OLTCA

Letter of Transmittal

To the Commissioners:

The impact of COVID-19 on the residents of Ontario's long-term care homes has been devastating. The lives of tens of thousands of residents, their loved ones, and the staff who care for them have been changed forever by the events of the last 12 months. We must never forget those individuals who have lost their lives and those they have left behind. We must honour loss and sacrifice by resolving to work together to build a stronger system of care for our most vulnerable citizens.

On behalf of our members, the Ontario Long Term Care Association (OLTCA) has conducted an extensive analysis of what happened – to understand the root causes and develop targeted solutions. The tragic losses of life call for a meticulous evaluation and clear accountability. As part of our collective assessment, we must remember that the real villain is COVID-19. Around the world, this faceless monster attacked our most vulnerable members of society, our seniors, most harshly. Their suffering and death will not go forgotten, and may be honoured by bringing urgent, creative, sustained, positive changes to seniors' care in Canada and around the world.

COVID-19 has been a global phenomenon. As countries around the world scrambled to prepare their health systems for COVID-19, mistakes were made that are easily recognized in hindsight. An international assessment concluded that, "with few exceptions, the initial response to COVID-19 in nursing homes was slow to develop."[i] Many jurisdictions applied "a narrow focus" on averting a crisis of capacity in hospitals. The consequences of this approach were grave and highlighted the historic vulnerabilities of each of our health and seniors' care systems and the impact of ageism. Organizations such as the Global Ageing Network (GAN) and others have long highlighted the prevalence of ageism in our society. Through the pandemic, representatives from the GAN met regularly to share experience in an effort to quickly learn and prevent suffering and loss of life. One clear root cause has consistently emerged: many seniors' care systems have been vulnerable due to a historic lack of prioritization, support and investment. With a growing seniors' population globally, the long-term care and nursing home systems that care for our most fragile and vulnerable seniors have been placed under significant pressure. As a global society, we have undermined the value of these systems, focusing our attention and investment on other parts of the health system and on caring for the younger members of our society. If we truly care for our seniors and believe that our society should honour the contributions and sacrifices they have made for our families, communities and the world, we must make seniors' care a shared priority.

In Ontario, we have a learned a lot in the past 12 months and we continue learning. The OLTCA supported the establishment of an independent commission to understand the COVID-19 response, address the longstanding issues highlighted by COVID-19, and – most importantly – recommend immediate actions to safeguard against further tragedies. We want to thank you for your commitment to bring forward recommendations for immediate action through your two interim reports. We also want to thank you for the opportunity to present to the Commission on our learnings, our recommended action plan and the importance of capital renewal. We want to take the opportunity to recognize the enormous burden the events of the past 12 months have placed on those in positions of leadership and public responsibility. Health care leaders across the clinical, administrative, and political domains have faced circumstances few thought they would ever encounter. Imperfect decisions were not the result of a callous disregard for the most vulnerable. We believe that Premier Ford and Minister Fullerton are deeply committed to learning from the events of the past year and to strengthening long-term care in Ontario. This Commission demonstrates a determination to learn from our shared experience and the tragic loss of life due to COVID-19 in long-term care. The historic level of investments made in long-term care since the pandemic began are evidence of the government's commitment to improving and transforming long-term care for the benefit of our seniors. We look forward to continuing to work with government, residents, families and health system partners to advance the implementation of your forthcoming recommendations.

Finally, we wish to share our grave concerns about the politicization of our sector and the voices that aim to oversimplify the challenges facing long-term care in an effort to assign blame. These voices serve to divide a sector and threaten to disrupt and destabilize it further at a time when we all must be working together to protect our seniors today and mobilize immediately to modernize our systems of care for our ageing population for tomorrow. This is our collective responsibility.

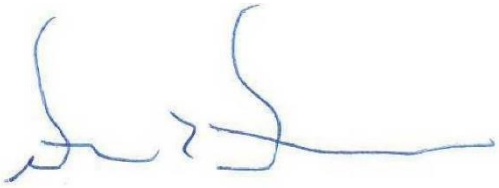
The OLTCA represents municipal, non-profit, and private operators. The key challenges we face are shared by all of our members. Research and analysis by OLTCA and the Ontario Science Table shows that community rate of transmission is the single largest contributor to outbreaks in long-term care homes – not ownership model.[ii] As we seek to understand the true causes, identify solutions that truly address them, and advance those remedies, we must be cautious not to misinterpret correlation for causation. The same research shows that once in a long-term care home, COVID-19 results in greater cases and tragic loss of life in homes that are older and more crowded. Our older homes have three- and four-person rooms and significantly less space throughout the facilities – they are half the square footage of homes built to the current standard. It is these factors that are the true causes of vulnerability in long-term care homes. The partial analysis cited by some that suggests private long-term care homes performed worst in COVID-19 and therefore private operations should be eliminated is misleading and dangerous. Private homes represent 75% of the older spaces that urgently need to be redeveloped. These homes had been identified for redevelopment more than a decade ago but have not moved forward because of a lack of approval and support from previous governments. The solution we need to focus on is implementing this government's enhanced capital program and its $1.75 billion commitment to kick start capital renewal of our long-term care homes, as well as to rebuild our work force.

While we should be careful, respectful and humble about attributing responsibility for failure, we must also be ambitious in our aspirations for change. We have a rapidly ageing population, with a growing need for investment and innovation in models of care and support. We have investments from government

that are laying the groundwork to redevelop our facilities, improve care, and make long-term care a great place to work. We can develop a markedly different long-term care system for the vulnerable Ontarians who require our care. The OLTCA looks forward to working closely with the Commission, government, health system, community care, post-secondary and other partners, our dedicated staff and their representatives, and with long-term care residents and their loved ones to define a shared vision for the future of care for our ageing population and to begin building the foundations for that future state as quickly as possible.

We have an opportunity to make things much better if we work together. The deliberations and recommendations of this Commission will make a significant contribution to building the strong system of care our residents deserve.

Sincerely,



Brent Gingerich
Chair of the Board
Ontario Long Term Care Association

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OLTCA

Ontario Long Term Care Association Submission to Ontario's Long-Term Care COVID-19 Commission

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Introduction

The impact of COVID-19 has been devastating, and shocking. Our governments, systems, sectors, and organizations were unprepared for the scale and scope of illness and death, lockdown, and economic upheaval. In the weeks following the declaration of a pandemic, dramatic actions were taken across all sectors to care for the ill, protect the most vulnerable, and prevent the spread of COVID-19. Further actions were taken to address the second wave of the pandemic in the autumn of 2020. Mistakes have been made, and we would be wise to learn from them. Despite the hope that is represented by the first stages of a COVID-19 vaccine, we anticipate continued waves and spikes. It is therefore appropriate to carefully analyze how systems and sectors responded to an unanticipated degree of sickness, death, and fear.

By contrast, no one can be shocked by the conditions that made Ontario's long-term care homes particularly vulnerable to COVID-19. The fundamental precarity of our system of long-term care has been documented repeatedly, consistently, and methodically. We know that the challenges facing long-term care homes in Ontario have intensified over the past decade. Provincial funding and policy have simply not kept pace with the changes we see every day in our homes – particularly a resident population with higher needs than ever before. The previous programs to renew older homes and build new facilities have been a failure.

The Ontario Long Term Care Association (OLTCA) represents 70% of the operators of long-term care homes in Ontario. Like the system itself, the OLTCA includes a range of ownership models: private operators, non-profit and charitable organizations, and municipally operated homes. We recognize the important task that government has presented the Ontario Long-Term Care COVID-19 Commission, and we offer the Commission members and officials our full cooperation.

Part A – Executive Summary

Long-term care before the pandemic

Our submission begins with an assessment of our sector pre-pandemic. There has been a broad range of reports documenting the ongoing challenges facing the long-term care sector. Sadly, many of the headlines about long-term care in Ontario in recent years related to the shocking serial murders of long-term care residents in Southwestern Ontario that came to light in 2017. This led to the establishment of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, led by Justice Eileen Gillese. Justice Gillese presented her report to government in July 2019. *Strained but not broken* is a summary of her appraisal of the long-term care system in Ontario. She noted that many staff provide excellent care to residents despite working under significant pressure. We certainly share this assessment.

But the hard work and dedication of so many staff cannot paper over some of the fundamental challenges that the sector faced pre-pandemic. Among them are:

Staffing – Prior to the pandemic, staffing was already the sector's greatest challenge. By any measure (and there are many), the supply of personal support workers and other staff is insufficient to meet the demand for care. These supply challenges are exacerbated by workload and burnout issues, the increased needs of residents, the rigid regulatory provisions that detract from patient care, and barriers to entry for prospective staff. The staffing issue was identified by Justice Gillese, who recommended the government convene experts to examine it in greater detail. The work began in the weeks prior to the pandemic, and was publicly reported in July 2020. This Long-Term Care Staffing Study has informed our plan for long-term action, described below.

Regulatory culture and quality improvement – Long-term care operators acknowledge that the public has a strong interest in protecting the vulnerable adults who live in our homes. Regulations and inspections are justified elements of the long-term care system. Yet the last 10 years have demonstrated that a rigid regulatory regime often has the unintended consequence of detracting from quality resident care. A culture of compliance drives behaviour that aims to reduce future findings of non-compliance. Staff and operators tend to overcorrect to avoid future non-compliance by diverting time from care to documentation and administrative tasks arising from predominantly low-risk inspection findings. These administrative pressures take focus and time away from resident care. Justice Gillese described the urgency of a culture change in long-term care – away from compliance toward a just culture of quality improvement. This is the approach generally pursued in other parts of our health care system.

Operating funds – The most significant change within long-term care homes over the past decade has been the growing needs of residents. This is an indicator that is closely measured, monitored, and reported, so we can be certain that our experiences are confirmed by the data. The intensified need of residents is a result of government policy to support Ontarians to age in their own homes and to delay admission to long-term care. We recognize the critical role of our homes in caring for those with high needs. Our homes strive to play this critical role with available resources. Yet government funding has simply failed to keep pace with the growth in intensity of need. Relative to a decade before, we are providing a comparable level of care to residents with much greater needs.

The mechanism of funding is also problematic. Funding is generally determined by a measure that combines occupancy with need. There is significant resident turnover in long-term care, and the needs of individuals evolve over time. Consequently, year-to-year funding can change significantly, and funding amounts are routinely adjusted well into a fiscal year. This makes planning difficult and makes it difficult for homes to maintain operational stability.

Capital funds – Over the past 10 years, previous governments have established goals to increase the overall supply of long-term care beds, or spaces. Governments have also created a program to redevelop 30,000 spaces to meet current design standards. These programs have failed to achieve their objectives. The previous government's program to upgrade current long-term care spaces resulted in the conversion of fewer than 4.5% of the spaces that do not meet the 1998 standards.[iii] Most notably, current standards do not permit bedrooms for occupancy by three or four persons.

Integration with the health care system – Long-term care homes play a critical role in providing clinical services to many Ontarians with the greatest chronic care needs. The inadequate supply of spaces contributes to hospital overcrowding, since many older patients are required to stay in hospital after their need for hospital care is complete. Yet long-term care homes are poorly integrated with other parts of Ontario's health care system. Successful collaboration with hospitals is the exception rather than the rule.

