Final Submission
to the Commission on Long-Term Care

Ontario Health Coalition

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Ontario Health Coalition
Protecting public healthcare for all.

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information.

Who We Are

The Ontario Health Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than half-a-million Ontarians, 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, Students for Medicare and other organizations committed to public health care for all under the principles of equity and compassion that underlie the Canada Health Act.

Foreword

The crisis that COVID-19 has presented cast an unflinching light on all of us. Heroic efforts have been made by public health, public servants, public hospitals, and hundreds of thousands of health care workers at every level. True selflessness and self-sacrifice have been demonstrated by so many. Our public health care system and our society have shown extraordinary resilience even after decades of planned undercapacity. Like nothing we have experienced, COVID-19 has brought to the forefront the immeasurable value of public health care in Canada and its foundational principles of equity and compassion. Through the pandemic we have been moved by the countless acts that we have witnessed of care, social solidarity and love by families, communities, local businesses, our health care institutions.

At the same time, COVID-19 has laid bare unconscionable inequities and shortfalls in care for the elderly and other vulnerable people who face discrimination. The suffering of the residents and staff in long-term care has indelibly marked the soul of our province. It is in the memory of those we have lost and in support of those who have experienced the terrible toll of COVID-19 in long-term care that we make this submission. We hope that the work of this Commission will contribute to righting the injustices they have experienced and will result in fundamental reform of and improvements to long-term care in our province.

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Introduction

In December, we submitted our interim submission to the Ontario Long-Term Care COVID-19 Commission. This is the final part of our submission, meant to add onto and complete, not to replace, our interim submission. We have also submitted our survey of staff from the long-term care homes with large outbreaks in the second wave in the hope that it will aid in the Commission's understanding of what has happened "on the ground" in those homes.

In our December submission we looked at the conditions that gave rise to the second wave of COVID-19 in Ontario's long-term care homes through to the beginning of December 2020. The details we gathered about the conditions in the long-term care homes with large outbreaks raised serious questions about why so little had changed since the first wave of the pandemic, six months after the military report exposing horrific neglect and incompetence in the long-term care homes in which they had been deployed, and eight months after the Ontario government's long-term care action plan was released. What we identified then was that accountability was still non-existent for long-term care homes that do not follow the Infection Protection and Control (IPAC) protections and other measures that were supposed to be in place. There remained no systematic intervention early enough to save lives and provide care in the homes that had outbreaks, and in some there was no evidence of intervention at all. As the fall progressed and the second wave gained amplitude, the provincial government made a priority of shielding long-term care homes against liability while at the same time doing substantively nothing to improve staffing and care levels, accountability and enforcement of protections. These findings are still true.

We identified factors that had contributed to the spread of COVID-19 in Wave I and reported on the improvements, improvements followed by lost ground, and failures to address them. These were grouped as follows:

1. Improvements
    a. No new admissions into 3- and 4-bed shared rooms
    b. Increase in PPE supply
    c. Improved (but still inadequate) Directive #5
    d. Emergency interventions including military teams, hospital rapid response teams, limited by being ad hoc, inconsistent, implemented too slowly and often voluntarily, or not implemented at all when warranted.
2. Advances followed by lost ground
    a. Testing, contact tracing, laboratory capacity. Improved through Wave I. Total failure to build capacity over the summer in time for school re-opening with devastating consequences in Wave II.
    b. Asymptomatic workers – anecdotally we had seen improvement over Wave I. This was lost in Wave II as staffing levels crumbled.
3. Failures
    a. Staffing levels had worsened and continued to decline. Total failure by the provincial government to improve conditions, recruit and train staff and get them into the homes.
    b. Failure to hold homes accountable for upholding clear systematic standards of safety and care. Only a handful of homes ever had management takeovers, despite horrific negligence and/or incompetence leading to harm and death of residents. Other homes had "voluntary or facilitated management agreements" the terms of which are secret and not accountable. No home has been fined. Not one home has lost their license.
    c. Failure to provide care. Thousands of long-term care residents were left in long-term care homes when staffing was perilously low, hundreds or more of them sick with woefully inadequate care as they were dying.

d. Failure to provide a coordinated systematic approach and emergency intervention at a low threshold when outbreaks could be contained.
e. Failure to recognize airborne transmission of COVID-19.

