four-bed ward rooms,
17 that has resulted in a substantial drop in
18 occupancy in homes through the period, which
19 obviously has significant benefit in terms of
20 crowding. So instead of 10,000 people in ward
21 rooms, which is where we would have been last
22 March, we're now at 2,000. So still a little
23 way to go, but substantial progress on that
24 front.

25 But relevant to this point, we

1 maintain homes funding as if they were fully
2 occupied.

3 So while their resident population has
4 dropped by about 12.5 percent, as a result of
5 that we've maintained funding levels so that
6 they can maintain full staffing within the home.
7 Which obviously has a significant -- if you
8 think about that across a hundred thousand
9 staff, that is a significant benefit in terms of
10 a home's ability to manage. And I think those
11 two things together did have a positive impact
12 as we headed into Wave 2 from a staffing point
13 of view, along with some others which we can
14 talk about.

15 JOHN CALLAGHAN: So if the Deputy
16 Minister is correct, Minister, why did more
17 people die in Wave 2 in long-term care than Wave
18 1?

19 MINISTER MERRILEE FULLERTON: Yes, and
20 so I have looked at that really carefully. And
21 Wave 1 did not have the same level of community
22 spread as Wave 2. Wave 2 had far greater
23 community spread. And so if that is a primary
24 driver -- we know that from the studies, the
25 community spread of the -- in the region of the

1 Public Health region is the biggest indicator for
2 outbreak potential.

3 And then the age of the home is the
4 prime driver for the severity of the outbreak.
5 So if you look at the community spread in the
6 second wave, substantially higher.

7 And so we were doing more testing and
8 certainly finding more, but if you look at the
9 numbers, even the ICU numbers in the hospital,
10 the hospitalization numbers reflect that, that
11 they were higher community spread.

12 So if all the IPAC, all the cleaning,
13 all the PPE, all the testing, and we still had
14 deaths. And so it leads me to the question is,
15 what are we missing? We've done the one site;
16 we've done all these measures. What is it that
17 we're missing?

18 And so I was talking with some of the
19 Science Table the other day and saying, we have
20 to keep an open mind. How is this being
21 transmitted? What other issues can we do in
22 long-term care?

23 We're calling an outbreak early; we're
24 getting all these partners involved; we're doing
25 the IPAC; we've got the staffing stable. And

1 stable, I use that because of course it could be
2 better. But it isn't what we had when the
3 staffing was collapsing in the first wave.

4 So as we learn more about this virus,
5 we will have to adapt and have to use more
6 measures. I do believe the rapid tests are
7 helpful here. And we need to be able to
8 understand the potential for the virus to get
9 in.

10 DEPUTY MINISTER RICHARD STEELE: If I
11 could just add one more point to your comment
12 around Wave 2 and Wave 1 deaths, and I say this
13 in absolute consciousness that it is very cold
14 comfort to the families of those who died in Wave
15 2, so let me preface that with acknowledging it.
16 There were obviously too many people who died in
17 Wave 2.

18 But to the Minister's point, if you
19 look at the pattern of outbreaks in Wave 2
20 versus Wave 1, they do indicate a significantly
21 higher -- the context in which long-term care
22 operating was a higher threat context, we had
23 significantly more outbreaks, I think around
24 double the number of outbreaks in Wave 2 versus
25 Wave 1.

1 If you look at the pattern of those
2 outbreaks, a dramatically lower proportion of
3 those outbreaks actually ended up being
4 significant large-scale resident impacting
5 outbreaks.

6 So I think in Wave 1, we saw -- if my
7 numbers are -- if my recollection is correct,
8 and this is looking at the period up to probably
9 about the end of January, it will obviously have
10 improved even more beyond that because of the
11 impact of vaccines. But we were looking at in
12 Wave 1 about 20 percent of outbreaks ended up in
13 situations where 25 or more residents became
14 infected. In Wave 2 that dropped significantly.
15 We were looking at about 7 percent of outbreaks
16 becoming significant outbreaks impacting more
17 than 25 residents. So good enough? No. But a
18 significant improvement? Yes.

19 JOHN CALLAGHAN: So we've heard that
20 the mortality rate in Wave 1 was 30 percent and
21 Wave 2 was 22 percent. So Minister, if the
22 Deputy Minister's analysis is right, then we had
23 a smaller number of completely out of control
24 outbreaks? Is that what we're led to believe?
25 Because that's what it sounds like.

1 MINISTER MERRILEE FULLERTON: I
2 wouldn't characterize it that way. What I would
3 say is, as the community spread was particularly
4 high in Ottawa in the beginning of Wave 2 and in
5 Toronto, it was very hard to keep it out of the
6 homes. And so despite the infection prevention
7 and control measures, despite the PPE, you know,
8 we had anticipated with the -- and the testing
9 that we were doing, that it would be less.

10 And then of course there is the
11 confusion over when the variants actually
12 started because some of our -- you know, some of
13 our residents passed away with the variant. And
14 that was something new. So this is, again, the
15 virus that's at work, our scientific
16 understanding of what else can be done.

17 And I want to say that every -- every
18 single outbreak was significant in terms of
19 impacting somebody, whether it was a staff
20 member self isolating at home, not in the home,
21 or whether it was a resident in the home or
22 staff member working in the home. Every single
23 outbreak had an impact on the people involved,
24 and so I want to make sure that that's
25 understood.

1 But if we look at Wave 2, you know,
2 were the variants there before we could detect
3 them? Were there simply the community spread,
4 you know the COVID bombarding the home? It has
5 to be detected. You have to be able to find it
6 to keep it out. And was our testing good
7 enough? And that's why we continued in the high
8 prevalence areas to address the amount of
9 testing.

10 Again, understanding the limitations
11 of turnaround times and capacity issues, doing
12 everything we could to get the rapid test
13 expedited that hadn't been approved by Health
14 Canada. So we were doing everything we could to
15 keep it out.