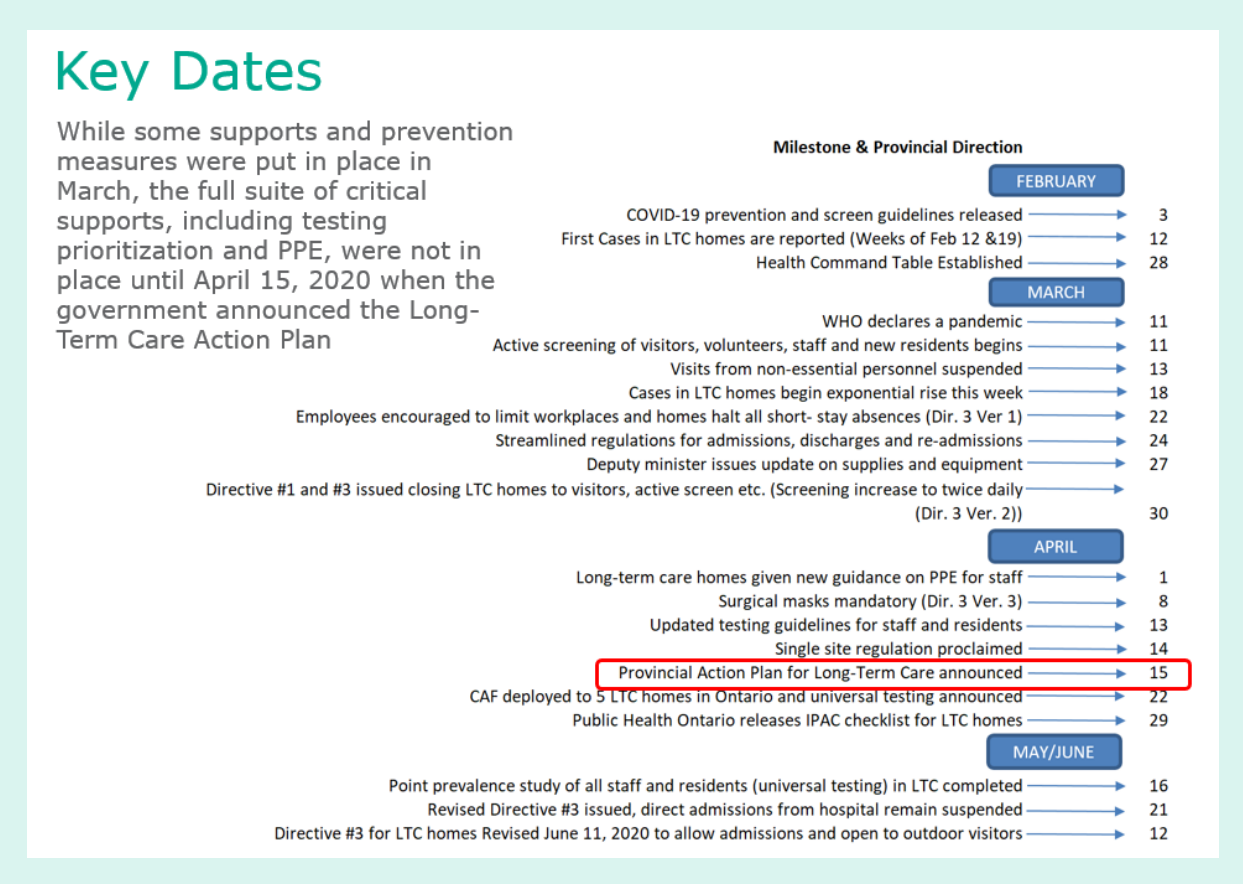
What made a difficult situation worse?

Data on COVID-19 outbreaks at Ontario long-term care homes provides very detailed information about the conditions that facilitated outbreaks. Underneath this data are countless stories of the decisions that were made by the homes, usually in conjunction with public health officials, hospitals, Ontario Health, and other officials. The key statistical determinants are the following:

Date of first infection – Early COVID-19 outbreaks in Ontario long-term care homes happened as the world was still learning about the virus. While there is still much that is not known, each day a home went without a case delivered precious preparation time. There were two key instances where action to improve preparedness in long-term care homes was delayed. (The chart below describes the sequence of events in detail.) First, the decision to make surgical masking mandatory was not taken until April 8, 2020. This resulted in long-term care homes accessing scarce supplies of surgical masks, which were being directed to hospitals as the priority. Second, many public health units in Ontario were opposed to the testing of asymptomatic individuals in the early weeks of pandemic – including of those in high-risk employment settings such as long-term care homes. Asymptomatic testing began in late April but was not made mandatory until May 2020. When a resident tested positive for COVID-19, no further testing of

residents was conducted, even when the resident was symptomatic. Cohorting of residents by symptom presentation likely contributed to the spread of COVID-19 in long-term care homes. Public health officials were generally recommending isolation measures that had been developed to cope with seasonal influenza outbreaks; these would prove woefully inadequate in containing COVID-19. These mistakes have largely been corrected, though logistics around symptom testing continue to be a challenge.

The timing of outbreak was also an important factor because of the government's response. The announcement on April 15th of the government action plan, which prioritized long-term care home and put in place emergency measures to address the acute staffing shortages, had a positive impact. The homes in COVID outbreak prior to the government's emergency response accounted for 47% of all wave one resident deaths.[iv]



Location in an area of community transmission – The OLTCA analysis and other independent research of COVID-19 outbreaks in long-term care homes in Ontario identifies a strong correlation of COVID-19 outbreaks to rates of infection in the surrounding community. Given the number of people (staff, visitors, trades) that go into LTC homes every day, the above finding makes sense. The more people in the community surrounding a LTC home with COVID-19, the more likely residents or staff in the long-term care home will have COVID-19.

Non-upgraded facilities with multi-bedrooms– Most of the worst outbreaks in Ontario struck older homes. These homes have many three- and four-person rooms, shared bathrooms, narrow hallways and ageing HVAC systems. These conditions make isolation and cohorting of residents difficult to achieve. Newer homes with an abundance of private rooms had much better success in controlling virus spread. The same was true in retirement homes where infection control and isolation were easier to implement.

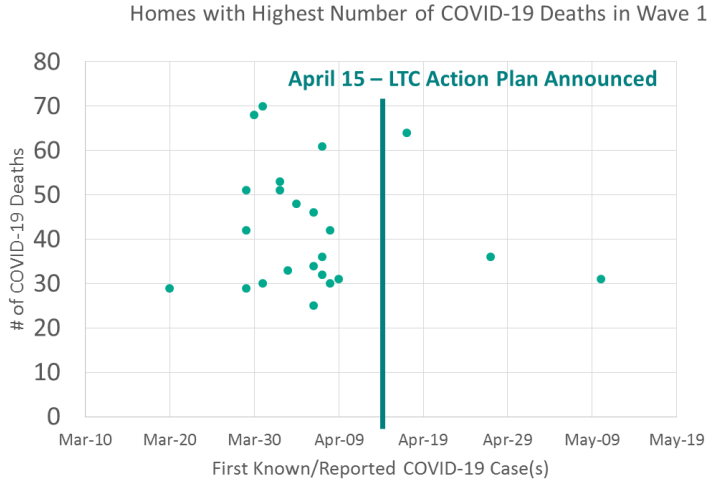
What we have learned about controlling COVID-19?

In addition to the factors that clearly contributed to COVID-19 outbreaks and the impact of these outbreaks, we have also learned a great deal about what works in controlling COVID-19. Among these key lessons learned are the following:

Health System Partnerships – Long-term care homes are generally insufficiently integrated with the rest of the health care system, including with hospitals. The early developments of Ontario Health Team proposals in 2019 and early 2020 rarely offered meaningful engagement with long-term care homes. When the time came to depend on hospital expertise in critical areas such as infection prevention and control, the most effective collaborations emerged from pre-existing partnerships. This is an area of focus for long-term care homes across the province, both in the months ahead (dealing with COVID-19) and the years ahead (building a truly integrated system of care).

Top Outbreaks in Wave One Began Before the Long-Term Care Supports were in Place

The 20 LTC Homes that experienced the most severe outbreaks in wave one, as measured by cumulative deaths, had outbreaks begin before the Action Plan was implemented



Testing – The appropriate availability and speed of testing is fundamental to any COVID-19 response. During the first wave, the absence of an effective testing regime challenged the sector's efforts to avert any future fears of outbreak among staff that turned a very challenging staffing situation into a crisis.

Government action makes a difference – The government's action plan announced in April saved lives. As already noted, the homes that went into outbreak before the release of the action plan

accounted for almost half of all wave one resident deaths. Among the key elements the prioritization of long-term care for the allocation of personal protective equipment had a significant impact. The decision to permit greater flexibility in staffing for non-clinical functions had the desired and intended effect of mitigating the staffing shortage resulting from COVID-19, fear of the infection, and the move to restrict multi-site movement among workers. The staffing flexibility offered by the temporary regulation may be time-limited, but it offers some insights into how the regulatory regime can be refocussed from meeting specific prescribed requirements to addressing the long-term staffing challenges in the sector. The resident support aide role has proven essential in helping homes manage through the pandemic and beyond. The role providing non-care related support to residents is cross trained to support social, recreational and dietary programs. This allows personal support workers and regulated staff to focus on delivering direct care. The Association of Residents' Councils of Ontario (OARC) describes this role as resident experience ambassadors. As we look for innovative models to immediately address the long-standing staffing shortages facing the sector, formalizing the resident support aide role is a key step forward to continue to free up scarce personal support worker time for care delivery. There is also an opportunity to secure individuals working in these roles to train as future personal support workers.

How do we build a more resilient system?

The fundamental challenges facing Ontario's long-term care sector are well-documented. They have been thoroughly described by many reports and reviews. They have been identified by operators, workers, partners in the health care system – as well as by long-term care residents and their loved ones. As uniquely tragic as the COVID-19 outbreaks in long-term care have been, long-term planning must be guided by the fundamental demographic, health care and fiscal changes we are all experiencing. These changes pre-date COVID-19 and will shape the way we choose to care for the elderly for decades to come. Among the key questions to be addressed are the following:

- How do we structure the care and support that will be required by the increasing percentage of Ontarians who are elderly?
- How do we balance support in the homes of elderly Ontarians with the growing need for residential care for those with the greatest needs?
- How do we change the culture of long-term care to support innovation and solutions that are particular to local communities?
- How can we quickly and efficiently construct new spaces in long-term care, and renew outdated facilities?
- How can long-term care interact effectively with the health care integration imperative represented by the Ontario Health Teams initiative?
- How do we make long-term care an employer of choice for those with a passion for empathetic care of the frail elderly?