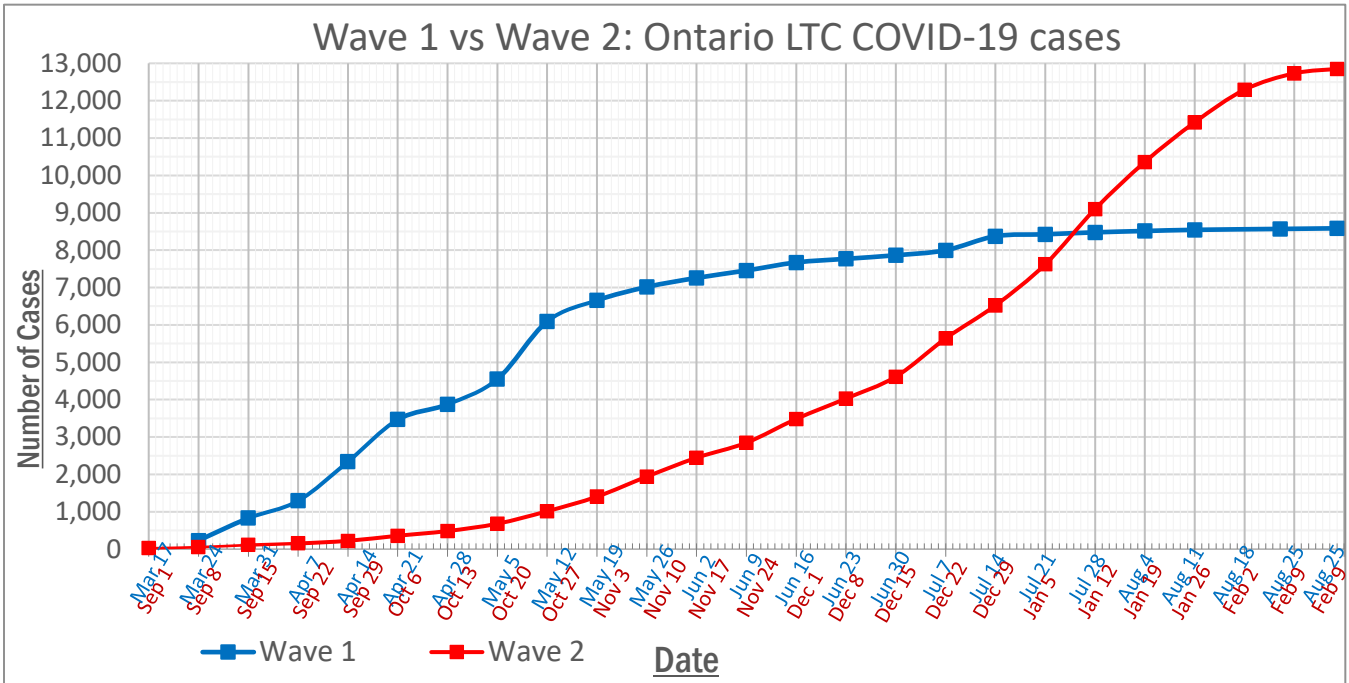
We documented these factors in detail in our interim submission and, unfortunately, they remain as true and relevant today as they were two-and-a-half months ago.

In this Submission we provide an update to the December report including:

- A comparison of COVID-19 numbers of residents and staff infected and deceased in Wave I & Wave II to date.
- An update on the geographic spread of the large long-term care outbreaks (as defined by >10 residents and staff infected) in Wave II.
- A status report on the current large outbreaks in long-term care homes in Ontario.
- A listing of the currently active large outbreaks with more than 150 residents and staff infected in Ontario's long-term care homes.
- An analysis of the Ontario government's policy response to the call for improved staffing and care levels.
- A brief on the new measures taken since our December interim submission.
- Concluding summary of the progress on infection control, care levels and interventions in outbreaks in Wave II.

1. Updates on Key Issues Identified in Interim Submission: Charting Our Progress

Wave I & Wave II in Ontario's Long-Term Care Homes



All data for markers in blue and red is from the daily epidemiologic reports by Public Health Ontario.

Wave I compared to Wave II: residents and staff who contracted COVID-19

- Wave I: 7,959 residents and staff contracted COVID-19. (March – July 13)
- Wave II to date: 12,848 residents and staff contracted COVID-19. (September 1 – February 15)

We surpassed the Wave I total number of residents and staff with COVID-19 as of January 7.

Long-term care deaths as a result of COVID-19 Wave I & Wave II to date

- Wave I: 1,924 residents and staff died. (March – July 13)
- Wave II to date: 1,989 residents and staff have died. (September 1 – February 15)

We have surpassed the Wave I total number of deaths as of February 7.