16 JOHN CALLAGHAN: Going back to the
17 staffing issue, just -- you've announced 8200 new
18 students with \$115 million worth of funds. First
19 I've got to ask, considering the mandate of the
20 Commissioners is to examine the initiatives of
21 government to address COVID, is there any reason
22 why the Commissioners weren't advised that this
23 was going to be -- this program was coming?

24 MINISTER MERRILEE FULLERTON: It was --
25 it had been -- it was being worked on, and we

1 were expediting this as quickly as possible.
2 I've never seen anything move faster in terms of
3 policy like that. So just understanding the
4 sense of urgency involved, and so I apologize if
5 this is something that was of surprise to you.

6 JOHN CALLAGHAN: Let's go -- I just
7 want to make sure that the Commissioners
8 understand the scope of the staffing issue. Your
9 commitment for 15,000 new beds is going to add
10 10,000 more PSWs? How many more PSWs? We
11 have 70,000 and 50,000?

12 DEPUTY MINISTER RICHARD STEELE: If you
13 think about it, not just PSWs but the total
14 staffing, it's around 1.2 to 1. So 15,000 beds,
15 you're probably -- additional beds, new beds,
16 when they come on stream that will add a
17 requirement of probably around 17, 18,000 staff
18 to support that; now not necessarily full-time
19 but that's staff.

20 JOHN CALLAGHAN: And then you're
21 increasing the amount of care from 2.45 hours to
22 4 hours. So how many more staff does that add?

23 DEPUTY MINISTER RICHARD STEELE: So to
24 achieve the 4 hours of care, again, in 4 years,
25 and this is precisely why it does take 4 years

1 that's about 27,000 extra staff.

2 JOHN CALLAGHAN: Right. So with the
3 attrition rates and all that, 8200 is just the
4 start? Is that what we're to understand?

5 DEPUTY MINISTER RICHARD STEELE: That
6 should absolutely be the understanding, yes.

7 MINISTER MERRILEE FULLERTON: Yes.

8 JOHN CALLAGHAN: And so on the mix of
9 care, which the Commissioners have heard about,
10 do you agree with the RNAO of 20 percent RNs,
11 25 percent RPN's and 55 percent PSWs?

12 MINISTER MERRILEE FULLERTON: I would
13 say not necessarily. I think it's a good
14 position to understand and start from. I
15 looked -- when we looked at the staffing study
16 they did not comment on the mix, and that was
17 something that really stood out for me. And I
18 think the rationale was that we really needed to
19 look at the regional aspect of -- and the
20 regional differences.

21 Of course there needs to be a
22 bolstering, I believe, of the -- across whether
23 it's RNs, RPNs or PSWs. And also in that --
24 in our staffing plan it's a 20 percent increase
25 for allied professionals within the home as

1 well; so social workers, physiotherapists,
2 20 percent increase in time.

3 JOHN CALLAGHAN: I thought that was
4 going to be 100 percent. It's only 20 percent
5 for allied?

6 MINISTER MERRILEE FULLERTON: Yes,
7 20 percent.

8 JOHN CALLAGHAN: So in the context of
9 pay, because we've been told that there's some
10 concern about pay because the hospitals are paid
11 more and home care is paid less. How do you
12 avoid cannibalization from one sector on the
13 other when everybody's paid different amounts for
14 what is basically part of the healthcare system.

15 MINISTER MERRILEE FULLERTON: And
16 that's such an important question and one we've
17 grappled with during COVID, because as we're
18 putting up measures to shore-up the long-term
19 care sector there was a concern how this would
20 affect the other sectors. So there was a more
21 holistic approach that was desired, and for good
22 reason. But again, that does slow things down in
23 terms of a COVID response.

24 And I'll let the --

25 DEPUTY MINISTER RICHARD STEELE: It's

1 absolutely a couple of challenges. It's a
2 challenge between groups of staff within
3 long-term care, and it's certainly a challenge
4 across the system.

5 We've certainly heard that with the
6 implementation of the wage premium for PSWs in
7 wave 2 that creates compression issues with
8 Registered Practical Nurses, for example. So
9 there aren't easy answers to this.

10 Absolutely your work and thinking
11 happening around how do you try to -- how do you
12 try to attack this problem? Which is big and
13 complex across the whole system. Definitely
14 work under way. I don't think there are easy --
15 this is -- again, it is a very long-standing
16 challenge. There aren't easy answers to this.
17 The staffing study advisory kind of -- didn't
18 make specific recommendations on compensation.
19 I think partly because -- because of the
20 complexity of that issue.

21 So compensation is certainly something
22 that the government will want to keep looking
23 at. But what the solution will be I think we
24 have lots more work to do.

25 JOHN CALLAGHAN: And the Ontario Nurses

1 Association said to us this part-time employment
2 caused a lot of problems, and we've talked about
3 the part-time employment. And they suggested
4 that the real mix should be 70 percent full-time
5 and 30 percent part-time. Are you working
6 towards making available, to PSWs and nurses in
7 long-term care, more full-time employment and if
8 so to what percentages?

9 MINISTER MERRILEE FULLERTON: I'm just
10 going to quickly make a comment that, I think
11 with an aging population I think we also have to
12 understand that there may be more demand for
13 part-time work; and to create the flexibility for
14 people at the ends of the spectrum; so whether
15 they're in their early -- perhaps having a family
16 or whether they're at the other end of the
17 spectrum and have -- want a slightly lighter
18 number of hours.

19 So I think we have to be very attuned
20 to the demand of the people who would be willing
21 to work in this sector. So I think there's a
22 bit of a reactive response that says everyone
23 wants full-time work. And I think with an aging
24 population that might not be a case, so we have
25 to keep an open mind.

1 JOHN CALLAGHAN: But just before the
2 Deputy Minister speaks, even your staffing study,
3 I believe, suggested that a significant amount of
4 those who had part-time work wanted full-time
5 work, and it doesn't diminish your comment,
6 Minister, that there would be some that still
7 want part-time work, but you appreciate that
8 there was still a sizeable amount that wanted
9 full-time work?