Part B: Long-Term Care in Ontario – The Pre-Pandemic State

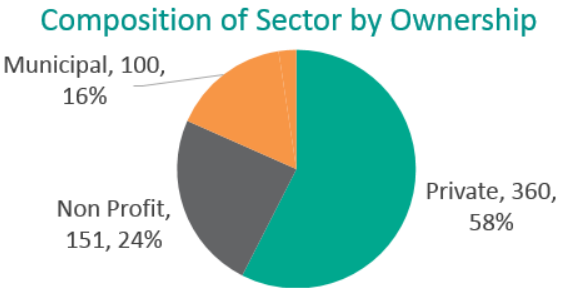
At the beginning of 2020, there were 626 long-term care homes with 78,800 spaces licensed by the Government of Ontario. Long-term care homes serve approximately 110,000 residents.[vvi] In 2020-21 the government budgeted about $4.5 billion for providing long-term care – an amount that includes operational support to long-term care homes and subsidies that support low-income Ontarians to afford the required co-payments. Highly detailed legislation, regulation and policy governs key elements of long-term care homes: who gets into them, who is permitted to operate them, how they are funded, and how minimum regulated standards are enforced. While the regulatory requirements are uniform across the sector, long-term care licensees are highly diverse. They include municipalities, non-profit organizations, and private providers. Within each ownership type there are individual homes, as well as large multiple home operators. Individual long-term care homes range in size from 14 beds to 472 beds.[vii]

Our Homes – A mix of operating models

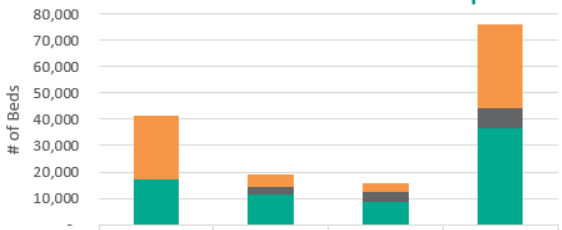
Long-term care homes vary in size and age

- 40% are small homes with less than 96 spaces
- 37% are medium homes with 97- 160 spaces
- 23% are large homes with more than 161 spaces

Related to the evolution of long-term care as three separate system - Nursing Homes Act, Homes for the Aged and Rest Homes Act and the Charitable Institutions Act – the age of homes varies by ownership status based on historic development initiatives

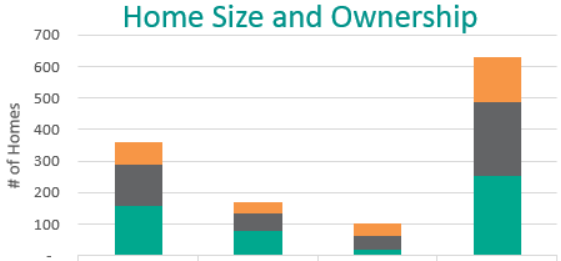


Composition of Sector by Bed Classification and Ownership



	Private	Non Profit	Municipal	Total
B/C/Up D	23,912	4,595	3,372	31,879
A	213	3,106	4,040	7,359
New	17,046	11,268	8,543	36,857

Composition of Sector by Home Size and Ownership



	Private	Non Profit	Municipal	Total
Large	69	36	39	144
Medium	132	56	45	233
Small	158	78	17	253

Just a few months before the first COVID-19 case arrived in Canada, the Ontario government received the report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, led by the Honourable Eileen E. Gillese. The Gillese Commission was created by Ontario's government in 2017 following revelations that a registered nurse had admitted to the murder of multiple long-term care

residents, across several homes in Southwestern Ontario. The Commission's mandate was not restricted to the particular circumstances surrounding the serial killings of long-term care residents. Justice Gillese was asked to explore broader policy and regulatory issues that may have facilitated these horrific incidents. As Justice Gillese reported, much of this analysis had already been conducted in a wide range of reports that documented in methodical detail the sector's key challenges.

The legislative and regulatory framework governing long-term care has been in force for about 10 years. Ontario's Long-Term Care Homes Act, 2007 (LTCHA) came into force on July 1, 2010. The new act promised greater consistency by replacing the Nursing Homes Act, Homes for the Aged and Rest Homes Act and the Charitable Institutions Act. The goal of the act and accompanying regulation is to help ensure that residents of long-term care homes receive safe, consistent, high-quality, resident-centred care.

Ten years into a regulatory regime, and only months after a comprehensive review of long-term care, COVID-19 arrived in Ontario. The virus affected the province, the country, and most of the world with a shocking intensity, prompting the greatest public health crisis in 100 years. The impact on Ontario's long-term care residents and staff was enormous. The deaths and serious illness of long-term care residents – particularly when coupled with severe restrictions on family caregivers and visitors – were tragic, unprecedented, and disturbing. The impact of the deaths, illness, and trauma of the long-term care workforce will be felt by workers and their families for years to come.

There is broad agreement about the fundamental conditions that made Ontario's long-term care sector particularly vulnerable to COVID-19. These conditions have been meticulously documented by Justice Gillese and the many reports she cited. Nobody predicted the impact of COVID-19 on long-term care residents and staff in Ontario. But many knew about the complex web of conditions that have contributed to the precarity of the sector, and its vulnerability to disruption and external shock.

Staffing

Staffing is the single greatest challenge facing Ontario's long-term care sector. While the sector has exemplary retention levels for full-time staff, the resilience and sustainability of part-time staff in long-term care in Ontario is threatened by the difficulty attracting, supporting, and retaining a workforce capable of providing comprehensive care to a population with significant – and increasing – needs. This was the sector's greatest challenge pre-COVID. The pandemic brutally revealed the vulnerability of the sector's human resource capacity and demonstrated in the starkest terms the impact of staffing shortages on long-term care residents. This challenge was identified by Justice Gillese. That is why she recommended that the Ministry of Health and Long-Term Care complete a staffing study to assess the required levels of staffing to provide clinical care in long-term care homes. In response, the ministry (now the Ministry of Long-Term Care) launched a study in early 2020, which was released in July. This report is the source for the following data that documents the staffing shortages.[viii]

The study reported significant challenges related to training, recruiting and retaining personal support workers in long-term care. PSWs constitute the largest portion of the long-term care workforce.

- About 25% of the PSW workforce is over 55 years of age. There has been a reduction in demand for programs that train personal support workers, resulting in a decline in annual training registrants from over 8,000 in 2015-16 to about 6,500 in 2018-19.

- About one-quarter of experienced PSWs leave the long-term care sector each year.
- To address the 24/7 nature of work, about 41% of PSWs work full-time, 48% work part-time, and 10.7% casual.

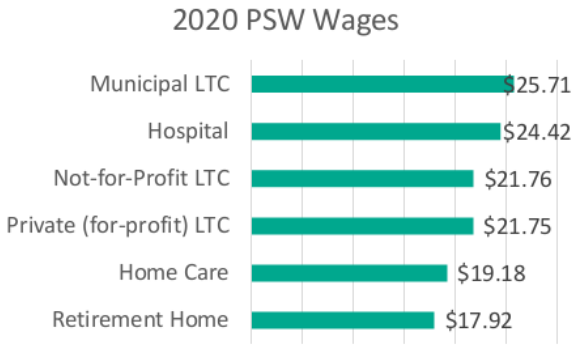
Registered nursing staff constitute the second largest portion of the long-term care workforce.

- The number of registered nursing staff in long-term care has increased by 9.6% since 2013. But proportionally the number of registered nurses has declined, while the number of registered practical nurses has increased significantly.
- Like PSWs, registered nursing staff in long-term care receive an hourly wage somewhat lower than nurses in hospitals, but significantly higher than nurses in home and community care.

Staffing Facts & Figures

WAGES

- PSW wages vary across sectors, and can vary within sectors based on collective agreements and the structure of the bargaining process.
- Both full-time and part-time staff fall under collective agreements in long-term care homes, and receive benefits.



STRUCTURE OF WORK

- Given the heavy nature of the work, staff work 8-hour shifts.
- To provide 24/7 coverage in a home a mix of full-time and part-time staff is required, full-time staff work 5 days a week (10 days biweekly), and part-time staff cover the other two days weekly (4 days biweekly).

Full-Time Staff
Ten 8 hour shifts biweekly

Part-Time Staff
Four 8 hour shifts biweekly

A key challenge relating to staffing in long-term care homes is increased workload and pressures relating to the high and increasing needs of long-term care residents. Operators are unable to meet these increased needs with greater staffing and resources because of insufficient government funding. The increase in resident acuity is demonstrated by the case mix index regularly reported to the ministry for all long-term care residents. The case mix index seeks to measure the resource required to adequately care for residents and allocate funding accordingly. This measure increased by about 20% between 2004 and 2018. The number of long-term care residents who need extensive or complete support with daily activities has risen by 12% from 2012 to 2019.[ix]

In October, the Commission's interim advice to government included a call for a comprehensive human resources strategy, and a commitment to a minimum daily average of four hours of care per resident. These recommendations have wide support, and the move to a minimum daily average of four hours of direct care was embraced by government with an announcement of a historic commitment of $1.9 billion to achieve this within four years. In December, the government subsequently released a staffing strategy, which highlights the need for a comprehensive plan to ensure that long-term care homes have the supports in place to improve staffing to meet growing residents' needs and to achieve the average of four hours of care. As we move to achieving this increased staffing, we must plan for a continued increase in care needs and an increase in the number of seniors requiring long-term care. The demands on human resource supply will be great. We look forward to working with government to ensure this historic investment and support staffing strategy is implemented in a way to achieve the best resident outcomes today and in the future. We have learned that the rigid enforcement of the regulated standards is not sufficient to build a culture of quality, innovation, and accountability.

The culture of long-term care

Justice Gillese was eloquent in her description of the regulatory culture in long-term care, and why it must change. She reported that "collaboration, co-operation, and communication must become the watchwords for the system." She called on long-term care operators to "cultivate a 'just culture' – one in which human error is dealt with openly rather than punitively." Operators of long-term care homes cannot change the culture without government support to eliminate the counterproductive and perverse impacts of the current regulatory requirements and inspection process. Recognizing that a change in the relationship between the ministry and operators is required, Justice Gillese also called on the ministry to support long-term care homes struggling with compliance. That is why a comprehensive review of the Long-Term Care Homes Act, its regulations, and the inspection system is required. The OLTCA echoes this recommendation: a comprehensive review is required to address the long-standing issues plaguing the sector, which require a fundamental change in culture. The experience of the last 10 years under the more rigorous and growing Long-Term Care Homes Act and inspection regime demonstrate that the foundational issues in the sector cannot be solved by legislation and regulation alone. The oversight for long-term care homes needs to shift to support continuous quality improvement, actively support the resolution of issues with tangible supports, and promote a truly resident-centered approach that is driven to achieve better resident outcomes and experience first and foremost.

The public has a very strong interest in establishing and enforcing regulated standards in long-term care. Residents in our homes are among the most vulnerable people in Ontario. The growing need of our population means that – as a group – long-term care residents are becoming more vulnerable, with growing rates of cognitive disability, for example. The problem described by Justice Gillese is not that regulated standards of care exist; instead, the problem is that the compliance regime works against the provision of quality care to residents. This happens for three reasons:

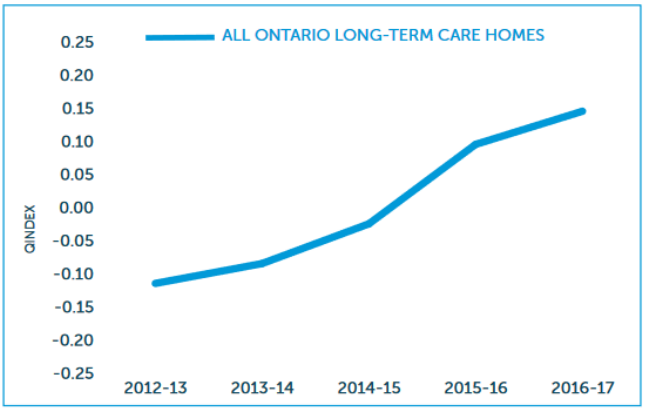
- *Diversion of staff resources* – Frontline care workers are diverted from providing direct care to fulfill the documentation requirements created through regulation and duplicate reporting. This reduces direct care hours and creates a culture that perversely encourages a focus on compliance and process rather than resident care and improving health outcomes. When an inspector visits a long-term care home it is estimated that each day requires 1.7 days of staff time, which is almost always PSW and nursing staff. This would suggest that inspector visits should be focused on cases of elevated risk to residents, since such visits necessarily deprive residents of personal care when staffing is already routinely stretched thinly. During one recent inspection, staff were required to spend time examining why there was a particular fruit substitution on a daily menu. In this particular example, an overall total of 6.8 staff days were required to gather information, answer questions and respond to inspector queries.

When an inspector visits a long-term care home it is estimated that each day requires 1.7 days of staff time, which is almost always PSW and nursing staff.