Current state of long-term care outbreaks (as at February 9, 2021):

Each period of several weeks throughout the second wave, we have tracked the state of the large outbreaks in Ontario's long-term care homes (as defined as outbreaks including more than 10 residents and staff) from data from local Public Health Units and Ontario Public Health. There continue to be more large outbreaks each period of several weeks that we measure. The severity of those outbreaks is still peaking, as shown in the numbers below. Approximately 20 of the large outbreaks in the second wave have resulted in virtually all residents having contracted COVID-19. Five of the currently active large long-term care outbreaks are at homes that have already had another, now resolved, large outbreak earlier in the second wave. Our regular tracking reports, including a report from January listing the percent of residents infected in the homes with the largest outbreaks, can be found on our website here. What is clear, from this data, is that the measures that have been taken are clearly not adequate to stop devastating

spread of COVID-19 on a level that is almost unmatched in the developed world. There is no question that we could have done better, and must do better going forward.

Of the currently active large Ontario long-term care home outbreaks (February 9):

- 101 outbreaks include 10 or more residents and staff infected;
- 52 outbreaks include 50 or more residents and staff infected;
- 23 outbreaks include 100 or more residents and staff infected;
- 8 outbreaks include 150 or more residents and staff infected;
- 4 outbreaks include 200 or more residents and staff infected;
- 1 outbreak includes 250 or more residents and staff infected, and;
- 1 outbreak includes 300 or more residents and staff infected.

By comparison, the large long-term care outbreaks as at January 19 were as follows:

- 99 outbreaks include 10 or more residents and staff infected;
- 53 outbreaks include 50 or more residents and staff infected;
- 29 outbreaks include 100 or more residents and staff infected;
- 15 outbreaks include 150 or more residents and staff infected;
- 7 outbreaks include 200 or more residents and staff infected;
- 3 outbreaks include 250 or more residents and staff infected, and;
- 1 outbreak includes 300 or more residents and staff infected.

The thirteen long-term care homes with active outbreaks of 150 or more cases in both residents and staff are in Table 1 (page 4), with full details in the report as per the region the home is in.

Geographic spread of the outbreaks:

Most of the large long-term care outbreaks in Ottawa, where the second wave began, are now resolved. Barrie has a devastating large outbreak that is now confirmed to include the U.K. variant of COVID-19. London is now seeing large outbreaks, as are the regions of Guelph and Waterloo. Toronto, Halton, Hamilton and Peel have been consistent hotspots throughout the second wave. Niagara, Windsor, and Eastern Ontario are seeing many new large outbreaks in the last 3 weeks. Northern regions such as the district of Thunder Bay were nearly untouched by COVID-19 in the first wave, but started seeing large outbreaks at the end of November, along with Durham. The public health units of Chatham-Kent, Lambton-Sarnia, and Timmins all saw their first large outbreaks of the second wave within the last two weeks, and Haliburton/Kawartha/Pine Ridge within the last month.

Table 1: Long-Term Care Homes with active outbreaks with 150 or more cumulative cases as of February 9th 2021

Region	Long-Term Care Homes	Total Cases	Resident Cases	Staff Cases	Resident Deaths	Unspecified/ Other Cases	Unspecified/ Other Deaths
Windsor	The Village at St Clair LTC	**313**	174	139	56		
Toronto	St. George Care Community	**239**	150	89	19		
Niagara	Oakwood Park Lodge LTC	**237**	116	121	35		
Simcoe Muskoka	Roberta Place LTC	**235**	129	105	69	1	1
Peel	Faith Manor LTC	**185**	92	93	28		
Halton	Extendicare Halton Hills	**165**	91	7	24	67	1
Niagara	Garden City Manor Long-Term Care Home	**163**	73	90	25		
Niagara	Extendicare St Catharines LTC	**154**	101	53	42		

Analysis of Ontario's Long-Term Care Staffing Plan

After repeated promises of reports that would contain a staffing plan to improve care levels in Ontario's long-term care homes, the Ontario government released a report, *A better place to live, a better place to work: Ontario's Long-Term Care Staffing Plan (2021-2025) on December 17, 2020*. The report was released as COVID-19 case numbers were escalating by more than 2,000 per day and there were 1,600 active cases per day in long-term care. More and more long-term care homes fall into dire staffing crises and desperate help was needed. This is still the case today. As such, the government's staffing report was deeply angering and disappointing.

The report is full of buzzwords and reannouncements. It was tone deaf to the anguish of residents, families and staff and lacked any sense of urgency.