10 MINISTER MERRILEE FULLERTON: Agreed.
11 Understood.

12 DEPUTY MINISTER RICHARD STEELE: And
13 it's absolutely a part of the staffing plan that
14 was released in December, to work on -- I think
15 there's a recognition that the number's never,
16 and shouldn't be, and can't be 100 percent, but
17 looking at how the full-time percentage can be
18 increased, absolutely part of the staffing plan.

19 And that's work that is getting
20 underway with the sector to try to understand
21 how does that happen? How do you run a
22 24-hour -- 24/7 operation, which is one of
23 challenges? How do you staff -- how do you
24 staff a 24/7 operation with larger number of
25 full time?

1 So understanding what are the best
2 practices here? Who is achieving higher
3 percentages? How are they doing that? And
4 making sure that's well understood across the
5 sector. That's a piece of work we are doing
6 with the sector.

7 COMMISSION CHAIR FRANK MARROCCO: Mr.
8 Callaghan, before you leave, Minister, do you
9 have a sense of why there's this significant
10 resort to part-time staff in the industry or in
11 the long-term care sector?

12 MINISTER MERRILEE FULLERTON: It's not
13 clear to me why that is. And some of it, I have
14 heard, through people who have been working on
15 mechanisms to allow PSWs to choose their time.
16 It may be that some PSWs want certain hours
17 during the day to accommodate school children.
18 They only want mornings but they can't get all
19 the mornings in one location. So it could also
20 be that there is a sense that to fill a position
21 quickly if someone can't come in to work.

22 And I actually think we need more data
23 on this whole piece to understand what it is
24 that is driving that portion of it. And I do
25 believe that we should be offering more

1 full-time work to people who want it, and also
2 the flexibility for those that prefer part time.

3 COMMISSION CHAIR FRANK MARROCCO: We
4 heard from I think it was York Region, but we
5 have heard, in any event, that the level of IPAC
6 knowledge or training behaviour becomes more
7 problematic with the more -- with part-time staff
8 than with full-time staff.

9 MINISTER MERRILEE FULLERTON: So you
10 know, I think if you look at it from a
11 perspective where the number of staff, if you
12 have high community spread, if you have high
13 numbers of staff coming into the home you're
14 increasing risk because there's more chance --
15 there's more vectors. There's more vectors that
16 COVID can come in on.

17 By having a smaller number of staff,
18 if they're all full-time, then you certainly
19 would have fewer individuals. Do you know
20 follow my thinking?

21 COMMISSION CHAIR FRANK MARROCCO: Yes.

22 MINISTER MERRILEE FULLERTON: In terms
23 of the infection prevention and control, I think
24 it's important that we have the regular ongoing
25 training. And some of the turnover that's in the

1 homes has made it so that people are not as
2 familiar and they need to be.

3 And I think this is a role that can be
4 addressed -- or a problem that can be addressed
5 through ongoing repetitive training. But if the
6 more people that are coming in only part-time or
7 not on a regular basis that poses more risk.

8 DEPUTY MINISTER RICHARD STEELE: Just
9 to add to that -- sorry, Commissioner. I was
10 just going to add, I think the issue is perhaps
11 less the full-time/part-time in terms of the IPAC
12 training and more the stability of staffing.
13 Because you can be well trained and part-time if
14 you're there for a prolonged period.

15 The other thing we've certainly heard,
16 to that point around stability and training, is
17 that agency staff were more of a challenge to
18 train around IPAC as well. So that's certainly
19 something we heard too.

20 COMMISSION CHAIR FRANK MARROCCO: Yeah,
21 I perhaps misspoke. I think that's what I was
22 getting at was agency staff and suggesting that
23 they were more of a problem is perhaps a calmer
24 way of expressing the way it was expressed to us.

25 But my concern is though that this is

1 such a long-standing fact of life in long-term
2 care. My concern is that there's not an
3 appreciation of why that is. Because you can't
4 address it until you know why the reality is
5 expressing itself this way.

6 It's such an ingrained fact, across
7 certainly the for-profit sector, unless you know
8 why it's been that way for so long there seems
9 to be no real data around why this is. It's
10 just anecdotal.

11 MINISTER MERRILEE FULLERTON: And
12 that's such an important point. Because, first
13 of all, agency staff make up about 2 percent of
14 the workforce for long-term care, so it's not a
15 high workforce but it's the data.

16 And if you look around the world it's
17 the same thing. There is very little data about
18 how the long-term care system functions. It's
19 not unique to Ontario. It's not unique to
20 Canada. It's around the world, from what I have
21 studied. And so I think it really speaks to a
22 neglected sector that we need the data, we need
23 to modernize the sector and its capacity, it's
24 staffing, it's integration, it's innovation.

25 And the data just isn't there. It's

1 shocking actually how little data we had coming
2 in as a new ministry to rely on, very little
3 data.

4 COMMISSION CHAIR FRANK MARROCCO: Well
5 presumably the Ministry of Health didn't have any
6 data either or you would have got it.

7 MINISTER MERRILEE FULLERTON: Yes.

8 COMMISSION CHAIR FRANK MARROCCO: So
9 it's just a problem that, as you say, perhaps
10 speaks to the neglect of the sector more than
11 anything else.

12 MINISTER MERRILEE FULLERTON: Yes.

13 COMMISSION CHAIR FRANK MARROCCO: I'm
14 sorry, Mr. Callaghan, go ahead.

15 JOHN CALLAGHAN: With that I wanted to
16 -- well, actually before I leave that, for the
17 Minister's benefit, you may want to read Dr. Gary
18 Garber's transcript where he talked about -- he
19 was the head of IPAC for Public Health Ontario.
20 And how he would go in and train -- speak to a
21 long-term care community and go back shortly
22 thereafter and there would be a whole new group
23 of people who didn't know what to do. But
24 anyway, you may to take a look at it.

25 MINISTER MERRILEE FULLERTON: I think I

1 did read that. I hear you.

2 JOHN CALLAGHAN: I did want to talk
3 about the structure of long-term care, and it's a
4 bit of a topic that you and the Commissioner
5 touched on already about the future of it.

