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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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom video conference, with all participants attending remotely, on the 26th day of February, 2021, 10:00 a.m. to 2:00 p.m.

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

MINISTRY OF LONG-TERM CARE:
The Honourable Merrilee Fullerton, Minister of Long-Term Care
Richard Steele, Deputy Minister of Long-Term Care

COUNSEL:
Kristin Smith, Counsel, Ministry of Health/Ministry of Long-Term Care
Amy Leamen, Counsel, Ministry of Health/Ministry of Long-Term Care
Sunil Mathai, Counsel, Ministry of Attorney General
Eric Wagner, Counsel, Ministry of Attorney General
Ann Christian-Brown, Counsel, Ministry of the Attorney General
Michele Valentini, Counsel, Ministry of Attorney General

Stephanie Figliomeni, Counsel, Ministry of Health/Ministry of Long-Term Care
Roopa Mann, Counsel, Ministry of the Attorney General
Conner Scott, Articling student, Ministry of Health / Ministry of Long-Term Care

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
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Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angeline Hawthorn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat

John Callaghan, Co-Lead Commission Counsel, Gowling WLG
Lynn Mahoney, Counsel, Gowling WLG
Michael Finley, Counsel, Gowling WLG
Peter Gross, Counsel, Gowling, WLG
Patricia Brooks, Counsel, Gowling WLG

ALSO PRESENT:
Helen Martineau, Stenographer/Transcriptionist

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

COMMISSION CHAIR FRANK MARROCCO: Minister, and, Deputy Steele, I'll take a break about every hour and 15 minutes. It gives the reporter a chance to catch her breath and the rest of us a brief 5 or 10 minutes to regroup.

DEPUTY MINISTER RICHARD STEELE: Okay.

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

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

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

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

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

a little bit about your background?

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

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

I was able to have the opportunity to help with the HIN1 outbreak back in, I guess that would be 2009 or so, and working with the City of Ottawa and Public Health at that time. And so that was a very meaningful experience.

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

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: That's very helpful.

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

JOHN CALLAGHAN: Then I have to get

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

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

MINISTER MERRILEE FULLERTON: Certainly .

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

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

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

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

MINISTER MERRILEE FULLERTON: Remembers it well, yeah.

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

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

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

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

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

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

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

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

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

> "Under OIC 1157/2009, the Minister of Health and Minister of Long-Term Care have been assigned the responsibility for the formulation of emergency plans in respect of:
> Human health, disease, epidemics.
> Health services during an emergency.
> Ministry continuity of operations."

And then it says the:

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

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

Following down, it says:

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes, yes.

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

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

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

JOHN CALLAGHAN: Were you aware that

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

-- [TECHNICAL ISSUES]

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

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

MINISTER MERRILEE FULLERTON: No, no.

I'll ask the Deputy if he did.

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

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Yes,

absolutely.

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

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

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

MINISTER MERRILEE FULLERTON: Absolutel y, absolutely.

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

MINISTER MERRILEE FULLERTON: Absolutel y, yes.

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

MINISTER MERRILEE FULLERTON: Between

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

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

MINISTER MERRILEE FULLERTON: 15,000, yes.

JOHN CALLAGHAN: One five.

MINISTER MERRILEE FULLERTON: Yes, 15, one five.

JOHN CALLAGHAN: Right. And redevelop another 15.

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

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

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

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

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

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

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

So we were dependent on the Ministry

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Pardon me?

JOHN CALLAGHAN: Tab 31, Michael.

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

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

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

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

JOHN CALLAGHAN: Yes, page 76.

It says:

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

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

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

were guidelines issued to our long-term care homes.

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

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

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

JOHN CALLAGHAN: And then she goes on to say:

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

And that was something that we were --

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

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

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

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

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

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

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

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

> "And I think that in a nutshell reflects the challenge that faced long-term care in the early stages of the pandemic. By creating a kind of separate, stand-alone, tiny Ministry that really is just the inspectorate, plus some specialized policy and funding expertise, I don't think it will have -- I don't think history will judge the decision last summer -- a year ago last summer to create a stand-alone long-term care ministry as having been a wise one.
>
> "I think that its separation from the Ministry of Health has created systemic kind of silos and barriers to integrated

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

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

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

It was the Ministry of Health and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yeah.