The concrete items announced are as follows:

- Reannouncement of the 3,700 staff (across all health care) that was supposed to start in September. There is no evidence that this is actually happening.
- Reannouncement of the new beds and funding for them. (Note: more beds with existing staff will actually make staffing and care levels per resident worse not better.)
- Adoption of for-profit long-term care homes' industry language of "continuous quality improvement". This is a euphemism for not having comprehensive surprise inspections, enforcement and accountability, penalties for negligent home operators.
- A new promise that the Ontario government would spend "up to" $1.9 billion by 2024-25 to improve staffing. This would encompass funding new beds and getting care levels up to an average of 4-hours of care per resident per day. However, these promises come with a long timeline:
    - By the end of 2021 -22 the government would implement a 15 minute average of more hands-on direct care. This is the earliest date for which they have any commitment to improved care. Bottom line: it means that by the April after next, there will be 15 minutes more daily hands-on direct care (RN, RPN, PSW).
    - By the end of 2022-23 another 15 minutes of daily hands-on direct care.
    - The majority of the care increase is back-end loaded: the larger increases are in year 3 (25 mins) and year 4 (20 mins).
- Thus, by the end of four years from now, and two years after the next provincial election (which is well beyond the average life-expectancy in long-term care) residents would finally get to 4-hours of care per resident per day.

There is no information in the report on when the Ontario government will actually start any serious recruitment. No word on improving full-time work. No word on improving wages and working conditions. Dangerous adoption of the language of continuous quality improvement. Frankly, this report reads like a delay tactic, not like any serious commitment to address the critical shortfalls of care that are happening right now.

Summary of New Measures Taken on COVID-19 in Ontario's Long-Term Care Homes

There are several new measures that have been taken to address the COVID-19 crisis in long-term care in our province. The following is a quick summary and analysis of these measures.

1. **Organization of hospitals associated with each long-term care home to provide support in emergency.**

   In the fall it became evident that a system had been created whereby local public hospitals would take responsibility for providing support for local long-term care homes in their area. We have not found a policy document or anything describing this relationship and what was expected to happen. We do know what has happened on the ground, which was disorganized and delayed, resulting in a worse outbreak without early intervention.

   The context is important. By December, there were outbreaks spreading across both long-term care and hospitals. As of December 1 there were 117 outbreaks in long-term care homes of which 45 were large outbreaks (with more than 10 residents and staff infected) and 42 hospital outbreaks of which 2 were large outbreaks (>10 patients and staff infected). The sharp escalation over the month of December and into January is evident when we look at those same numbers for January 8. By that point there were 231 long-term care home outbreaks of which 81 were large outbreaks and 72 hospital outbreaks of which 20 outbreaks in 10 hospitals were large outbreaks. Local public hospitals had already redeployed staff for the better part of a year, and many had worked through the fall to clear the surgical backlogs created during the first wave shutdown. As local hospitals fell in outbreak, and as staffing shortages in hospitals became more severe, particularly around the winter holiday, they were unable to provide support or were delayed in doing so. Such delays proved fatal. We must note that in May we wrote to the Premier and that letter was sent by the Premier to the Minister of Long-Term Care. We asked for the government to take the lull in the summer to build community and hospital teams to provide early intervention at a very low threshold of cases in long-term care homes, to get outbreaks under control and provide needed care. This did not happen.

   ### Case Study 1. The Village at St. Clair, Windsor

   The Village at St. Clair is a for-profit long-term care home in Windsor. As its December outbreak began, we began to receive calls from family about the care levels deteriorating in the home. Family described severe shortages of staff to the point that PSWs were working 12-16 hours to cover for staff who had not shown up for work. They described too few staff to provide basic care: feeding, pain medication, answering call bells.

   The outbreak, which was declared on December 8 spread very quickly. As the outbreak became known to families and staff on Saturday December 12, there were media reports that no staff had been fit-tested for N95 masks and that staff were being required to sign waivers before being given universal masks.[1] We received panicked calls from family and media began to pick up similar reports from family about what was happening in the home.[2]

[1] https://blackburnnews.com/windsor/windsor-news/2020/12/16/lack-ppe-contributes-outbreak/ and https://www.iheartradio.ca/am800/news/unifor-calls-on-province-to-step-in-at-the-village-at-st-clair-home-1.14173517 and https://windsorstar.com/news/local-news/windsor-long-term-care-facility-reports-major-covid-19-outbreak-with-dozens-of-positive-cases

[2] https://www.cbc.ca/news/canada/windsor/windsor-long-term-care-home-1.5842469

On Tuesday, December 15, we called together a Zoom meeting of the Unifor local president representing the workers at the home, MPPs Taras Natyshak and Lisa Gretzky, Windsor Health Coalition Co-Chair Tracey Ramsey and OHC executive director Natalie Mehra. We agreed to seek intervention to get a rapid response team into the home. The union sought meetings with the home operators (Schlegel Villages) to see what was being done and to advocate for more staffing. The MPPs called the local Chief Medical Officer of Health to see if he would issue an order akin to those issued by York Region's Chief Medical Officer of Health requiring the home operator to increase staffing and provide adequate care, and adhere to sound IPAC practices.[3] The MPPs also called the hospital leadership to see if they would send in a team.