6 So just to set the stage, we know that
7 there are basically three types of owners, a
8 municipal, not-for-profit and profit. Do you
9 agree with that?

10 MINISTER MERRILEE FULLERTON: Yes.

11 JOHN CALLAGHAN: And we're told that
12 the profit it's a diverse group. There are those
13 that I think Mr. Hilmer said if they owned more
14 than one home was considered a chain, and of
15 course some are bigger than that and some are
16 just single owners. Right, Minister?

17 MINISTER MERRILEE FULLERTON: Yes,
18 that's correct.

19 JOHN CALLAGHAN: I'm just setting the
20 groundwork here.

21 And then we understand that obviously
22 some are traded on public exchanges, correct?

23 MINISTER MERRILEE FULLERTON: Correct.

24 JOHN CALLAGHAN: And some are
25 mission-driven. In other words they're really

1 there because they believe in the sector at a
2 level that is not driven by profit but that just
3 happens to be the vehicle, right?

4 MINISTER MERRILEE FULLERTON: Correct.

5 JOHN CALLAGHAN: And we've talked a
6 little bit about -- and just so people who read
7 the transcript know, there are 355 for-profit and
8 271 not-for-profit which would include municipal,
9 is that about right?

10 MINISTER MERRILEE FULLERTON: Yes.

11 JOHN CALLAGHAN: And that the spend
12 that you spend on this industry, that is the
13 government spends 4.6 billion a year. And there
14 is a co-pay arrangement where residents pay about
15 1.6 billion, is that about right?

16 MINISTER MERRILEE FULLERTON: Correct.

17 DEPUTY MINISTER RICHARD STEELE: Obviou
18 sly this year the spending has been significantly
19 higher. PreCOVID that would be correct.

20 JOHN CALLAGHAN: And there are some 71-
21 to 73,000 residents in long-term care.

22 MINISTER MERRILEE FULLERTON: As we
23 currently know, yes.

24 JOHN CALLAGHAN: And then I think you
25 said there's some 35,000 waiting on waiting

1 lists, right.

2 MINISTER MERRILEE FULLERTON: Yes.

3 JOHN CALLAGHAN: So we met with the
4 FAO, the Financial Accountability Office. And
5 just so that people understand, that the growth
6 of Ontarians between 2011 and 2018 over the age
7 of 75 went up 20 percent but long-term care beds,
8 I think we talked about, went up .8 percent,
9 right? So you inherited a much older population
10 and no appreciable growth in long-term care beds?

11 MINISTER MERRILEE FULLERTON: Correct.

12 JOHN CALLAGHAN: And I just want to
13 talk to you a little bit because we're trying to
14 sort out where the industry's going. And we've
15 been told that -- and I recognize there are lots
16 of different envelopes, but the level-of-care
17 envelopes, which are the principle funding
18 envelopes, it's about -- we were told it was
19 \$184.96 per day as of April; and that it
20 comprised four essential envelopes plus the
21 global per diem. And it includes a nursing and
22 personal care envelope, a raw food envelope, a
23 program and support service envelope, another
24 accommodation envelope and a global per diem. Do
25 you understand that?

1 MINISTER MERRILEE FULLERTON: Yes.

2 JOHN CALLAGHAN: And so we were told
3 that the nursing and personal care, the raw food
4 and the program and support services they are
5 specified envelopes that must be spent on the
6 care of the resident, correct?

7 MINISTER MERRILEE FULLERTON: Correct.

8 JOHN CALLAGHAN: And then of the global
9 per diem of \$4.50 a day, all but 32 percent must
10 be spent on the -- must, by which I mean it's
11 mandatory, must be spent on the care of the
12 resident, right?

13 MINISTER MERRILEE FULLERTON: That's my
14 understanding.

15 JOHN CALLAGHAN: So there's this other
16 accommodation, which is \$56.52. And we
17 understand that that is used by the homes for
18 things like wages, equipment, supplies, that type
19 of thing. But it also for the for-profit homes,
20 that's where the profit comes from; is that
21 right?

22 MINISTER MERRILEE FULLERTON: I'm going
23 to comment on that for clarification. Because I
24 think there is a sense that the for-profit homes,
25 and I'm not defending anywhere here; I just think

1 it needs to be clear, that the for-profit homes
2 are making large amounts of profit and,
3 therefore, are paying out dividends.

4 Many of the chains that are for-profit
5 also have a retirement home piece.

6 JOHN CALLAGHAN: Right.

7 MINISTER MERRILEE FULLERTON: And it's
8 the retirement home piece that tends to have more
9 profit.

10 The reason our homes -- one of the
11 reasons our homes did not get rebuilt is that
12 the funding formula didn't work. You couldn't
13 build -- you couldn't buy the land, you couldn't
14 build for the price that was being provided for
15 by government in some cases.

16 So there is a belief that the dollars
17 that the for-profit companies, or the chains,
18 that they're bringing in is all -- it's all
19 profit, and yet that is not the case. And so
20 it's -- if you look at the whole industry it's
21 often the land that they're on, it's often those
22 other assets that are of value over time.

23 And the linkage of the licences are --
24 am I getting too many places?

25 JOHN CALLAGHAN: No, no, no --

1 COMMISSION CHAIR FRANK MARROCCO: No,
2 no, no. Please go on.

3 MINISTER MERRILEE FULLERTON: So one of
4 the issues is that the licences are tied together
5 with the construction funding over a duration of
6 time, 25 years. So it's that linkage that
7 requires the homes to put in an application to
8 rebuild and they can rebuild.

9 And over time they have the value of
10 the land and the building; the building
11 obviously depreciates. But there's an idea that
12 whatever they make in profit is what's going out
13 in a dividend from the long-term care, and it's
14 just not linked like that. So that the license
15 is tied to the construction funding aspect, the
16 capital piece, it does make a very complicated
17 scenario for innovation or changing what we do.

18 DEPUTY MINISTER RICHARD STEELE: I just
19 wanted to clarify your one technical point on
20 Mr. Callaghan's comments in terms of the sources
21 of profit. Absolutely correct that of the
22 funding envelopes the other accommodation is the
23 one where there is some flexibility for profit to
24 be drawn. Important to note thought that a
25 significant source of potential profits would be

1 resident co-pays for preferred accommodation.
2 That is a significant piece of the puzzle as
3 well.