JOHN CALLAGHAN: -- during that period.

MINISTER MERRILEE FULLERTON: Yes.

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

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

JOHN CALLAGHAN: So we have had an opportunity --

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

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

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

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: We did

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

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

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

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

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

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

asymptomatic spread by February 5th?

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

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

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

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

JOHN CALLAGHAN: And we've talked to

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

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

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

But I'm not the expert. And I

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

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

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

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Specifica lly about locking down?

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

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

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

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

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

MINISTER MERRILEE FULLERTON: It was very close, yeah.

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: Yes.

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

DEPUTY MINISTER RICHARD STEELE: Right.

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

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

JOHN CALLAGHAN: So those are part of

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

DEPUTY MINISTER RICHARD STEELE: Correct.

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

DEPUTY MINISTER RICHARD STEELE: Correct. Once the state of emergency was declared, then that became another route or another tool that could be used to provide direction through emergency orders.

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

DEPUTY MINISTER RICHARD STEELE: Correct.

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

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

MINISTER MERRILEE FULLERTON: I'm

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

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

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

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

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

"The panel heard that the problem of casualization is most severe in long-term care and community care sectors but remains a concern across all sectors of care. Those employed on a casual basis tend to work at multiple sites raising the spectre of healthcare workers transmitting the disease. Although there was no definitive incident of such transmission during SARS, many submissions to the panel expressed concern that it could easily have happened and the risks are too high."

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

MINISTER MERRILEE FULLERTON: Agreed,

yes.

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

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

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

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

JOHN CALLAGHAN: Right. And -- and the

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

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

JOHN CALLAGHAN: But --

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

I don't think it would be accurate to

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

MINISTER MERRILEE FULLERTON: Thank you.

I think we really had to understand

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

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

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

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

JOHN CALLAGHAN: So, well, let's just

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

You're writing Dr. Williams and you say:

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

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

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

JOHN CALLAGHAN: April 2nd.

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: I

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

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

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

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

If you go down to the last bullet point.

> "Further support for limiting staff working multiple locations. Our

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

Again, as we were having these

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

calling the community spread at that time.

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But there was ongoing efforts in the

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: Michael, if you could

put that document back up?

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

DEPUTY MINISTER RICHARD STEELE: Correc t.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: Yup.

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

And given what we talked about with

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

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

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

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

JOHN CALLAGHAN: I think people

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

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

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

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

MINISTER MERRILEE FULLERTON: Thank you, Commissioner.

DEPUTY MINISTER RICHARD STEELE: Thank

you.

-- RECESSED AT 11:28 A.M.

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

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

JOHN CALLAGHAN: Thank you.

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

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

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: We did.

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

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

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

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

JOHN CALLAGHAN: So Revera told us, and

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

DEPUTY MINISTER RICHARD STEELE: Delivery of PPE?

JOHN CALLAGHAN: Right.

DEPUTY MINISTER RICHARD STEELE: Correct.

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

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

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

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

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

But one issue we have heard that falls

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

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: We

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

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

DEPUTY MINISTER RICHARD STEELE: Yes.

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

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

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

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

So there is certainly the mechanisms

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

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

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

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

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

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

To the --

JOHN CALLAGHAN: Can I ask on that?

DEPUTY MINISTER RICHARD STEELE: Yes.

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

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

MICHAEL FINLEY: It may be document F,

John. Is this the Order?

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

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

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

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

And it talks about using:

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

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

DEPUTY MINISTER RICHARD STEELE: Sure.

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

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

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

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

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

And that's --

JOHN CALLAGHAN: That's this order here?

DEPUTY MINISTER RICHARD STEELE: Sorry?