- *Regulatory requirements exacerbate the staffing shortage* – Short-staffing is the single greatest threat to high-quality resident care. Given the impact of chronic staff shortages, individual homes might be encouraged to provide professional care that meets regulated standards but responds creatively, based on local labour force availability. But rigid, province-wide regulations prevent such initiatives. For example, homes are required to ensure that at least one RN employed by the home is always on duty and present in the home at all times. Many homes, especially in rural and northern homes, are experiencing a severe shortage of RNs. However, all homes employ registered practical nurses (RPNs) who have the clinical competency to ensure continuous 24 hour registered nursing coverage
- *Compliance does not build a culture of quality* – Inspections and compliance are necessary elements of providing service to a highly vulnerable population. But compliance with province-wide regulations needs to be balanced with an approach to quality improvement that relies on key elements that no inspection process can deliver. Health Quality Ontario describes an integrated quality improvement approach that considers the experiences of patients, the value of

Ontario long-term care homes show significant results in improving quality of care

About this figure: New evidence from the Qindex shows that long-term care homes across Ontario made great strides in improving quality of care over the five-year period between 2012-2013 and 2016-2017.[15]



care provided, the health of the population and the experience of providing care (*quadruple aim*). In long-term care specifically, one integrated quality measure has documented consistent, incremental improvements in quality outcomes across a range of indicators. The Qindex, a composite metric of the nine CIHI LTC Quality Indicators, shows overall performance and trends of quality improvement in long-term care improve over time.[x]

Overall quality performance is a critical ingredient to system improvement. These measures are distinct from inspection infractions, which constitute neither an effective, comprehensive assessment of quality nor a framework for quality improvement.

Operational funding

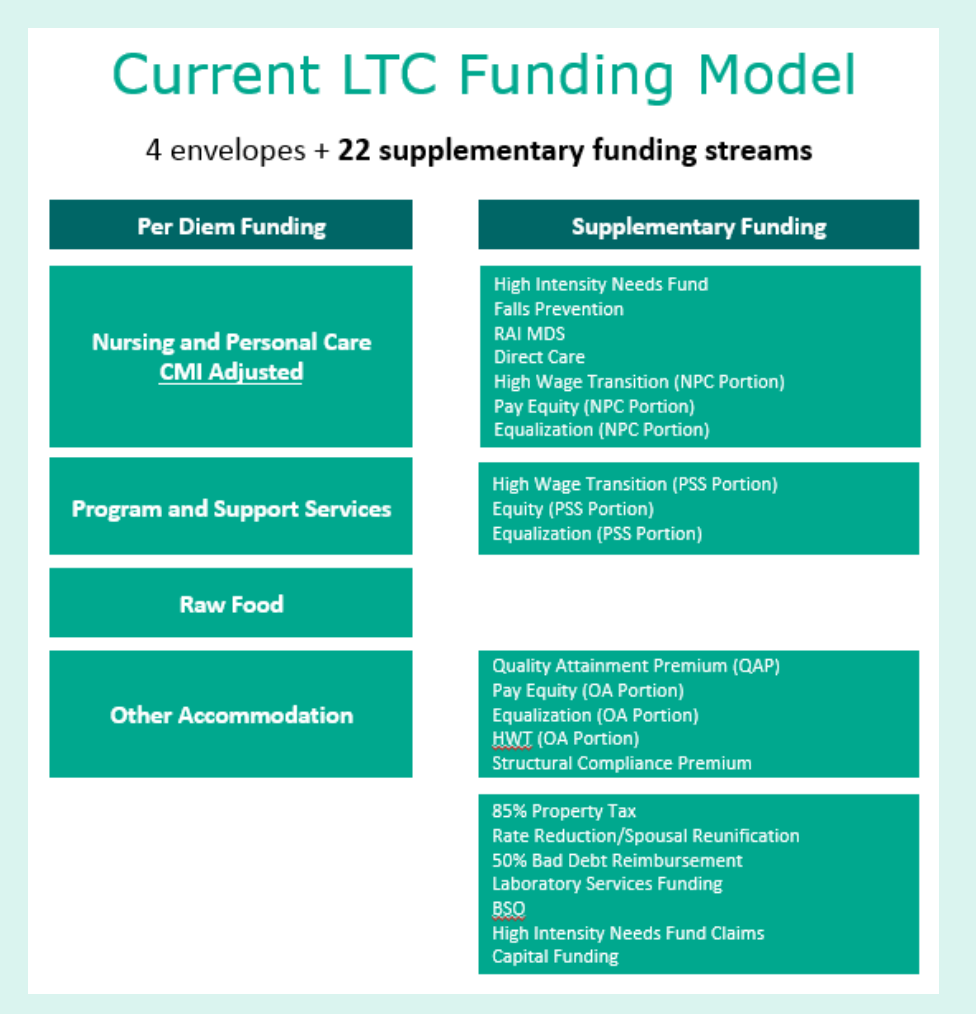
The investment in Ontario's long-term care homes has simply not kept pace with the growing demands on the sector. The bulk of long-term care operating funds are provided through a portion of the funding formula intended to cover the costs of nursing and personal care. The funds devoted to the daily care of our residents has simply failed to respond to the documented increase in the intensity of resident need, particularly as it relates to cognitive impairment and challenging behaviours. It is important to note that the profile of residents in long-term care will become increasing complex in the years ahead. Policy and funding designed to support ageing at home will continue, which means long-term care residents tend to be those residents with greater needs that cannot be addressed by in-home services. And the population of older seniors is increasing, with an expected 100% increase in the number of seniors over 80 years of age by 2036.[xi] For example, in 2020 the funding provided for Nursing and Personal Care represented a year-over-year increase of 1.4%. This funding is intended to support staffing and supplies to meet resident needs. The wage increases in 2020, largely driven by labour negotiations and arbitration awards, represented an average increase in staffing costs of 1.5%. This left an unfunded gap for wage costs of 0.1% and did not provide any residual funding to address an observed 1% increase in need as measured by the Case Mix Index. As such, homes have limited capacity to increase staffing levels to meet the increasing resident needs.

The inadequacy of operational funding is the key contributor to the staffing issues that threaten the quality of care delivered to long-term care home residents. This is experienced by all homes in Ontario, from independent operators to larger chains, and across all ownership types: municipal, non-profit, and private. Generally, municipals are able to mitigate these funding issues by relying on their municipal tax base. Without adequate funding, the system has not been able to deliver the quantity of care hours that homes, employees, residents and families have been recommending, and that have been the subject of a recent government commitment.

In addition to the amount of historic funding being inadequate, the *mechanism* for allocating existing funding is also a significant challenge to the overall stability and sustainability of the sector, and of individual homes. The funding formula is complex and fails to recognize the fixed costs of operating a home. This is particularly difficult for smaller homes, which make up 40% of the sector and are more vulnerable to funding fluctuations and cash flow delays. The formula reflects the government's approach to long-term care, which often focuses on addressing specific issues within the sector without a comprehensive approach to addressing overall viability, sustainability, and effectiveness across a heterogeneous care delivery system. A simplified model that provides stable, predictable and sustainable

funding is required. In the absence of such an approach long-term care homes are funded through per diem funding divided into four envelopes and 22 supplementary funding streams. Each of these funding streams reflects laudable policy objectives, such as falls prevention, spousal unification, and the consistent implementation of a resident assessment tool.

Yet the cumulative impact of information collection and reporting places a significant administrative burden on the sector, which diverts resources and energy away from care. Administrative burden is also disproportionately challenging for smaller long-term care homes.



In addition to the administrative burden, the funding mechanism also creates instability in the sector. The Nursing and Personal Care funding is adjusted on an annual basis based on the case mix index and available funding. This variability of allocations poses a risk to the viability of smaller homes and makes it more challenging for all homes to maintain stable operations and staffing. It is routine for facilities to be three months into the fiscal year before knowing their operating funds. This funding arrangement does not support stable and predictable operations to provide consistent level and quality of care.

Capital funding

Over the past 10 years, previous Ontario governments have announced ambitious plans to expand and upgrade Ontario's long-term care homes. Increased capacity has been identified as a partial solution to hospital overcrowding, as the population of seniors in hospital beds who do not need acute services is large and growing. The redevelopment imperative grows with each passing year. About 32,000 of Ontario's 79,000 long-term care spaces require re-development by 2025, in order to meet new revised standards. Among the key improvements to standards are an elimination of three- and four-person rooms, and improved HVAC systems and air conditioning. Eliminating the three- and four-person rooms

provides greater privacy, dignity and quality of life, responds to resident demand, and increases the capacity of homes to contain infection and safely isolate residents when necessary.

The previous governments' capital programs have failed to meet their objectives. Less than 4.5% of the spaces that do not meet the current standards have been redeveloped. Very few projects are underway because of unstable and insufficient funding, and a redevelopment program that does not offer sufficient support to operators. The process for achieving approvals has been unnecessarily lengthy and increased costs of already underfunded construction projects. In areas of high population, the cost of land has threatened the viability of any new build. Many homes have submitted multiple applications over the last decade but had not received approvals to proceed. As such, when the pandemic hit, the older homes were most vulnerable to COVID-19 due to their design and crowding.

In July 2020, this government demonstrated progress on their commitment to renew long-term care homes with the announcement of an enhanced long-term care home capital program. The enhanced program addresses critical affordability issues that had been ignored over the last decade. The new program recognizes the cost of land, development changes and historic inflation. This sets a good foundation to rebuild and build long-term care homes on an expedited basis.

Integration with the rest of Ontario's health care system

The need for greater capacity in long-term care is often described as a solution to hospital over-crowding. The number of hospital beds devoted to older people who no longer need acute hospital care is a serious problem for Ontario's health system, prompting a cascade of patient flow problems with implications for surgery waitlists and over-taxed emergency departments. There is no doubt that increased supply of long-term care homes, described above, can help address these problems. But improving patient flow – and matching high-need seniors with the best, most appropriate care – is not only a bricks and mortar issue. Building an integrated system requires far stronger relationships and clinical pathways built around the requirements of high-needs seniors.

The care for older Ontarians with high health care needs is not well integrated. There is a set of services designed to support older people to live longer and better in their own homes. This system has attracted significant investment to help older people live longer in the community with enhanced supports. Hospitals admit seniors with acute needs, often after a chronic health condition has resulted in a fall or other crisis. Long-term care often admits residents directly from hospital. These three elements of seniors' care – ideally coordinated at the patient level by strong primary care – each have strengths and capacities to offer patients, and the health care system Yet the organizations and sectors providing these services communicate poorly or not at all. Long-term care residents often need short-term hospitalization due to specialized treatment or diagnostics. Better integrated care ought to play a lead role in decreasing avoidable hospitalizations and facilitating smoother patient pathways and transitions.

Part C – COVID-19: What Made a Difficult Situation More Challenging?

COVID-19 has had a devastating impact on the residents of long-term care homes in Ontario, and on many of the staff who care for them. The OLTCA has spoken to many of the homes that experienced a COVID-19 outbreak in what we now refer to as the first wave. We have learned a great deal about the conditions that contributed to outbreaks, and the response of LTC homes. There has also been comprehensive, independent, empirical analysis of the conditions that increased the intensity and impact of the outbreaks. We know that the following were key factors:

Date of first infection – COVID-19 may be with us for years. We will never know *less* about all aspects of this infectious disease than we did in March and April 2020. The pandemic struck Canada as the world was still learning about its characteristics and behaviour. Consequently, every single day that a long-term care went without a case delivered precious preparation time and increasing advantages. Homes with early outbreaks suffered immensely from limited knowledge of COVID-19's range of symptoms and transmission risks. Most notably, information about the spread of the virus via asymptomatic individuals was either unknown, or not fully appreciated. Public health directives at that time were confusing – they changed regularly and were often contradictory. Preparation for the pandemic among LTC homes was based on existing respiratory disease outbreak prevention and isolation protocols that depended on symptomatic screening of visitors and staff – an approach that has been used successfully for many years to manage outbreaks of influenza and other viruses. But this approach proved ineffective in defending homes against COVID-19.

Most public health units were opposed to testing asymptomatic individuals through March and April, a decision partly due to the limited testing supply. Tests were generally not performed until a person was symptomatic. If a resident tested positive, the home was declared in outbreak, and no further testing of additional at-risk residents was conducted, even if symptomatic. At the time, those able to gain access to testing routinely waited a week or more for a result – some as long as four weeks. Many tests were lost and had to be repeated days later. Testing logistics and reporting were chaotic. All these circumstances reduced or eliminated the efficacy of testing as a COVID-19 containment strategy.