4 JOHN CALLAGHAN: That's not deducted
5 from your contribution? That's in addition to
6 your contribution?

7 DEPUTY MINISTER RICHARD STEELE:

8 That's in addition to our
9 contribution. So this is where somebody is
10 opting for a private room, we pay the same rate,
11 they are basically choosing to upgrade. They
12 are paying -- the co-pay is higher.

13 And again, some of the economics of
14 this for all operators frankly, not just for a
15 private operator, would be the same for a
16 not-for-profit operator. The economics are that
17 they can -- they will make additional revenue
18 from the resident co-pay in that preferred
19 accommodation.

20 JOHN CALLAGHAN: That's funny, because
21 I thought that I read somewhere that the
22 operators prefer the ward rooms because they're
23 more -- which are the basics.

24 MINISTER MERRILEE FULLERTON: Well, I
25 think as we go forward, and certainly under the

1 design standards, the most recent design
2 standards, they can't build four-bed ward rooms.
3 And many of the homes that are in the 1970s
4 vintage unfortunately are in the for-profit
5 sector, but they were not, in many instances that
6 I'm aware of they were not able to get their
7 applications approved to rebuild. So because the
8 licences are tied to the construction, you know,
9 some of them will be coming due. But it's a
10 pretty sticky ball of wax and it's not
11 straightforward.

12 JOHN CALLAGHAN: I'm going come back to
13 that. That actually wasn't where I was going,
14 Minister, when you started.

15 What I wanted to show you was York
16 Region. And I was going to ask you -- and I
17 don't know, Michael, if you can get slide 7 of
18 document -- I think it's 87.

19 It's more of a nuanced question at the
20 moment, although I'll come back to that. There
21 it is.

22 So you'll appreciate that a resident
23 doesn't have a right to just knock on a door and
24 go to a long-term care, they have to go on a
25 list. And, as you know from your own lived

1 experience, you may end up going anywhere
2 depending on the need at the time and where you
3 are on the list, correct?

4 MINISTER MERRILEE FULLERTON: Yes,
5 basically.

6 JOHN CALLAGHAN: Here is what York
7 Region -- York Region, because it's a
8 municipality run as long-term care, as does a lot
9 of them. And you'll see that they add more money
10 than the province into the care of the long-term
11 care residents. The province adds 39.5 percent
12 and York Region gives 46.6 percent.

13 So what I'm asking, Minister, if I'm a
14 resident in York Region and it comes my turn and
15 I end up in a for-private (sic) home, or I end
16 up at York Region, why should that differential
17 of care cost come about? What -- how is that
18 equitable?

19 MINISTER MERRILEE FULLERTON: Important
20 question. The municipal homes are -- have the
21 ability to -- they function somewhat different in
22 terms of their labour negotiations, in terms of
23 their ability to levy taxes. And it's -- it is a
24 discrepancy.

25 And I will ask the details from the

1 deputy --

2 DEPUTY MINISTER RICHARD STEELE: Yeah,
3 I saw these numbers yesterday in the document
4 that you provided. Absolutely I think generally
5 true that municipalities supplement provincial
6 funding from the local municipal revenue.

7 I must admit to being somewhat
8 surprised on this table to the degree to which
9 York Region is indicating that the relative
10 proportion of municipal and provincial funding.
11 I've not heard anything like that kind of
12 quantity from many municipalities I've had that
13 conversation with.

14 So I have to say I haven't seen these
15 numbers before yesterday. And I think what I'd
16 want to do with these particular numbers and the
17 magnitude, is sit down with York Region and
18 understand them a bit better before really
19 commenting.

20 Other than in general it is certainly
21 true that many municipalities do supplement
22 provincial funding with local municipal funding,
23 that is absolutely true.

24 JOHN CALLAGHAN: So, I mean, the City
25 of Toronto was last I think it was \$20,000 per

1 year per resident. York Region -- this is a real
2 practical concern. York Region talked about
3 supplementing the fresh food envelope so they
4 could have fresh fruit and vegetables.

5 And I guess the question is, are we
6 undervaluing and underservicing our long-term
7 care residents through the provincial amount
8 when other -- when the municipalities feel
9 obligated to increase 20,000 or 46 percent in
10 accordance with York Region? Is that what's
11 happening, Minister?

12 MINISTER MERRILEE FULLERTON: Well,
13 there's many factors at play here. So certainly
14 a home that has efficiencies of scale, so the
15 size of the home, the number of beds, the
16 efficiencies of scale in terms of being able to
17 provide more people with the same level of
18 service because they can have better processes
19 for food procurement, et cetera. So there's
20 economies of scale for larger groups.

21 We've heard from municipalities, and
22 municipalities are required by law or regulation
23 to have at least one long-term care home. We're
24 hearing from municipalities, some of them, that
25 they do not want to do this any more. It has

1 become too complicated and they don't want to
2 keep going. And some municipalities are doing
3 very well and would like to have more. So there
4 is variation.

5 But just to say that there is a level
6 where there is -- there are economies of scale
7 and that's an important concept, and some
8 municipalities may not have that.

9 JOHN CALLAGHAN: So let me just touch
10 base back on what you just said. We did hear
11 that some municipalities would rather use their
12 tax dollars elsewhere but they're obligated to do
13 it. That did come up in our presentation with
14 the OMA.

15 The economies-of-scale issue is a bit
16 of a prickly one because we're told that the
17 municipal homes are generally larger so they
18 would have economies of scale, which would
19 suggest they should pay less per resident and
20 they're paying more per resident.

21 We were told they did generally pretty
22 much universally better during COVID, not just
23 because they -- I presume they pay their
24 employees more, for example, so they have a
25 happier employee that comes to work. They had

1 surge capacity because in the City of Toronto
2 they took their outside works, or their parks
3 and rec people and they put them in the homes
4 when they were running out of staff. So there
5 are all these other benefits.