JOHN CALLAGHAN: That's what this order here?

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: Okay.

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

MINISTER MERRILEE FULLERTON: May I add something?

COMMISSION CHAIR FRANK MARROCCO: Sorry, is that --

MINISTER MERRILEE FULLERTON: It's Minister Fullerton.

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

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

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

DEPUTY MINISTER RICHARD STEELE: What

sometimes --

COMMISSION CHAIR FRANK MARROCCO: Well go ahead, Deputy.

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

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

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

further or are you going on to another --

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

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

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

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

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

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

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

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

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

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

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

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

So we had -- there had been initiated

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

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

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

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

And so we were -- we were seeing more

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

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: Can

I --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

excuse me.

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

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

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

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

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

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

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Certainly .

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

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

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

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

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

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

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

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

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

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

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

And yet the acuity of the residents

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Thank you.

MINISTER MERRILEE FULLERTON: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: I just want to make

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

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

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

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

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: I can speak to that.

MINISTER MERRILEE FULLERTON: I'll ask the Deputy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So it was always something we had to

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

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

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

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

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

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

So that was happening as we headed into Wave 2.

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

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

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

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

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

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

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

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

And we absolutely have to understand

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

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

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

But what is your view as to how and

who should be doing IPAC and environmental inspections particularly?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So here is one:

"I left the other day and I came

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

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

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

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

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

be a workable, workable isolation plan."

Another January 28th.

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

Here is another one.

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

We heard that on February 11:

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

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

And the next day the DOC had us -- made us come in her office. And she showed me all the PPE that she locked up and she told me that none of us would be getting any of it."

We heard that on February 11th.

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

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

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

We heard that on February 11th.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It has to be an understanding that the

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

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

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

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

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

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

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

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

And when you go into some of the homes

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

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

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

MINISTER MERRILEE FULLERTON: Yes, yes.

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

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Right.

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

MINISTER MERRILEE FULLERTON: Yes, that's correct.

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

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

MINISTER MERRILEE FULLERTON: Correct.

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

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

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

JOHN CALLAGHAN: Thank you, that's helpful.

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

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

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

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

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

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

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

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

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

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

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

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

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

gone on staffing. So that was a key element.

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

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

But relevant to this point, we

maintain homes funding as if they were fully occupied.

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

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

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

Public Health region is the biggest indicator for outbreak potential.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that's about 27,000 extra staff.

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes, 20 percent.

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

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

And I'll let the --

DEPUTY MINISTER RICHARD STEELE: It's

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

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

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

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

JOHN CALLAGHAN: And the Ontario Nurses

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

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

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

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

MINISTER MERRILEE FULLERTON: Agreed. Understood.

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Yes.

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

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

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

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

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

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

But my concern is though that this is

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Yes.

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

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

MINISTER MERRILEE FULLERTON: I think I

did read that. I hear you.

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

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Yes, that's correct.

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

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

MINISTER MERRILEE FULLERTON: Correct.

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

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

MINISTER MERRILEE FULLERTON: Correct.

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Correct.

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

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

MINISTER MERRILEE FULLERTON: As we currently know, yes.

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

lists, right.

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Correct.

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

MINISTER MERRILEE FULLERTON: Yes.

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

MINISTER MERRILEE FULLERTON: Correct.

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

MINISTER MERRILEE FULLERTON: That's my understanding.

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

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

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

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

JOHN CALLAGHAN: Right.

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

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

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

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

JOHN CALLAGHAN: No, no, no --

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

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

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

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

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

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

DEPUTY MINISTER RICHARD STEELE: That's in addition to our contribution. So this is where somebody is opting for a private room, we pay the same rate, they are basically choosing to upgrade. They are paying -- the co-pay is higher.

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

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

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

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

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

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

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

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

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

MINISTER MERRILEE FULLERTON: Yes, basically.

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

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

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

And I will ask the details from the

deputy --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JOHN CALLAGHAN: Yes.