In the early days of the pandemic the separation and isolation of resident groups ("cohorting") was done exclusively on the basis of symptoms. In retrospect, this practice likely contributed to COVID-19 spread, rather than containment. It is quite likely separating residents based on symptoms may have facilitated the spread of COVID-19 due to asymptomatic spread. When universal testing of residents and staff was implemented in late April/early May, it became clear that many more people were infected by the virus that was first thought. One positive test result meant that typically 20 or more residents would follow, proving that the virus was circulating in the home asymptomatically long before first symptoms became evident.

Older homes with three- and four-person wards – Most of Ontario's worst outbreaks occurred in older long-term care homes. These homes do not meet the current standards established for all new and redeveloped homes since 1998. These homes have three and four-person rooms, shared washrooms and hallways, and ageing HVAC systems. These conditions make isolation and cohorting of residents difficult

to achieve. New homes with an abundance of private rooms had much better success in controlling the spread of the virus.

The intensity of community transmission – Long-term care homes are not isolated from their surrounding communities. Everyday there are staff, visitors, suppliers and contractors who move from the local community into the long-term care home. It is not surprising, therefore, that single biggest predictor of long-term care home outbreaks is the rate of community transmission. The latest report from Ontario's Science Table quantifies this causal relationship. The table finds that when community cases are 2.3 per 10,000 in the community there is a 75% chance of a long-term care home outbreak within five days.

The key factor in the impact and intensity of an outbreak was the loss of staff – As described above, staffing has been the greatest challenge facing long-term care homes for many years. When an outbreak was declared, some homes experienced precipitous drops in staffing levels. In some cases as many as 50% of staff were ill or absent due to concern about contracting the virus, or as a result of an order from local public health officials to self-isolate. Compounding this impact, homes with extensive outbreaks often saw leadership off sick with COVID-19. Recruiting and sourcing replacement staff from outside agencies to a COVID-19 positive environment was nearly impossible. In addition, while appropriate and essential to limit the risk of spread between homes, the single-site order also resulted in staffing reductions in many long-term care homes. The marked reduction in staff made it difficult to manage an outbreak while providing care to residents. The closing of schools and child care centres and the federal government's emergency income support program were also factors. The provincial directive barring family members from visiting removed a significant source of volunteer support in the homes. The decision to prohibit part-time workers from employment in multiple homes also reduced the pool of experienced, qualified workers in the homes.

Ownership model was <u>not</u> linked to COVID-19 outbreaks – Although multiple factors undoubtedly contributed to elevated risk of outbreak, ownership model was not a factor. OLTCA analysis demonstrates that community transmission and the crowdedness of older homes with three- and four-person rooms were key determinants of outbreaks, rather than ownership model. This conclusion was independently confirmed by Dr. Nathan Stall of Sinai Health and his team, as well as the most recent Science Table report. Their statistical analysis of outbreaks and the characteristics of homes led to this conclusion: "…the risk of an outbreak of COVID-19 at an LTC home was related to the COVID-19 incidence rate in the public health unit region surrounding the home, the total number of spaces and older design standards, rather than for-profit status."[xii]

Part D – What We Have Learned About Controlling COVID-19?

Ontario's Long-Term Care COVID-19 Commission began its work in the summer of 2020. On the day of the Commission's first hearing on September 2nd, the seven-day average of new COVID-19 cases identified in Ontario was 123. This was a much lower number than had been experienced in March, April, and May – what has been called wave one. By the time the OLTCA presented to the Commission at the end of September, the seven-day average of daily cases exceeded 500 – what we now call wave two was well underway. And by mid-December the average daily counts were close to 2,000 and greater to almost 3,000 in January. While this submission is being finalized, the first Ontarians are receiving the COVID-19 vaccinations. And, yet long-term care homes are now presented with additional challenges as the new more easily transmittable UK variant is identified in long-term care. It appears that the first few months of 2021 are likely to be very difficult and deadly, in Ontario and across North America.

The Commission's terms of reference give it the authority to issue interim advice, and the Commission provided such advice on October 23rd. Subsequent interim advice was offered on December 4th. Given the ongoing challenges of COVID-19, the OLTCA commends the Commission for providing these recommendations. We have had two opportunities to engage in a lively discussion with the Commissioners, and we appreciate the interest of the Commissioners in the information we have presented. As a sector we have learned a great deal from COVID-19. Some of what we learned was very specific to the early days of the pandemic in March, April and May of 2020, when important decisions were made every day, sometimes in the absence of the best information. We offer the following advice for the containment of COVID-19 in long-term care homes, which we believe will continue to be relevant and applicable to future waves of COVID-19. It should also increase the sector's capacity to prevent and respond to other infectious diseases.

The OLTCA has been consistently advocating for a plan for containing COVID-19 in long-term care homes since June of this year. Though the pandemic continues to evolve along with the science and new technologies for testing and vaccinations, the core elements are the same.

Based on lessons learned from the first wave of the coronavirus pandemic, the OLTCA developed a COVID-19 Wave Two Action Plan to help Ontario's long-term care homes protect the health and safety of residents and the hardworking staff who care for them during the ongoing pandemic. The plan consists of 11 elements to ensure that long-term care homes have the resources, expertise and supports required to prevent and contain COVID-19 in the ongoing pandemic.

This section outlines a proposal for each element, including the key challenges faced in the first wave, the recommendations going forward and key implementation considerations.

Recommendations

1. Continue prioritization of Personal Protective Equipment (PPE)

Long-term care homes require reliable access to sufficient supplies of personal protective equipment. During the first wave of the pandemic in spring 2020, the lack of PPE was a contributing factor to making a precarious staffing situation a major health challenge. A recent analysis has confirmed that PPE shortfalls were a direct result of "the decision to prioritize protective equipment and bed capacity for hospitals, which resulted in all other health organizations having to source and procure protective equipment on their own.[xiii] We are committed to the safety of our staff, and we are also concerned when staff have any reason to fear that coming to work in long-term care might constitute a threat to the health of our personnel and their families. We are also committed to supporting the family caregivers who play such an important role in providing care and comfort to long-term care residents. An adequate supply of PPE will support the safe integration of family visitors essential for resident social and mental wellbeing. That is why the provincial government must continue to work with the federal government to increase procurement of masks, gloves, gowns and sanitizer to avoid periodic shortages.

To date, the government has required homes to procure their own PPE while supporting homes for emergency supply. This fall, the government also made available a one-time program to top up long-term care home PPE stockpiles for up to eight weeks. Many smaller homes are still struggling with procuring quality PPE as the traditional supply chain continues to be strained and periodic shortages are experienced (e.g. gowns, gloves, common models of N95s).

Recommendation: Establish a provincial approach to ongoing sourcing and procurement of PPE for those homes that don't have the capacity. And, in cases of supply shortages, ensure long-term care homes are prioritized.

2. Enhanced testing and logistics for long-term care

Reliable testing and rapid turnaround of results is a critical foundation to successful ongoing management of the pandemic in the community and in LTC homes. Test results inform key infection prevention and control measures in the homes and with increased presence of asymptomatic carriers, test results are the only means by which homes can determine which residents to isolate. There is a need for a systematic, provincially coordinated surveillance and diagnostic testing program for LTC residents, staff, essential caregivers and contractors who have to come into the home, developed in partnership with long-term care operators.

The experience of operators with public health testing has varied greatly by community and has been largely affected by the general demand for testing from the public. Many operators have reported lengthy turnaround of results – in many cases a week or more. This timing is a significant risk to the safety of residents and staff in long-term care. Inconsistency in testing practices and frequency has also been confusing with a patchwork of directives and guidelines from multiple health service and public health authorities. Finally, the burden of repeated invasive nasopharyngeal swabbing of resident and staff has also posed a challenge for homes. That is why the scheduled implementation of new rapid testing technologies is so critical. Rapid testing will allow long-term care homes to undertake less invasive real-time surveillance testing of residents and staff.

OLTCA has had the privilege of learning from a number of its members who have piloted the new rapid testing. The homes have highlighted many successes with the new Panbio rapid test, namely the ability to screen real time to prevent staff from inadvertently bring the virus into the home. The homes did however identify significant staffing pressures in implementing the testing protocol. As Ontario considers moving to more frequent rapid testing, supports need to be put in place to ensure homes have the resources to implement rapid testing while also prioritizing vaccinations and ongoing IPAC as wave two intensifies. The test sites have estimated that to implement twice weekly rapid testing for staff across the province would require 1,250 additional registered staff as the current regulated staff in long-term care homes are already overwhelmed with the demands of supporting vaccination rollout, preventing and managing COVID-19 outbreaks and providing care to residents. Expanding rapid testing to caregivers would require additional resources beyond this. As a sector, we are committed to rapid testing, but we must find innovative models to resource this properly. Finally, as rapid testing is rolled out provincially,

public health support will continue to be required to prioritize PCR results for staff that have a positive Panbio. As such, the ongoing logistical issues of PCR testing and communication must be addressed.

Recommendation: Provide homes with innovative model of support to implement more frequent rapid testing in homes and continue to prioritize PCR testing for staff that test positive for Panbio and require the confirmation PCR test.

3. Train, certify and hire an army of Infection prevention and control (IPAC) specialists

Infection control and prevention capacity in Ontario's long-term care sector was clearly inadequate. This was an assessment shared by many hospitals, which partnered with long-term care homes to strengthen IPAC procedures. As with the supply of PPE, the early focus of IPAC investments was focused on protecting hospital patients and staff, to the detriment of Ontario's long-term care homes and their residents and staff. Strengthening IPAC in long-term care homes in Ontario requires systematic, sustained investment in staff and accredited training, with effective medical leadership and clearly defined roles. Improving IPAC will pay dividends far beyond COVID-19 containment; it must be a priority in confronting a range of infections that are often lethal for the vulnerable elderly in long-term care.

To create IPAC capacity in all long-term care homes, there must be funding for a new position as the in-house IPAC expert. The IPAC lead should be a trained and certified specialist with responsibility to assign infection control responsibilities, provide continuing formal and informal education on IPAC procedures, and support each home's compliance with health and safety requirements. This is an area where collaboration with local hospitals can make a big difference; each long-term care IPAC specialist must be able to leverage the IPAC expertise at the local hospital. As the Commission noted in its December 4th advice to government, experience from other jurisdictions suggests that a designated staff person with responsibility for infection control and prevention makes a real difference.

To date, the government has provided mobile supports and committed $30 million for in-home IPAC staffing and training and access to mobile supports through a hub and spoke model with hospitals. While this supports the homes, it is not sufficient to support dedicated and sustainable IPAC experts within each home. We must move swiftly to support each home in establishing at least one in-house IPAC expert.

Recommendation: Support long-term care homes with targeted funding to train and appoint at least one in-house IPAC expert per home.

4. Enhanced long-term care medical and clinical support

Stronger medical support services are part of the solution to strengthening the response of long-term care homes to COVID-19 and other infectious disease outbreaks. Long-term care residents are more medically complex than ever before. Physicians are a critical part of the leadership group in long-term care homes that also includes the home administrator and the director of nursing and personal care. Medical leadership can play a lead role in building IPAC capacity, improving medication management and

facilitating collaborative relationships with hospitals and medical specialists. But the compensation model for medical directors does not enable physicians to provide this range of service in the home. In addition, the training of long-term care medical directors needs to be enhanced, as recommended by the Gillese Inquiry.

The absence of clear leadership roles is – at the best of times – a frustrating aggravation to residents and staff. In moments of crisis, confusion about roles becomes a problem with severe consequences. This was noted in the Commission's December 4th advice. We endorse efforts to formalize the training for medical directors, as suggested by the Gillese Inquiry and many others. Physicians and nurse practitioners should be better supported through improved access to clinical services such as laboratory, diagnostic, subcutaneous and IV services. The compensation model for medical directors must be amended to provide greater support for physician on-site attendance, engagement and communication, including efforts to collaborate with medical personnel at local hospitals.