These inquiries spurred some action, though it was slow and reluctant. The local CMOH did not agree to make an order. We ascertained that Hotel Dieu Hospital was assigned the Village at St. Clair Home. They explained that they too were in outbreak and staff was overstretched. They told our team that they would send in support if required to do so but it was clear that it was a difficult position for them. We held a press conference to apply public pressure to get action. In the end, the home operators, unable to find agency staff locally, bused in staff from outside the region. The hospital did send in a small team initially. But help was delayed as these measures were put into place, only after we applied considerable public pressure. Ultimately Hotel Dieu Hospital took over management of the home but not until December 24 when there were more than 160 positive COVID-19 cases among staff and residents and at least 12 residents had died.[4] This is far from the systematic, early response that we had been calling for since May after we saw the devastation of the first wave. The following is the trajectory of the outbreak at the Village at St. Clair:

The Village at St Clair LTC oubreak

- **Dec 8:** outbreak started [5]
- **Dec 23:** 164 cases total, 97 residents and 67 staff [6]
- **Jan 5:** 240 cases total, 136 residents including 35 deaths and 104 staff [7]
- **Jan 8:** 255 cases total, 150 residents including at least 35 deaths and 105 staff [8]

Case Study 2. Oakwood Park, Niagara

The outbreak at Oakwood Park Lodge in Niagara started on December 12. By December 20, 88 residents and 30 staff had contracted COVID-19 and 6 had died. The hospital that was paired with Oakwood Park was the Niagara General hospital. However, it too was in an outbreak that would, over the month, spread into a very serious facility-wide outbreak. By mid-December local MPP Wayne Gates was calling on the provincial government to send in help, citing complaints from families of short-staffing, inadequate PPE, inadequate infection control.[9] On December 23, Niagara's Acting Medical Officer issued an order supporting a voluntary management support

[3] https://www.york.ca/wps/wcm/connect/yorkpublic/0a21e8f1-4462-4195-898d-5aa6b999582b/122_Order+Section+29+Langstaff+Care+Square+Centre-Nov20.pdf?MOD=AJPERES&CVID=nnI.IzY
[4] https://www.cp24.com/news/windsor-ont-hospital-takes-over-management-of-care-home-where-150-people-have-covid-19-1.5245149?cache=y
[5] *Local COVID-19 Data*. Windsor Essex Public Health. January 5 2021. https://www.wechu.org/cv/local-updates
[6] https://windsorstar.com/news/local-news/health-unit-records-highest-single-day-increase-of-covid-19-infections
[7] *Local COVID-19 Data*. Windsor Essex Public Health. January 5 2021. https://www.wechu.org/cv/local-updates
[8] *Local COVID-19 Data*. Windsor Essex Public Health. January 5 2021. https://www.wechu.org/cv/local-updates
[9] https://niagaraatlarge.com/2020/12/22/mpp-demands-more-action-on-huge-outbreak-at-niagara-falls-long-term-care-home/

agreement between the home operator and the Niagara Health System.[10] On December 31, after approximately 200 people had contracted COVID-19 in the home, the Ontario Ministry of Long-Term Care announced a Management Agreement between the home operator and the Niagara Health System.

Jennifer Penney's mother Yvette Brauch died at the home on December 26 after having contracted COVID-19. Ms. Penney was able to get into the home to see her mother and she describes a scene in which staffing had crumbled – there were few staff around and despite the best attempts of the staff present, evidence of caregiving was almost invisible. She says that despite the announcement on December 23 that the hospital was providing management and support to the home, she saw no evidence of any hospital team in the home until after her mother died (December 26).

In a conversation with Ontario Health Coalition executive director on January 13, 2021, MPP Wayne Gates described his efforts to get help into the home. He said that there were approximately 122 residents at Oakwood Park Lodge when the outbreak started. By mid-January 116 of those residents (approximately 96%) had contracted COVID-19 and more than 120 staff had tested positive as well. He said that he had called for the Red Cross to come into the home. As we reported in our case studies in our interim submission, the Red Cross is limited in the support it can provide, with staff that do not have PSW training and cannot do the full range of PSW work (including feeding, bathing, repositioning, etc.). He said that the Red Cross had been in and done and assessment but their scope would not have been helpful. Agency staff had been brought in. The Niagara General hospital, which was in outbreak was overstretched and eventually staff had to be arranged from the Shaver hospital in St. Catharines. Again, help was delayed and insufficient, and this outbreak burned on until virtually all residents and most of the staff were infected with COVID-19. By the latest data we have found, at least 116 residents and 121 staff were infected with COVID-19 and at least 35 died.