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: If I

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

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

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

MINISTER MERRILEE FULLERTON: There's many pieces to this. And so when we look at the

not-for-profit versus for-profit versus the municipal, you know, with the growing demand of an aging population there is room for many different solutions.

And I've often said COVID doesn't identify whether it's for-profit, not-for-profit or municipal. It is largely driven by the community spread, that is the indicator of the most -- the biggest driver for an outbreak in the first place, and then it's the age of the home that is the biggest driver for the severity of the outbreak in terms of, you know, the ongoing aspect of the finances of each home.

I would say -- I'm not an expert in that field but I would have to say that when we look at all of these different solutions they are going to be different. They are not all going to be the same. But we need many, many different solutions to provide for an aging population. And we're just going to need everything we've got.

DEPUTY MINISTER RICHARD STEELE: I would justs add to the Minister's comments, and it's a good question. Important to recognize that all of the sectors, municipal,

not-for-profit, for-profit, are all subject to the same expectations, regulatory requirements and expectations around quality.

COMMISSION CHAIR FRANK MARROCCO: Yes, we know that.

DEPUTY MINISTER RICHARD STEELE: So I think that's an important overlay to the conversation around their cost structures. There are different cost structures. I would say by no means is this -- what you set out as a puzzle perhaps is by no means unique to long-term care.

Certainly in my previous ministry, responsible for social assistance, you know, a wide variation amongst municipalities who are responsible for the delivery of Ontario Works around the yearly budget they spent on the program. But, again, all had the same set of requirement in terms of what they were expected to deliver.

So I think we do see in a number of programs that the required results can be delivered with different cost and profit structures. That's not, I don't think, unique to long-term care.

JOHN CALLAGHAN: You say there are some

that have questioned why you would have a real estate investment trust which would then in turn retain a care company. So you have the real estate invest trust, looking to return profit to its unit holders, hiring a for-profit, publicly-traded care company who is returning dividends on the one side, so eating into the envelope, and on the other side, of course, you have York who is adding 46 percent.

So, I mean, how is it that we have companies that aren't even involved in the care business in long-term care?

MINISTER MERRILEE FULLERTON: That is something that, you know, historically has evolved. But if we're looking forward the magnitude of the problem that we're facing with an aging population it's not going to be one solution, it's going to be many solutions.

And, you know, that's where we saw with our community paramedicine program; our long-term care at home, 24-hour, 7-days-a-week emergency response and remote monitoring. We have to look at every single possible solution to address what is coming and what is here already. We're seeing ALC problems in hospitals

ramping up now and it's because people are coming from the community. And we need many mechanisms to be able to provide for the numbers that are coming.

JOHN CALLAGHAN: So if somebody were to read this transcript, on the "ALC" that's Alternate Level Care, and there are about 4,000 sitting in hospital beds and about 2,000 are waiting for long-term care. And I think the stat is they may wait up to 120 days or thereabouts. Have I got that right, Minister?

MINISTER MERRILEE FULLERTON: Yeah, 140, 150 days on average is the wait for long-term care. It might be slight differences whether you're coming from the community or whether you're coming from a hospital.

JOHN CALLAGHAN: And it's part of the hallway health issue you're trying to resolve, correct?

MINISTER MERRILEE FULLERTON: Correct.

COMMISSION CHAIR FRANK MARROCCO: Mr. Callaghan, the Minister has a commitment at 2:00 I think.

MINISTER MERRILEE FULLERTON: Yes, thank you.

COMMISSION CHAIR FRANK MARROCCO: Where are you?

JOHN CALLAGHAN: Let me just ask a couple more questions.

Just listening to what you say, we were told that you had to increase the return rate in order to attract investors from 4.1 to 7.2 percent. And that is what you're talking about in terms of trying to attract investors into this field? Is that part of what is going on?

MINISTER MERRILEE FULLERTON: In part, but essentially the cost of building, the cost of financing the land vary from region to region. And the previous government put out allocations that didn't get built and so, you know, we inherited a design that didn't work for the funding, and that's why we developed the modernized funding model.