6 But the question is, why is there that
7 difference? Why should someone actually get
8 that benefit while others can't?

9 MINISTER MERRILEE FULLERTON: So just
10 to address and clarify the first piece. I
11 believe many of the municipal homes have been
12 upgraded and updated and redeveloped. And just
13 exactly the process why they got to do it and
14 other didn't that's before my time.

15 JOHN CALLAGHAN: Yes.

16 MINISTER MERRILEE FULLERTON: But many
17 of the municipal homes are up-to-date with their
18 standards because they were able to be developed.

19 In terms of the efficiencies of scale,
20 it may not just be within a home, although we do
21 know the homes that are above a hundred tend to
22 have better economies of scale; and the chains
23 would have additional abilities because they
24 have much larger scale when they come together.
25 So there is efficiencies to be found there.

1 As I said, with the municipal homes
2 there's also issues with different types of
3 labour agreements and certainly there are
4 regional differences in costs. We've seen that
5 when we developed the modernized funding model.
6 So there are regional differences as well and I
7 would say there is multiple factors involved
8 here.

9 DEPUTY MINISTER RICHARD STEELE: Certai
10 nly the point you referenced around wage rates
11 would be significant in terms of the cost
12 structure the municipalities are facing, they do
13 pay more and that does mean that their costs are
14 higher.

15 Now, has there been some benefit to
16 that in the context of COVID? Potentially yes
17 in terms of staffing stability. I agree with
18 you, particularly in wage 1 -- in wave 1, excuse
19 me, the ability for municipalities to draw on
20 other resources, once that redeployment
21 authority was put in place through the EMCPA, I
22 think was helpful. It was useful that they had
23 that non-long-term care staffing base to draw
24 on, there's no question.

25 COMMISSION CHAIR FRANK MARROCCO: If I

1 can just ask a question, Mr. Callaghan, are you
2 concerned, and I address it to both, as
3 Mr. Callaghan indicated, we were told by more
4 than one municipality that they contribute money
5 to the cost; at the same time the for-profit
6 operators are able to pay dividends.

7 And I guess we're having some
8 difficulty with how you put the two things
9 together? And I appreciate what you said about
10 retirement residence revenue, but you're not
11 going to put your parent or loved one in a
12 retirement residence -- not put them but support
13 them going in there only to find out that when
14 they're older and sicker they're put back out
15 with no place to go.

16 The long-term care residence is a
17 necessary part of the continuum of care that
18 they need. So you can't be looking for that
19 when you've got a seriously ill person on your
20 hand. So the retirement residence is part of
21 the overall business. But the concern is one
22 group is contributing in money and the other is
23 taking money out.

24 MINISTER MERRILEE FULLERTON: There's
25 many pieces to this. And so when we look at the

1 not-for-profit versus for-profit versus the
2 municipal, you know, with the growing demand of
3 an aging population there is room for many
4 different solutions.

5 And I've often said COVID doesn't
6 identify whether it's for-profit, not-for-profit
7 or municipal. It is largely driven by the
8 community spread, that is the indicator of the
9 most -- the biggest driver for an outbreak in
10 the first place, and then it's the age of the
11 home that is the biggest driver for the severity
12 of the outbreak in terms of, you know, the
13 ongoing aspect of the finances of each home.

14 I would say -- I'm not an expert in
15 that field but I would have to say that when we
16 look at all of these different solutions they
17 are going to be different. They are not all
18 going to be the same. But we need many, many
19 different solutions to provide for an aging
20 population. And we're just going to need
21 everything we've got.

22 DEPUTY MINISTER RICHARD STEELE: I
23 would just add to the Minister's comments, and
24 it's a good question. Important to recognize
25 that all of the sectors, municipal,

1 not-for-profit, for-profit, are all subject to
2 the same expectations, regulatory requirements
3 and expectations around quality.

4 COMMISSION CHAIR FRANK MARROCCO: Yes,
5 we know that.

6 DEPUTY MINISTER RICHARD STEELE: So I
7 think that's an important overlay to the
8 conversation around their cost structures. There
9 are different cost structures. I would say by no
10 means is this -- what you set out as a puzzle
11 perhaps is by no means unique to long-term care.

12 Certainly in my previous ministry,
13 responsible for social assistance, you know, a
14 wide variation amongst municipalities who are
15 responsible for the delivery of Ontario Works
16 around the yearly budget they spent on the
17 program. But, again, all had the same set of
18 requirement in terms of what they were expected
19 to deliver.

20 So I think we do see in a number of
21 programs that the required results can be
22 delivered with different cost and profit
23 structures. That's not, I don't think, unique
24 to long-term care.

25 JOHN CALLAGHAN: You say there are some

1 that have questioned why you would have a real
2 estate investment trust which would then in turn
3 retain a care company. So you have the real
4 estate invest trust, looking to return profit to
5 its unit holders, hiring a for-profit,
6 publicly-traded care company who is returning
7 dividends on the one side, so eating into the
8 envelope, and on the other side, of course, you
9 have York who is adding 46 percent.

10 So, I mean, how is it that we have
11 companies that aren't even involved in the care
12 business in long-term care?

13 MINISTER MERRILEE FULLERTON: That is
14 something that, you know, historically has
15 evolved. But if we're looking forward the
16 magnitude of the problem that we're facing with
17 an aging population it's not going to be one
18 solution, it's going to be many solutions.

19 And, you know, that's where we saw
20 with our community paramedicine program; our
21 long-term care at home, 24-hour, 7-days-a-week
22 emergency response and remote monitoring. We
23 have to look at every single possible solution
24 to address what is coming and what is here
25 already. We're seeing ALC problems in hospitals

1 ramping up now and it's because people are
2 coming from the community. And we need many
3 mechanisms to be able to provide for the numbers
4 that are coming.

5 JOHN CALLAGHAN: So if somebody were to
6 read this transcript, on the "ALC" that's
7 Alternate Level Care, and there are about 4,000
8 sitting in hospital beds and about 2,000 are
9 waiting for long-term care. And I think the stat
10 is they may wait up to 120 days or thereabouts.
11 Have I got that right, Minister?