Recommendation: Enhance the role of Medical Directors in long-term care and implement enhanced funding in conjunction with new standardized contracts with long-term care.

5. Enhance and support long-term care pharmacy services

Effective January 1, 2020, the Government of Ontario moved to a capitation funding model for pharmacy services. The implications of this policy shift for long-term care homes has been significant. Homes experienced a reduction in medication management supports, and a loss of round-the-clock pharmacy support and technological capacity in the months before a world-wide pandemic. The timing could not have been worse.

The gravest impact on the sector has been an increase in workload for long-term care nursing staff. This has resulted in a diversion from resident care, and a more stressful work environment – two ongoing pressures which increased exponentially following the arrival of COVID-19. With reduced support from long-term care pharmacies, homes have lost access to pharmacist-led medication reconciliation and access to the technology-enabled pharmacy supports that play a key role in supporting virtual care. More effective medication reconciliation decreases ER visits and hospital stays.

The solution is to clearly define a long-term care pharmacy program that captures the critical services and supports that pharmacies can provide to improve medication management in long-term care while alleviating pressure on nursing staff. Some of these were previously provided. This is consistent with recommendations made by Justice Gillese to enhance medication management and oversight in long-term care. Funding will be required to purchase the required supports previously available in long-term care. We are grateful for the government's recent confirmation that the reduction to the revised capitation funding planned for April 2021 is on hold. We look forward to the opportunity to work with

government over the next year to reinstate funding and a supporting program to strengthen pharmacy services in long-term care homes consistent with Justice Gillese's recommendation.

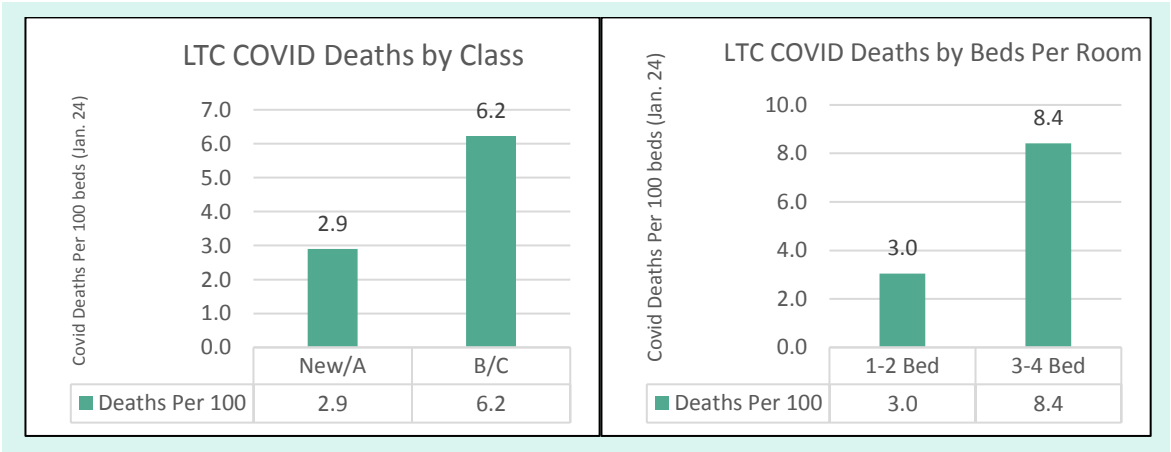
Recommendation: Restore funding for long-term care pharmacy services and implement a clearly defined long-term care pharmacy program that captures the critical services and supports required from pharmacies to improve medication management and reduce burden on nursing staff.

6. Reduce crowdedness and improve IPAC in older long-term care homes

In June 2020, the OLTCA recommended immediate minor capital supports required to support long-term care homes to undertake upgrades in preparation for the second wave of the pandemic. The IPAC assessments conducted by public health and hospitals identified a number of issues with the design, furnishing and equipment in long-term care homes, including:

- Limited ability to social distance and isolate due to ward style accommodation, shared bathrooms and limited dining areas.
- Lack of space for staff to take breaks, don and doff PPE, insufficient in-room washbasins for hand hygiene, etc.
- Cluttered, congested rooms with minimum storage and space for proper daily environmental service cleaning.
- Carpeting and upholstery in common spaces.

OLTCA analysis shows a strong correlation between the intensity of outbreaks and the structural classification of the home. The B and C class homes have been shown to have twice the number of COVID related deaths than new and A class homes. Furthermore, the COVID related deaths in homes with three- and four-person rooms are almost three times higher than homes with only one- and two-person rooms.



While targeted funding for minor capital to improve IPAC was provided in the fall, long-term care homes were not able to put in place many improvements before the second wave. However, the support of government directives to limit new admissions to three- and four-person rooms and overall occupancy protection helped homes reduce crowding.

Throughout the rest of the pandemic, to ensure homes can continue to reduce occupancy and crowdedness and make any other required retrofits, the following are required:

1. Continued financial support that enables a continued policy of not admitting new residents to three- and four-bed rooms already occupied by two residents. The decision by government to prohibit new admissions to these rooms continues to be necessary. The Ministry of Long-Term Care should confirm that licensees maintain the rights to the spaces taken out of occupancy, including the rights to develop these spaces.

2. Continued funding support is required to replace the lost funding related to converting the multi-bed rooms to two-bed rooms. Since this move – at full implementation – will represent a loss of 4,303 spaces, it involves significant loss of per diem funding for operators. In the event of an outbreak, homes also need the ability to properly isolate residents confirmed positive or awaiting testing results. This requires additional resources to provide isolation spaces in the home to segregate residents. A continuation of occupancy protection is critical.

3. Long-term care homes have been incurring minor capital costs of equipment and furnishing to limit sharing common spaces between units. Continued funding is required to address these and other urgent retrofits.

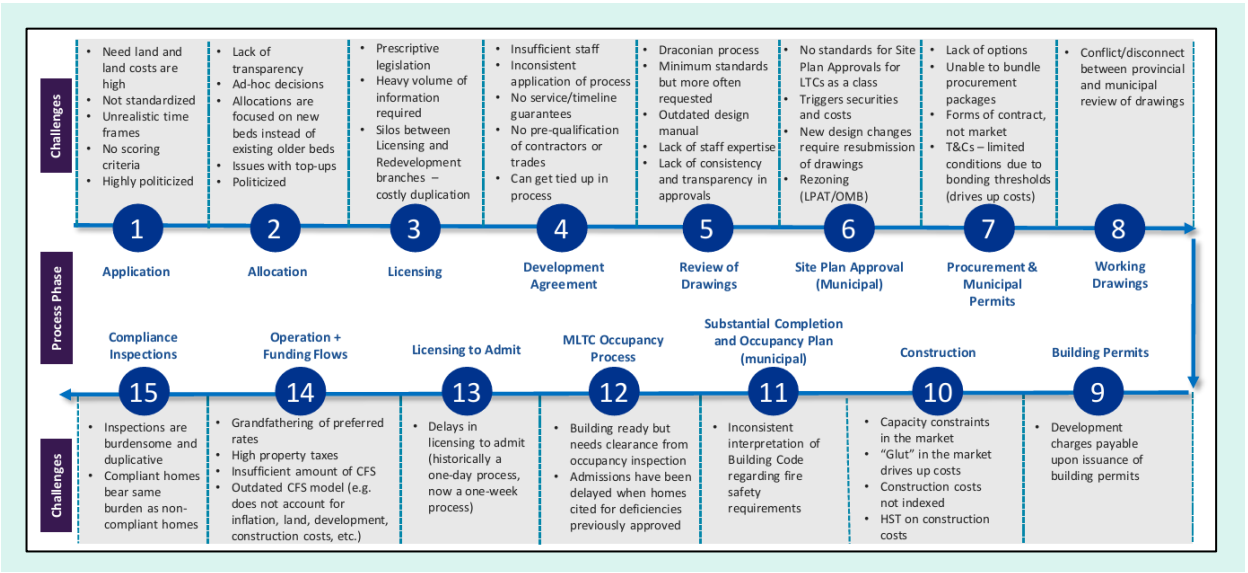
It must be emphasized that the failure to provide stable and predictable funding to support continued prevention of admission to three- and four-bed rooms would risk a destabilizing of staffing arrangements. As the sector plans to increase staffing to achieve an average of four hours of care per day such a risk is highly inadvisable. Despite the government's historic commitment of funding to support COVID-19 prevention and containment, many homes are experiencing escalating costs in excess of government support. A lack of occupancy protection will create greater funding shortfalls, leaving some homes with no choice but to reduce staff they worked so diligently to recruit. Stable funding is the most effective way to ensure current staffing levels are maintained.

Recommendation: Continue to support long-term care homes with funding to reduce crowdedness and lower occupancy in older long-term care homes.

7. Urgently expedite capital development program

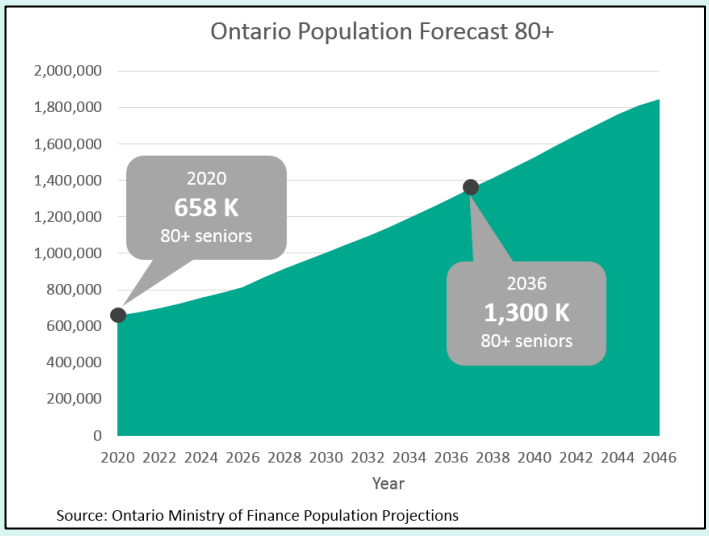
Ultimately, the government must urgently expedite the long-term care home capital program. Capital renewal is required to redevelop the homes that do not meet current standards and necessary to increase capacity in long-term care. As outlined in the OLTCA presentation to the Commission on the Long-Term Care Capital Program in November 2020, while the enhanced program improves the conditions for long-

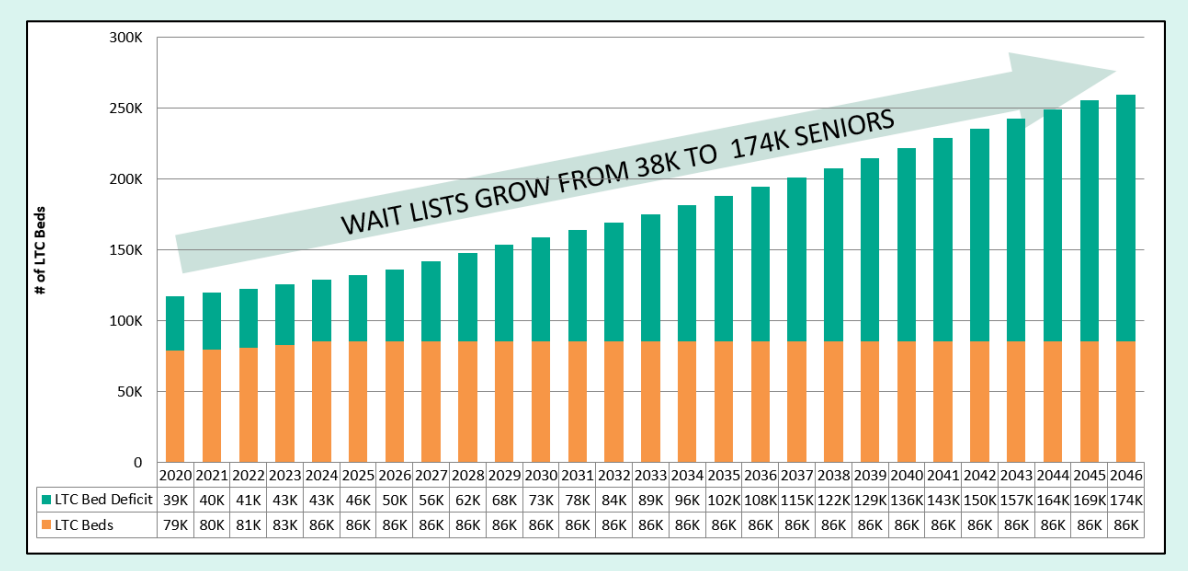
term care capital development, more action is required. Currently, of the 32,000 spaces that need to redevelop by 2025, only 8,000 have government approvals in place. The remaining 24,000 spaces are not yet approved to redevelop and have licenses expiring June 30, 2025, and will be required to meet the latest fire sprinkler system requirements by January 1, 2025. These homes cannot move forward with redevelopment without government approval. In addition, the historic process and policies remain complex, opaque and unpredictable. Historically, it takes three years to build a new home under a best-case scenario. In many cases it takes five or more years.