JOHN CALLAGHAN: So because, you know, the way the structure works the government basically is paying for the care of the resident and may be paying for a large portion of the hoteling, if I can put it that way. And it's been approached to us, why doesn't the government

consider a model like Infrastructure Ontario uses for things like courthouses where you would have private sector money to build the infrastructure, or like the Osler Hospital, and they would provide for a care structure akin to a hospital structure? Why wouldn't -- is that type of model being considered? Because that's what has been suggested.

MINISTER MERRILEE FULLERTON: So you're probably aware of the accelerated build projects; three locations, four buildings that will go up, 321 beds, 1280 in total. And this was another way of leveraging the land that the hospitals already had.

But ultimately we have to look at the licences as they're attached to the capital and the construction funding; because those are coupled it makes it far more challenging to look at a different model. And it's a historical -- historically that's the way it's been done. And because there are still remnants of that with various homes having certain channel of licences over a duration of time, it would have been receiving them at different times and so they're staggered. So there's that part of it if you

really want to understand the movement forward. And I'll let the deputy --

DEPUTY MINISTER RICHARD STEELE: I just wanted to make sure I understood the concept of the question, and there's certainly been lots of conversations, as the Minister notes, around different concepts and ways that you can come at the financing and then operation of the development of new facilities.

The concept you're setting out is essentially private financing of the construction of a facility but --

JOHN CALLAGHAN: Of the hoteling. For owning the facility, for hoteling the residents; and that the care, which is what people seem to be most concerned about, in the hands of the private sector, would be like a hospital or some such approach by those who are expert in care and those who are expert, like Reits are in real estate development.

DEPUTY MINISTER RICHARD STEELE: So I do think it's important to, in answer to that question, to clarify again the expectations and requirements of somebody coming into this business.

So let's say you are, as you say, a real estate investment trust and you want to get into the business of acquiring a license for a long-term care home. We're not going to allow you to just start running that home on your own. One of the requirements that we have as a ministry to run a home is you actually can demonstrate some experience in running a home.

So if you are a private investor that is, as you say, treating this as a -- you're interested in that facility hoteling investment you can do that. You're providing the capital, the much needed capital, as the Minister notes, but you will have to hire an experienced long-term care manager to operate that facility for you.

JOHN CALLAGHAN: And that's where some people think there's a disconnect.

But let me put this to you, Minister. The FAO says we'll need 55,000 beds by I think it's 2033 if we're going to meet the current demand with the aging population. So why would we worry about being stuck in an old model when if you're going to meet the demand, that's currently the demand, and I appreciate there

might be other ways to deal with this issue. Why would you worry about having an old model?

MINISTER MERRILEE FULLERTON: I agree in the sense that there is a huge demand going forward so what do we look at? So leveraging the hospital lands; looking at the surplus lands; looking at the accelerated builds; understanding how we can also keep people at home longer with the right supports, with the remote monitoring, with the virtual care, with the community paramedics and the wraparound home care services; and the integration with primary care, and the integration with acute care; understanding that a lot of people want to stay in their hone own home.

So when we look at a model where we uncouple the investment of capital from the operations we have to understand what that does. And so, again, complex system. When we do one thing something else happens somewhere else. And so we would need to understand how the operations, how would that -- how would uncoupling that affect the cost of the operational side? That would be -- because we need people to be on the operation side. And so

it's a complex concept and I totally agree that we have to look at new ways of doing things.

Given the pressures that we had coming in as a new ministry, and understanding the importance of getting the builds there was an urgency, an absolute urgency, to get the shovels in the ground and get going. And we do need to look at what other models are potential, and I've mentioned a few of them, but I agree with you.

JOHN CALLAGHAN: I'm just going to finish at least my part and the Commissioners might have questions, by reading you a few more of the snippets that we got from people. Here is one:

> "Our elderly people shouldn't be treated this way. If I had an animal that was treated like that I would be charged with animal cruelty. There is no excuse for it [...] And I feel bad that I even had to put my mother in there, but I didn't have a choice, and I didn't have a choice of homes either."
>
> That was January 14th.