12 MINISTER MERRILEE FULLERTON: Yeah,
13 140, 150 days on average is the wait for
14 long-term care. It might be slight differences
15 whether you're coming from the community or
16 whether you're coming from a hospital.

17 JOHN CALLAGHAN: And it's part of the
18 hallway health issue you're trying to resolve,
19 correct?

20 MINISTER MERRILEE FULLERTON: Correct.

21 COMMISSION CHAIR FRANK MARROCCO:
22 Mr. Callaghan, the Minister has a commitment at
23 2:00 I think.

24 MINISTER MERRILEE FULLERTON: Yes,
25 thank you.

1 COMMISSION CHAIR FRANK MARROCCO: Where
2 are you?

3 JOHN CALLAGHAN: Let me just ask a
4 couple more questions.

5 Just listening to what you say, we
6 were told that you had to increase the return
7 rate in order to attract investors from 4.1 to
8 7.2 percent. And that is what you're talking
9 about in terms of trying to attract investors
10 into this field? Is that part of what is going
11 on?

12 MINISTER MERRILEE FULLERTON: In part,
13 but essentially the cost of building, the cost of
14 financing the land vary from region to region.
15 And the previous government put out allocations
16 that didn't get built and so, you know, we
17 inherited a design that didn't work for the
18 funding, and that's why we developed the
19 modernized funding model.

20 JOHN CALLAGHAN: So because, you know,
21 the way the structure works the government
22 basically is paying for the care of the resident
23 and may be paying for a large portion of the
24 hoteling, if I can put it that way. And it's
25 been approached to us, why doesn't the government

1 consider a model like Infrastructure Ontario uses
2 for things like courthouses where you would have
3 private sector money to build the infrastructure,
4 or like the Osler Hospital, and they would
5 provide for a care structure akin to a hospital
6 structure? Why wouldn't -- is that type of model
7 being considered? Because that's what has been
8 suggested.

9 MINISTER MERRILEE FULLERTON: So you're
10 probably aware of the accelerated build projects;
11 three locations, four buildings that will go up,
12 321 beds, 1280 in total. And this was another
13 way of leveraging the land that the hospitals
14 already had.

15 But ultimately we have to look at the
16 licences as they're attached to the capital and
17 the construction funding; because those are
18 coupled it makes it far more challenging to look
19 at a different model. And it's a historical --
20 historically that's the way it's been done. And
21 because there are still remnants of that with
22 various homes having certain channel of licences
23 over a duration of time, it would have been
24 receiving them at different times and so they're
25 staggered. So there's that part of it if you

1 really want to understand the movement forward.
2 And I'll let the deputy --

3 DEPUTY MINISTER RICHARD STEELE: I just
4 wanted to make sure I understood the concept of
5 the question, and there's certainly been lots of
6 conversations, as the Minister notes, around
7 different concepts and ways that you can come at
8 the financing and then operation of the
9 development of new facilities.

10 The concept you're setting out is
11 essentially private financing of the
12 construction of a facility but --

13 JOHN CALLAGHAN: Of the hoteling. For
14 owning the facility, for hoteling the residents;
15 and that the care, which is what people seem to
16 be most concerned about, in the hands of the
17 private sector, would be like a hospital or some
18 such approach by those who are expert in care and
19 those who are expert, like Reits are in real
20 estate development.

21 DEPUTY MINISTER RICHARD STEELE: So I
22 do think it's important to, in answer to that
23 question, to clarify again the expectations and
24 requirements of somebody coming into this
25 business.

1 So let's say you are, as you say, a
2 real estate investment trust and you want to get
3 into the business of acquiring a license for a
4 long-term care home. We're not going to allow
5 you to just start running that home on your own.
6 One of the requirements that we have as a
7 ministry to run a home is you actually can
8 demonstrate some experience in running a home.

9 So if you are a private investor that
10 is, as you say, treating this as a -- you're
11 interested in that facility hoteling investment
12 you can do that. You're providing the capital,
13 the much needed capital, as the Minister notes,
14 but you will have to hire an experienced
15 long-term care manager to operate that facility
16 for you.

17 JOHN CALLAGHAN: And that's where some
18 people think there's a disconnect.

19 But let me put this to you, Minister.
20 The FAO says we'll need 55,000 beds by I think
21 it's 2033 if we're going to meet the current
22 demand with the aging population. So why would
23 we worry about being stuck in an old model when
24 if you're going to meet the demand, that's
25 currently the demand, and I appreciate there

1 might be other ways to deal with this issue.

2 Why would you worry about having an old model?

3 MINISTER MERRILEE FULLERTON: I agree
4 in the sense that there is a huge demand going
5 forward so what do we look at? So leveraging the
6 hospital lands; looking at the surplus lands;
7 looking at the accelerated builds; understanding
8 how we can also keep people at home longer with
9 the right supports, with the remote monitoring,
10 with the virtual care, with the community
11 paramedics and the wraparound home care services;
12 and the integration with primary care, and the
13 integration with acute care; understanding that a
14 lot of people want to stay in their hone own
15 home.

16 So when we look at a model where we
17 uncouple the investment of capital from the
18 operations we have to understand what that does.
19 And so, again, complex system. When we do one
20 thing something else happens somewhere else.
21 And so we would need to understand how the
22 operations, how would that -- how would
23 uncoupling that affect the cost of the
24 operational side? That would be -- because we
25 need people to be on the operation side. And so

1 it's a complex concept and I totally agree that
2 we have to look at new ways of doing things.

3 Given the pressures that we had coming
4 in as a new ministry, and understanding the
5 importance of getting the builds there was an
6 urgency, an absolute urgency, to get the shovels
7 in the ground and get going. And we do need to
8 look at what other models are potential, and
9 I've mentioned a few of them, but I agree with
10 you.