Oakwood Park Lodge LTC Outbreak

- Dec 12: outbreak started [11]
- Dec 20: 88 residents including 6 deaths and 30 staff [12]
- Dec 23: 196 cases total, 97 residents including 8 deaths and 91 staff [13]
- Jan 4: 231 cases total, 116 residents including 28 deaths and 115 staff [14]
- Jan 7: 237 cases total, 116 residents including 30 deaths and 121 staff [15]

[10] https://www.cbc.ca/news/canada/hamilton/oakwood-park-lodge-niagara-health-takeover-1.5852802

[11] *COVID-19 Outbreaks in Niagara.* Niagara Public Health. January 6 2021. https://www.niagararegion.ca/health/inspect/outbreaks.aspx

[12] Medeiros, Kyle. *Niagara's Oakwood Park Lodge in building-wide COVID-19 outbreak*. CHCH News. December 20 2020. https://www.chch.com/niagaras-oakwood-park-lodge-in-building-wide-covid-19-outbreak/

[13] *Niagara Health takes over long-term care home after 8 deaths, 188 COVID-19 cases.* CBC News. December 23 2020. https://www.cbc.ca/news/canada/hamilton/oakwood-park-lodge-niagara-health-takeover-1.5852802

[14] Howard, Gord. *Niagara hospital system 'stretched to its limits' by COVID-19*. The St. Catharines Standard. January 4 2021. https://www.stcatharinesstandard.ca/news/niagara-region/2021/01/04/niagara-hospital-system-stretched-to-its-limits-by-covid-19.html

[15] *Niagara has 138 new COVID cases; Ontario hits single-day records for cases, deaths*. NiagaraThisWeek.com. January 7 2021. https://www.niagarathisweek.com/news-story/10303589-niagara-has-138-new-covid-cases-ontario-hits-single-day-records-for-cases-deaths/

- **Feb 3:** at least 116 residents including 34 deaths and 121 staff [16]
- **Feb 8:** at least 116 residents including 35 deaths and 121 staff [17]

2. Vaccination of LTC Homes' Residents, Staff and Essential Caregivers

By the end of December, Ontario had enough vaccine supply to vaccinate all long-term care home residents and retirement home residents. Phase One of Ontario's vaccine implementation plan was to ensure that all residents, staff and essential caregivers at long-term care homes in York, Peel, Toronto and Windsor-Essex were to be vaccinated by January 21, 2021.[18] Regions with very significant long-term care outbreaks, including Hamilton and Niagara were not included. On February 15, it was reported that all residents and staff of long-term care homes in Toronto would receive their second vaccinations by Tuesday February 16.[19] We cannot find any publicly-available record of how many staff and essential caregivers have been vaccinated in those priority areas. On February 11 the Ministry of Long-Term Care corrected a news release issued earlier that claimed that all consenting long-term care home residents across Ontario had been vaccinated. Nonetheless, by the end of the week (February 12) 63,000 of 72,000 current long-term care home residents have received at least one dose of vaccine.[20] By the same date 6,300 essential caregivers had been vaccinated. There has been no reporting on the number of staff vaccinated. There is no clear deadline for the second doses of vaccine to be rolled out in long-term care.

As of Friday February 12, 442,000 doses of vaccine have been given in Ontario, according to the Ontario government's vaccine tracker.[21] But only a portion of those have gone to the supposed priority population in long-term care. It is not clear why all of long-term care has not been vaccinated. Between December 31 when Ontario had enough vaccine supply to inoculate all of long-term care and February 16, nine-hundred and fifty-one long-term care residents and staff have died as a result of COVID-19.

3. Rapid Antigen Tests

According to Ontario's new screening guidance for long-term care homes issued December 30, 2020,[22] rapid antigen tests are to be conducted in areas of high community prevalence of COVID-19 2-3 times per week and in areas of low prevalence 1-2 times per week. It is not clear when this was actually implemented in homes. It had not been implemented in at least some homes by mid-January and late-January. As of February 9, based on Public Health Ontario and local Public Health Unit data, we found 101 currently active large outbreaks in long-term care homes (as defined by more than 10 residents and staff infected) up from 99 large outbreaks on January 19.