"I do believe this is a systemic problem that's been going on for decades. And no one government is to blame totally; they're all in on it. They're all culpable.

A change in mindset. We are not doing them -- the residents a favour. They're -- the staff and the administration are not doing the residents a favour by caring for them or a favour to us. We all owe them. We have to change the mind set that they deserve a home that they can -- they can feel comfortable in, that they can be themselves in [...]."

That was family member group meeting on January 19th.

Here is another one:

"And I just put like a little snippet that says, it is time for the government to start treating the residents of long-term care like they would treat someone they love and care about and not like an accused convict.

I know that they are not treating

their own families like this. Why are we any different?"

And that was a residents group on January 27th.

And here is on, maybe the most poignant:

"And finally I encourage you take a brave and different path from what has been chosen in the past, one that can transcend partisan politics and be a model of care excellence in the long-term care sector."

And we heard that on January 25th.

And I just leave you with those because you should know your Commissioners have gone to great lengths to try to listen to the people you've asked them to consult; the families, the residents, the staff, the industry. And I know you're listening so I hope you will take that to heart.

MINISTER MERRILEE FULLERTON:

Absolutely and I -- it's -- this era has been such an emotional time. It has been an emotional time for so many team, and I'm sure it's been emotional for all of you at times.

And we have to come out of this stronger. People's lives cannot be lost in vain. And there will be good things that must come from this. Thank you.

COMMISSION CHAIR FRANK MARROCCO: Thank you.

First of all, I think the other Commissioners would have asked questions if they were so inclined. So let me say thank you to both of you for the time. It is an emotional time because when we go to these meetings with residents and families, especially the families, and the workers, I shouldn't have said especially, the workers too. It does move you no matter who you are, no matter what your experience is, no matter what you think you've heard in the past. It's an experience that leaves a mark on you.

So we will thank you for giving us a perspective that we didn't have before, which is sort of the perspective of the Minister and the ministry. And we will report back, as you have requested, Minister, and thank you for your time.

MINISTER MERRILEE FULLERTON: Thank you

so much.

DEPUTY MINISTER RICHARD STEELE: Thank you.

MINISTER MERRILEE FULLERTON: And appreciate all your efforts. People have to matter and they're at the centre. Thank you.

COMMISSION CHAIR FRANK MARROCCO: Thank you.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

--- Meeting ended at 1:56 p.m.

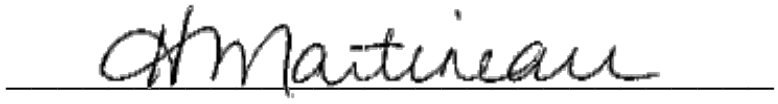
REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing meeting was taken before me at the time and date therein set forth;

All discussions had by the participants were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and accurate transcript of my shorthand notes so taken. Dated this 26th day of February, 2021.



PER: HELEN MARTINEAU

CERTIFIED SHORTHAND REPORTER.

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

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)

Page 54, line 4: "what were the impacts?" not "what were the impact?"

Page 63, line 3: "RNAO portal" not "RMAO portal"

Page 77, line 25: "concerned about" not "concerned around"

Page 78, line 5: "it could be met through the Easter weekend." not "it could be through the Easter weekend."

Page 83, lines 15-16: "call on Extendicare" not "call an Extendicare"

Page 105, line 23-24: "and respect their wishes" not "and respectful of their 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)

Page 162, line 25: "defending anyone here;" not "defending anywhere here"

Page 164, line 24: "to note, though," not "to note thought"

Page 174, line 23: "just add" not "justs add"

Page 175, line 18: "requirements" not "requirement"

Page 182, lines 14-15: "their own home" not "their hone own home"

Page 185, line 24: "so many people" not "so many team"

WORD INDEX