Beyond redevelopment of older long-term care homes, an expansion of long-term care homes is required. The population of seniors over the age of 80 will double by 2036, driving up already long wait lists for long-term care homes.

Wait lists could grow from 38,000 today to 108,000 by 2036 and 174,000 seniors by 2046. While some of this demand can be met through new models of seniors' care, expansion of long-term care home spaces will be required for those seniors whose needs cannot be met in the community.





	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046
LTC Bed Deficit	39K	40K	41K	43K	43K	46K	50K	56K	62K	68K	73K	78K	84K	89K	96K	102K	108K	115K	122K	129K	136K	143K	150K	157K	164K	169K	174K
LTC Beds	79K	80K	81K	83K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K	86K

Unfortunately, the pandemic has also created new risks to the long-term care capital program. The homes with construction underway are experiencing delays due to the COVID-19 restrictions and, in some cases, on-site outbreaks. In addition, a crisis in the international insurance and reinsurance industry has resulted in worldwide reductions in coverage for seniors' residences and long-term care homes. In Ontario, it is estimated that up to 60% of homes have experienced a reduction in insurance coverage as of January 1, 2021 as the four major insurers move, reduce, or eliminate coverage for directors and officers, COVID-19 pandemic and other infectious diseases.[xiv] The Supporting Ontario's Recovery and Municipal Elections Act, 2020 helps to limit liability related to the COVID-19 pandemic but is not sufficient for global insurers to reinstate full coverage. Insurance experts have advised that there is no private-sector solution to reinstate this coverage. As a result, long-term care homes are needing to self-insure for COVID-19 and other infectious diseases. This will limit the equity they have available to support capital development and increase the risks for long-term debt – resulting in fewer lenders and increased costs of financing.

To expedite the capital program, the OLTCA recommends:

1. Streamlining the capital process and policies to expedite construction and related approvals – essential to meet the 2025 deadline for B and C homes with licences expiring.
2. Providing additional funding support to homes in large urban and northern/rural communities facing extraordinary costs above the new funding announced.
3. Revising the policy for the new upfront grant to eliminate any unintended risks to securing financing.
4. Securing CMHC support for Ontario's LTC homes to reduce financing rates and increase the lender pool to secure financing.
5. Introducing an insurance back-stop program for long-term care homes to mitigate the risks with the current insurance crisis.

6. Providing stable and predictable operating funding for long-term care now and in the future and implementing the OLTCA proposed funding model (as outlined in the OLTCA 2020 Budget Submission).

Recommendation:

1. Provide an opportunity for all older long-term care homes to redevelop by 2025.

2. Building on the additional funding provided for capital development, address the insurance crisis and streamline the process and policies for development to ensure development can be completed by 2025, when the older home licences expire.

3. Additional investments are required to meet the growing population of seniors over the next decade.

8. Strengthen digitally-enabled care

Health care workers in most settings were challenged in 2020 to find new ways of connecting with other health professionals, patients receiving care, and their loved ones. In many cases, technology has enabled new ways of establishing these connections, and this learning will inform health care delivery for decades to come. For long-term care, we have seen negative consequences related to failed communication with hospitals, and for residents whose critical social connections were severed. Both of these problems could have been mitigated by a stronger, pre-pandemic investment in in technological capacity.

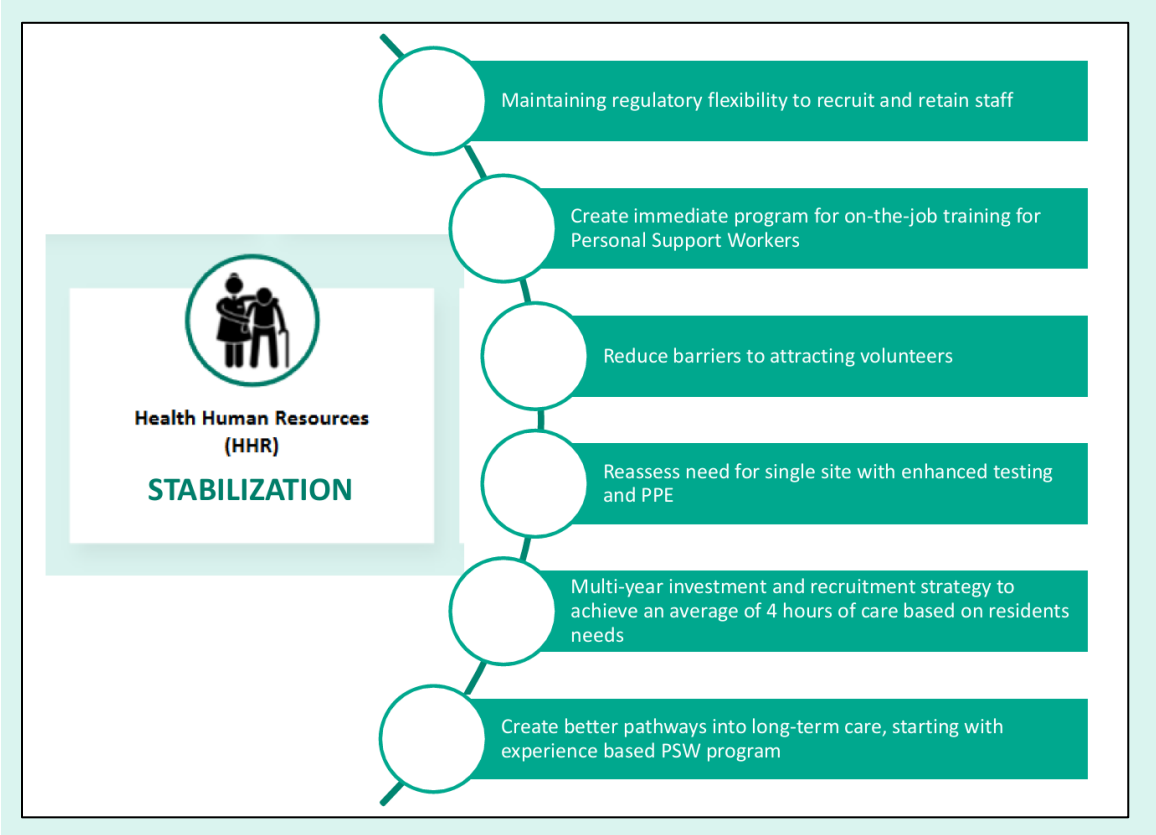
We believe that digital care can play a significant role in safely improving care and the quality of life of residents. Virtual visits, technologically delivered clinical care, and the delivery of programming and training for staff are all examples of what operators have developed or intensified during the pandemic. These efforts can go further, provided long-term care homes have the infrastructure required to support adequate connectivity and security. This is an area where government can provide financial support with clear minimum expectations. Within this framework, each home should have the flexibility to develop innovative solutions that are appropriate for each home's size, resident profile, and local health care circumstances.

Recommendation: Provide greater flexibility within the existing funding and management policies to invest in technology and innovation and to align operational processes to implement these innovations.

9. Stabilize Health Human Resources

Staff constitute the foundation of the care and services to our vulnerable seniors in long-term care. The complexity of the care required by our residents intensifies every year. The sector faced a staffing crisis before the pandemic with a shortage of personnel, predominantly personal support workers, but also other staff. The issues contributing to the staffing crisis are complex and longstanding, and include a

stigma associated with long-term care homes, physical demands, administrative burden, lack of flexibility to augment staffing models and lack of pathways into the sector. COVID-19 exacerbated this pre-existing staffing crisis and its underlying issues and was also driven by fear and concern for personal safety in the first wave. In the short term, measures taken to enhance adequate supplies of PPE, increase testing, support regulatory flexibility to expand newly created roles like the resident support aide and introduce designated family caregivers have helped with staffing. As outlined in its September 2020 presentation to the Commission, the OLTCA has identified six recommendations (see figure) to stabilize staffing in long-term care homes. Most notably, actions are required through partnerships between the sector and academic institutions, labour and government to address shortages and create better pathways into employment at long-term care homes and address working conditions to support retention and professional growth. For example, it is possible to condense the in-class training requirements for PSWs and better prepare these key staff for work in long-term care through on-the-job based training where students can earn as they learn.



In December 2020, the Ministry of Long-Term Care announced a workforce strategy for recruitment and training to increase hours of daily direct care to an average of four hours per day for each long-term care resident. This four-year $1.9 billion annual investment as well as other initiatives are targeted to expand staffing, improve working conditions for existing staff, and drive effective and accountable leadership. The OLTCA and its Human Resources Emergency Task Force, Quality Committee and Financial Liaison

Committee are developing recommendations on how to successfully implement these historic initiatives in support of improved outcomes and experience for long-term care residents. The OLTCA interim recommendations are as follows:

1. The average of four hours of care commitment should defined as a sector level commitment – some homes may not require an average of four hours of care based on the needs of their resident population, while other may require more.
2. The resident support aide (RSA) should be formalized within the sector and included in the definition of the average of four hours of care.
3. Beyond the investments to increase the work hours of nurses and personal support workers and achieve of an average of four hours of care, the broader Staffing Strategy must focus on defining *care* to include the full breadth of the care team. This includes not only nursing and personal care, but also social, restorative, spiritual and emotional supports.
4. The skill mix and level of care must be flexible and defined at each home level based on:
    a. The needs of residents, and
    b. The local staff and skills available to meet those needs.
5. A robust staffing strategy to create a pipeline of staff into long-term care is required – the strategy is to support innovations in training, recruitment and part-time retention.
6. The goal must be to improve resident outcomes and experience, with a supporting quality framework for measuring improved outcomes and not just the hours of care.
7. The approach to implementation must be based on proven quality improvement principles, rather than a compliance and enforcement regime. Homes that are struggling must be provided with coaching and tangible support to address staffing shortage and other structural impediments.
8. The culture and stigma of long-term care must be addressed to attract and retain staff.
9. To grow long-term care staff capacity requires enhancing leadership capacity to ensure the teams are working effectively. This will require targeted investment.
10. The OLTCA proposed funding model should be implemented to provide greater flexibility for homes to staff according to residents' needs – in support of delivering on this commitment.

Recommendation: A multi-year investment and recruitment strategy to achieve an average of four hours of care and to enhance staffing across the full care team, and to provide homes with flexibility to recruit staff based on the needs of their residents and the labour market realities in their community.