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[16] *Active Outbreaks.* Government of Ontario. February 3 2021. https://data.ontario.ca/dataset/long-term-care-home-covid-19-data

[17] *Active Outbreaks.* Government of Ontario. February 9 2021. https://data.ontario.ca/dataset/long-term-care-home-covid-19-data

[18] https://news.ontario.ca/en/release/59871/ontario-accelerates-covid-19-vaccinations-for-long-term-care-homes-in-priority-regions

[19] https://www.cp24.com/all-toronto-long-term-care-residents-and-staff-will-have-been-offered-full-vaccination-by-tuesday-1.5309479

[20] https://torontosun.com/news/provincial/levy-if-its-friday-there-must-be-new-vaccine-numbers

[21] https://covid-19.ontario.ca/covid-19-vaccines-ontario

[22] http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/Antigen_Screening_Guidance_2020-12-30.pdf

Concluding Summary: Updates on Key Issues Identified in Interim Submission

Residents, families and their advocates, careworkers and their unions, and health professionals have been united in the millions in calling for similar measures to address the crisis in long-term care. The factors that have been identified by the Ontario Health Coalition and our half-million members and our more than 400 organizations are echoed and supported across the spectrum of public interest voices in long-term care. There may be some differences, but there is deep consensus on the factors that have contributed to the spread of COVID-19 and the terrible inadequacy of care in too many of our province's long-term care homes.

In our interim submission, we provided evidence and detailed accounts of the Ontario government's response to the first wave and where there had been progress and failure in the second wave to the beginning of December. Many of the priority issues we identified are still not addressed. We will not provide an exhaustive list and detailed evidence as we did in our interim submission. Here is a brief update on a number of the key issues we identified about which there has not been sufficient action:

- **Staffing:** as more than 12,000 long-term care residents and staff, with approximately half of those numbers being staff, have contracted COVID-19 in the second wave, the impact on staffing and care has become even more profound. We have heard hundreds of accounts from families and staff of homes, both in outbreak and those not in outbreak, in which staffing levels are the worst we have heard in decades of advocating in this sector. Staffing is critical and staffing shortages beget worsening staffing shortages as staff leave from sickness, injury, despair, burn out, fear and anger. A longer-term staffing strategy cannot preclude immediate action to address the staffing crisis. As outlined in Section 2 of this report, Quebec recruited and trained between 7,000 and 10,000 PSW equivalents over the summer and early fall to deploy into the homes for the second wave and has had a much better second wave. (In addition, Quebec did launch an initiative at the end of August -- as your Commission has recommended in Ontario -- identify an IPAC lead accountable for safe practices in each home.) Regardless of whether or not we are facing a new third wave, and regardless of the vaccination program, the staffing and thus care crisis in Ontario's long-term care homes is not any closer to being solved than it was in December. The current plan to increase care by 15 minutes by April 2022 will likely bring us back to the crisis-level short-staffing our province suffered before the pandemic, if that. This is the priority issue. It requires fully paid training, not ad hoc private college programs in some areas, safe homes in which to work, improved working conditions including wages and benefits. There has been no progress on these critical issues. If anything, staffing and care levels are worse in many of the homes and as the occupancy levels in the homes begin to rise again we fear for the safety of the residents given the emergency-level staffing shortages across the province. We ask the Commission to make stronger, clearer recommendations for immediate action to address this crisis.
- **Emergency Interventions:** despite the apparent formalization of relationships between hospitals and long-term care homes, emergency support and interventions have been fatally delayed in a significant number of homes in large outbreak. The majority of large outbreak homes have had no intervention at all, despite devastating outbreaks and reports of inadequate care. In homes where there have been teams sent in, these interventions were made too late to save lives and provide desperately needed care.
- **Provision of care in alternative settings:** the vast majority of long-term care residents have never been given an option to be transferred to hospital or any other setting even in out-of-control outbreaks and even when staffing has crumbled and care is not being provided.

- **Inspections:** as we reported in our interim submission, there is no evidence that in-person inspections have been made in homes with outbreaks. We recommended that comprehensive (RQI) inspections be reinstated across the province. This has not happened. We also recommended that in-person inspections, take place as soon as an outbreak is declared, including speaking with residents, families, to ensure that proper infection control procedures are being followed and that there is adequate staffing to provide safe care for residents. This too, has not happened.
- **Accountability and enforcement:** there is still no accountability and enforcement for long-term care home operators who do not uphold safe infection control practices and provide adequate care for the residents for whom they are responsible. Compliance orders have never been sufficient to ensure compliance in a significant number of homes where routine non-compliance has been demonstrated. As we detailed in our interim submission, amendments to the Long-Term Care Homes Act (2007) made in 2017 provide the Ministry with additional powers to levy significant fines and suspend licenses, in addition to the existing power to revoke licenses. Continued failure to hold the homes accountable in ways that are understood to be meaningful to operators has resulted in inadequate and even dangerous care or lack thereof.