11 JOHN CALLAGHAN: I'm just going to
12 finish at least my part and the Commissioners
13 might have questions, by reading you a few more
14 of the snippets that we got from people. Here is
15 one:

16 "Our elderly people shouldn't be
17 treated this way. If I had an animal
18 that was treated like that I would be
19 charged with animal cruelty. There is
20 no excuse for it [...] And I feel bad
21 that I even had to put my mother in
22 there, but I didn't have a choice, and
23 I didn't have a choice of homes
24 either."

25 That was January 14th.

1 "I do believe this is a systemic
2 problem that's been going on for
3 decades. And no one government is to
4 blame totally; they're all in on it.
5 They're all culpable.

6 A change in mindset. We are not
7 doing them -- the residents a favour.
8 They're -- the staff and the
9 administration are not doing the
10 residents a favour by caring for them
11 or a favour to us. We all owe them.
12 We have to change the mind set that
13 they deserve a home that they can --
14 they can feel comfortable in, that
15 they can be themselves in [...]."

16 That was family member group meeting
17 on January 19th.

18 Here is another one:

19 "And I just put like a little
20 snippet that says, it is time for the
21 government to start treating the
22 residents of long-term care like they
23 would treat someone they love and care
24 about and not like an accused convict.

25 I know that they are not treating

1 their own families like this. Why are
2 we any different?"

3 And that was a residents group on
4 January 27th.

5 And here is on, maybe the most
6 poignant:

7 "And finally I encourage you take
8 a brave and different path from what
9 has been chosen in the past, one that
10 can transcend partisan politics and be
11 a model of care excellence in the
12 long-term care sector."

13 And we heard that on January 25th.

14 And I just leave you with those
15 because you should know your Commissioners have
16 gone to great lengths to try to listen to the
17 people you've asked them to consult; the
18 families, the residents, the staff, the
19 industry. And I know you're listening so I hope
20 you will take that to heart.

21 MINISTER MERRILEE FULLERTON:

22 Absolutely and I -- it's -- this era
23 has been such an emotional time. It has been an
24 emotional time for so many team, and I'm sure
25 it's been emotional for all of you at times.

1 And we have to come out of this
2 stronger. People's lives cannot be lost in
3 vain. And there will be good things that must
4 come from this. Thank you.

5 COMMISSION CHAIR FRANK MARROCCO: Thank
6 you.

7 First of all, I think the other
8 Commissioners would have asked questions if they
9 were so inclined. So let me say thank you to
10 both of you for the time. It is an emotional
11 time because when we go to these meetings with
12 residents and families, especially the families,
13 and the workers, I shouldn't have said
14 especially, the workers too. It does move you
15 no matter who you are, no matter what your
16 experience is, no matter what you think you've
17 heard in the past. It's an experience that
18 leaves a mark on you.

19 So we will thank you for giving us a
20 perspective that we didn't have before, which is
21 sort of the perspective of the Minister and the
22 ministry. And we will report back, as you have
23 requested, Minister, and thank you for your
24 time.

25 MINISTER MERRILEE FULLERTON: Thank you

1 so much.

2 DEPUTY MINISTER RICHARD STEELE: Thank
3 you.

4 MINISTER MERRILEE FULLERTON: And
5 appreciate all your efforts. People have to
6 matter and they're at the centre. Thank you.

7 COMMISSION CHAIR FRANK MARROCCO: Thank
8 you.

9 COMMISSIONER JACK KITTS: Thank you.

10 COMMISSIONER ANGELA COKE: Thank you.

11

12 --- Meeting ended at 1:56 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, HELEN MARTINEAU, CSR, Certified
4 Shorthand Reporter, certify;

5 That the foregoing meeting was taken
6 before me at the time and date therein set
7 forth;

8 All discussions had by the
9 participants were recorded stenographically by
10 me and were thereafter transcribed;

11 That the foregoing is a true and
12 accurate transcript of my shorthand notes so
13 taken. Dated this 26th day of February, 2021.

14
15
16  _____

17 PER: HELEN MARTINEAU
18 CERTIFIED SHORTHAND REPORTER.

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

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Page 21, line 15: "15,000 new beds" not
"15,000 beds"

Page 30, line 16: "tied to the Ministry of
Health" not "ties to the
Ministry of Health"

Page 36, lines 4-5: "a Minister's directive, a
directive from the Chief
Medical Officer of Health"
not "a Minister's directive
from the Chief Medical
Officer of Health"

Page 43, lines 3-4: "Correct." not "Correc t."

Page 44, line 24: "on an ad hoc basis" not "on
an ad hoc way basis"

Page 46, line 5: "were considering during
COVID" not "were considering
COVID"

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

(Continued)

1
2
3
4 Page 54, line 4: "what were the impacts?" not
5 "what were the impact?"
6

7 Page 63, line 3: "RNAO portal" not "RMAO
8 portal"
9

10 Page 77, line 25: "concerned about" not
11 "concerned around"
12

13 Page 78, line 5: "it could be met through the
14 Easter weekend." not "it
15 could be through the Easter
16 weekend."
17

18 Page 83, lines 15-16: "call on Extendicare"
19 not "call an
20 Extendicare"
21

22 Page 105, line 23-24: "and respect their
23 wishes" not "and
24 respectful of their
25 wishes"

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

(Continued)

Page 107, line 3: "look at decanting" not
"looking at decanting"

Page 116, line 24: "There are a few" not "They
are a few"

Page 118, line 14: "lots of boots" not "loots
of boots"

Page 126, line 1: "you're saying" not "you've
saying"

Page 131, line 10: "training programs" not "a
training programs"

Page 133, line 5: "need to do" not "need do"

Page 140, line 2: "resident aides" not
"resident aids"

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

(Continued)

1
2
3
4 Page 162, line 25: "defending anyone here;"
5 not "defending anywhere
6 here"

7
8 Page 164, line 24: "to note, though," not "to
9 note thought"

10
11 Page 174, line 23: "just add" not "justs add"

12
13 Page 175, line 18: "requirements" not
14 "requirement"

15
16 Page 182, lines 14-15: "their own home" not
17 "their hone own home"

18
19 Page 185, line 24: "so many people" not "so
20 many team"

21
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