10. Focus on performance monitoring and public accountability

There has been significant demand for more rigorous inspections of long-term care homes throughout the pandemic. It is critically important that inspections are centred on critical areas related to resident care and focused on quality improvement, not compliance. Such an approach would be consistent with Justice Gillese's insistence that the culture of long-term care needs to change – toward a just culture. A 2019 report from the European Ageing Network described how the exclusive use of regulatory compliance and scientific management principles "degrades workers with a caring heart to tick lists and seeking permission for every decision they want to make." A more appropriate starting point, they argue, would be to "use the life experience of employees, most of whom are women, as the front line employees: they know how to care and love. So use common sense instead of requiring "tick a list" employees."[xv] In the context of the pandemic, how could Ontario begin to shift the culture of long-term care, while also providing government and the public with the assurances they seek about appropriate accountability? We believe that the answer lies in a balanced and risk-based approach to inspections and refocused inspections on high-risk incidents rather than low-risk compliances and complaints. As a signal of this approach, the government should consider shifting the responsibility for complaints management to the Office of the Patient Ombudsman who has experience in managing patient relations and effective complaint resolution. The Patient Ombudsman also has greater capacity and authority to explore system issues that promote overall quality of care.

The tools available to government and the sector to address continued outbreaks of COVID-19 or other infectious disease should be measured, proportionate, and focused. The imposition of mandatory management orders is not a sustainable response when a long-term care home identifies a problem and seeks support. Hospitals have strong expertise in areas such as infection control and protection, and their medical expertise compensates for the gap in medical leadership resulting from inadequate compensation and a poor role definition, as noted earlier. But the imposition of a mandatory management order does not recognize the particular expertise of supporting high-needs residents in home-like settings, and is not a sustainable solution for government. Instead, the Ministry of Long-Term Care must provide support and coaching to ensure that shortcomings are addressed. This is the most effective way of achieving clearly identified, common quality measures. Government needs a broader range of tools to support long-term care homes to operate sustainably, even during and after outbreaks of infectious disease. In moments of crisis the Ministry of Long-Term Care must have options to shift from compliance to support, particularly since almost every compliance issue is directly related to the staffing challenges that are exacerbated during moments of crisis. One key element of sustainability is the ability of homes to access liability insurance. Unless this problem is addressed the viability of all but municipal homes and large private chain operations is threatened.

Recommendation: Through the pandemic, focus government efforts on supporting long-term care homes to remedy any deficiencies in IPAC and performance, especially as it relates to systemic issues of older infrastructure and staffing shortages, which are outside the home's control to remedy in a timely way. Longer term, a comprehensive review of the Long-Term Care Homes Act and supporting inspection system is required to create a culture of quality improvement and high performance that is truly resident centered.

11. Better integrate long-term care homes into health system

COVID-19 highlighted the lack of understanding of long-term care homes and the care they provide among health system partners, who came in to assist during the pandemic. COVID-19 also highlighted that the lack of established working relationships and trust between long-term care homes and their health system partners slowed down and, in some cases, hindered efforts to ask for and receive help.

Learning from the experiences of the pandemic and looking to the future, with a steady increase in the seniors' population, it is critical that long-term care homes are better integrated into the health continuum. To achieve this, Ontario must:

1. Educate health system partners on the model of care in long-term care homes, which is founded in providing a home-like environment while being challenged to care for an increasingly complex resident population.

2. Continue to cultivate the relationships established between long-term care homes, hospitals and other health system partners through the pandemic and proactively plan to engage these partners in response to the next waves of COVID-19.

3. Proactively include long-term care homes in local and regional planning for Ontario Health Teams and ensure they are integrated into continuums of care as an equal partner.

Recommendation: Continue to engage long-term care homes as equal partners in health system planning and leverage their expertise in seniors' care to inform new models of care for seniors today and in the future.

Key Enablers

There are two key relationships that need to be improved to successfully implement these eleven recommendations – caregivers and labour partners.

Visitation and essential caregivers

When COVID-19 hit Ontario in March 2020, extremely strict limitations were imposed on visitors, including the visits of crucial family caregivers. This may have reduced infections and deaths in areas of broad community spread, but we may never know the full impact of this change on the health and well-being of our residents and their loved ones. It was also difficult for the staff of long-term care homes, who were deprived of extra assistance when it was desperately needed and became responsible for enforcing unpopular restrictions with anxious and exasperated family members. While there is no perfect solution to this difficult problem, homes are learning how to strengthen the relationship with key family caregivers, and to reduce risk by including them more proactively in issues such as infection control and proper use of PPE.

Labour relations

Long-term care is a highly unionized sector, with established protocols of sector-wide pattern bargaining. The OLTCA is committed to supporting its member organizations to work respectfully with its labour partners. In a sector whose greatest challenge is recruiting, supporting, and retaining a high-quality workforce, effective labour relations is a critical element of a stronger system. During COVID-19 outbreaks, staff fear and anxiety were among the greatest contributors to the intensity of the staffing crisis. In moments of crisis, labour leaders have a key role to play in conveying evidence-based, measured information that addresses the legitimate concerns of all those who work in long-term care. We are encouraged by the collaborative effort between government, labour and the sector in promoting the COVID-19 vaccination program. We hope this will serve as a foundation for further collaboration. A stronger relationship with labour partners can put operators in a better position to work with staff and develop measured, effective communication.

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Part E - Summary of Recommendations

The pandemic continues to challenge Ontario and the world, with the emergence of new variants as Ontario experiences record high daily case counts. Despite the improvements achieved over the last year, there remains an urgent need for action to strengthen long-term care homes' ability to prevent and contain this virus.

Of the 11 recommendations that OLTCA has been promoting since June of this year, the most urgent areas of action remain:

- **The need to stabilize staffing levels when outbreaks occur – and rapidly mobilizing external supports to address the staffing losses posed by illness, fear, and the need to isolate.**
- **The need to continue to provide support for older homes to reduce crowdedness – and to move urgently to redevelop these homes. This cannot be accomplished without addressing the insurance crisis.**
- **The need to support homes with coaching and resources rather relying on an enforcement approach. Management orders and punitive directives will not help homes stabilize and provide the best care for residents.**

Long-term, a comprehensive review of the Long-Term Care Homes Act and inspection system are required to support a culture shift that focuses on high performance and quality improvement towards a truly resident-centered regime.

1. Continue prioritization of personal protective equipment (PPE)

Establish a provincial approach to ongoing sourcing and procurement of PPE for those homes that don't have the capacity. And, in cases of supply shortages, ensure long-term care homes are prioritized.

2. Enhance testing and logistics for long-term care

Provide homes with innovative model of support to implement more frequent rapid testing in homes and continue to prioritize PCR testing for staff that test positive for Panbio and require the confirmation PCR test.

3. Train, certify and hire an army of infection prevention and control (IPAC) Specialists

Support long-term care homes with targeted funding to train and appoint at least one in-house IPAC expert for each home.

4. Enhanced long-term care medical and clinical support

Enhance the role of Medical Directors in long-term care and implement enhanced funding in conjunction with new standardized contracts with long-term care homes that clearly set out the key accountabilities for strong clinical leadership.

5. Enhance and support long-term care pharmacy services

Restore funding for long-term care pharmacy services and implement a clearly defined long-term care pharmacy program that captures the critical services and supports required from pharmacies to improve medication management and reduce burden on nursing staff.

6. Reduce crowdedness and improve IPAC in older long-term care homes

Continue to support long-term care homes with funding to reduce crowdedness and lower occupancy in older long-term care homes.

7. Urgently expedite the province's capital development program

1. Provide an opportunity for all older long-term care homes to redevelop by 2025.
2. Building on the additional funding provided for capital development, address the insurance crisis and streamline the process and policies for development to ensure development can be completed by 2025, when the older home licences expire.
3. Additional investments are required to meet the growing population of seniors.

8. Strengthen digitally-enabled care

Provide greater flexibility within the existing funding and management policies to invest in technology and innovation and to align operational processes to implement these innovations.

9. Stabilize Health Human Resources

Implement a multi-year investment and recruitment strategy to achieve an average of four hours of care and to enhance staffing across the full care team, and provide homes with flexibility to recruit staff based on the needs of their residents and the labour market realities in their community.

10. Focus on performance monitoring and public accountability

Through the pandemic, focus government efforts on supporting long-term care homes to remedy any deficiencies in IPAC and performance, especially as it relates to systemic issues of older infrastructure and staffing shortages, which are outside the home's control to remedy in a timely way. Longer term, a comprehensive review of the Long-Term Care Homes Act and supporting inspection system is required to create a culture of quality improvement and high performance that is truly resident centered.

11. Better integrate long-term care homes into the health system

Continue to engage long-term care homes as equal partners in health system planning and leverage their expertise in seniors' care to inform new models of care for seniors today and in the future.

Appendices

Please see links below to supporting documents.

1. Budget Submission 2020-2021 - Challenges and solutions: Rebuilding long-term care for Ontario's seniors
2. 2020 Budget Submission Letter
3. Red Tape Submission: Cutting Ontario's red tape in long-term care: Immediate solutions to unleash capacity now and for the future
4. September 29, 2020 Submission to Ontario's Long-Term Care COVID-19 Commission
5. November 30, 2020 Submission to Ontario's Long-Term Care COVID-19 Commission
6. OLTCA Wave One Data Story: August 2020 Knowledge Break Webinar

[i] John Hirdes et al, The Long-term Care Pandemic: International Perspectives on COVID-19 and the Future of Nursing Homes, Balsillie School of Public Affairs website, https://www.balsillieschool.ca/the-long-term-care-pandemic-international-perspectives-on-covid-19-and-the-future-of-nursing-homes/

[ii] Ontario COVID-19 Science Advisory Committee,COVID-19 and Ontario's Long-Term Care Homes, available at https://covid19-sciencetable.ca/sciencebrief/covid-19-and-ontarios-long-term-care-homes-2/

[iii] OLTCA Internal Database of Homes, 2020

[iv] Ontario COVID-19 website, https://covid-19.ontario.ca/data/long-term-care-homes

[v] Ministry of Health and Long-Term Care. Health Data Branch: Long-Term Care Homes System Report, January 2020

[vi] Canadian Institute for Health Information (2019). Continuing Care Reporting System: Profile of Residents in Continuing Care Facilities 2019-20 Ottawa: CIHI

[vii] OLTCA Internal Database of Homes, 2020

[viii] Long-Term Care Staffing Study,2020, https://www.ontario.ca/page/long-term-care-staffing-study

[ix] Canadian Institute for Health Information (2012-13,2019-20). Continuing Care Reporting System: Profile of Residents in Continuing Care Facilities 2012-13, 2019-20 Ottawa: CIHI.

[x] Wilkinson A, Haroun V, Wong T, Cooper N, Chignell M. Overall Quality Performance of Long-Term Care Homes in Ontario. Healthc Q. 2019 Jul;22(2):55-62. doi: 10.12927/hcq.2019.25903. PMID: 31556381

xi Ministry of Finance (2020). Ontario Population Projections, 2019-2046 https://www.fin.gov.on.ca/en/economy/demographics/projections/

[xii] Nathan Stall et al, For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths, CMAJ 2020 August 17

[xiii] Anne W. Snowdon, Michael Saunders and Alexandra Wright, Key Characteristics of a Fragile Healthcare Supply Chain: Learning from a Pandemic, Longwoods Health Care Quarterly, April, 2021 (pre-release)

[xiv] This is an OLTCA estimate based on information provided by the insurance industry and OLTCA members.

[xv] Dr. Freek Lapré, MCM, RN(np), Dale Stevenson, Bach. Eco. and Pol. and MBA, Dr. Markus Leser, Dipl. Gerontologe Ing. Jiří Horecký, Ph.D., MBA, Beatrix Kaserer, Markus Mattersberger, MMSc MBA (C) 2019, Long-Term Care 2030 2nd edition, European Ageing Network