2. Case Study: Long-Term Care in Quebec in the First & Second Wave

Devastation in the First Wave

Quebec's long-term care homes were devastated during the first wave of the COVID-19 pandemic with 3,890 deaths among their residents, and 13,000 cases and 11 deaths among staff members.[23] During the first wave of the pandemic from February 23 to July 11, as defined by the National Public Health Institute, 14% of all long-term care homes had more than 50 cases per 100 beds and 39% had at least one case.[24] Deaths in long-term care accounted for 69 percent of COVID-19 deaths to July 11 in Quebec.[25] Like Ontario, this devastation was partially caused by inadequate access to PPE, understaffing, insufficient room for isolation and inadequate Infection Protection and Control (IPAC) measures but was exacerbated by the decision to offload COVID-19 patients from hospitals into long-term care homes. [26]

Preparing for the Second Wave

Knowing that there was likely to be a second wave and committing to better protect elderly and vulnerable residents from the tragedy of the first wave, Quebec took a number of steps in preparation in the summer lull, including hiring 10,000 PSW equivalents, hiring a manager for each home paired with an infection control specialist, and emphasizing homes' compliance with infection prevention and control measures (IPAC).

- On June 1, the provincial government launched a recruitment drive to recruit 10,000 orderlies or PABs, the equivalent to Ontario's Personal Support Workers or PSWs. They created a tailor-made course to prepare these workers to work in long-term care homes, paid them $21 per hour during training and set the pay for PABs at $26 per hour upon hiring as well as giving raises for existing PABs. Two days after announcing the program, the province had received 55,000 applications for these positions[27] and by September they had hired 7,000 more PABs and were continuing to hire 3,000 more.[28] They conducted an accelerated 3-month paid training program starting June 15.[29]

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[23] Lowrie, Morgan. CTV News. *Quebec government failed miserably to protect those living in long-term care facilities: Ombudsperson*. December 10 2020. https://montreal.ctvnews.ca/quebec-government-failed-miserably-to-protect-those-living-in-long-term-care-facilities-ombudsperson-1.5225401

[24] Serebrim, Jacob. Global News. *Long-term care homes in Quebec better protected during second COVID-19 wave: report*. December 17 2020. https://globalnews.ca/news/7529166/long-term-care-homes-in-quebec-better-protected-during-second-covid-19-wave-report/

[25] Author's calculation from the total case numbers reported by the Quebec National Institute of Public Health here: https://www.inspq.qc.ca/covid-19/donnees

[26] Lowrie, Morgan. CTV News. *Quebec government failed miserably to protect those living in long-term care facilities: Ombudsperson*. December 10 2020. https://montreal.ctvnews.ca/quebec-government-failed-miserably-to-protect-those-living-in-long-term-care-facilities-ombudsperson-1.5225401

[27] Mignacca, Franca. CBC News. Thousands send in applications to work in Quebec long-term care homes June 2 2020. https://www.cbc.ca/news/canada/montreal/chsld-orderlies-training-program-announced-1.5595010

[28] Thomas, Katelyn. CTV News. *Quebec reveals changes made to long-term care homes ahead of second wave* September 23 2020.https://montreal.ctvnews.ca/quebec-reveals-changes-made-to-long-term-care-homes-ahead-of-second-wave-1.5117188

[29] Boshra, Basem. CTV Montreal. *'We need you': Quebec launches ambitious plan to hire 10,000 orderlies for embattled seniors' residences* June 2, 2020 https://montreal.ctvnews.ca/we-need-you-quebec-launches-ambitious-plan-to-hire-10-000-orderlies-for-embattled-seniors-residences-1.4965339

- The Health Minister also announced that each long-term care facility would have a manager who would be paired with an infection control specialist and would be responsible for ensuring infection control directives were followed in their facility and that staff would be stopped from moving within the long-term care system.[30] [31]
- In addition to increases in staffing, the premier announced in April that all 2,600 long-term care homes would be inspected, and measures would be taken to make sure that all homes were operating safely.[32]
- The Health Minister, Christian Dube also announced $106 million in additional funding for regional public health authorities to hire 1,000 full-time employees to conduct contact tracing.[33] By early fall Quebec had increased its contact tracers from 800 to 1,600 and vowed to increase that number to 3,000.[34]

Early Second Wave Success

During the first wave, 14% of Quebec's long-term care homes had 50 cases per 100 beds, whereas during the beginning of the second wave from August 23- November 21, that number had dropped to 2%. The number of homes with at least one case had also dropped in the same time periods from 39% of homes having one case to 26% of homes.[35] With the increased staffing, inspections and lower rates of infection in long-term care, Quebec seemed better set to handle the second wave compared to other provinces. As the second wave intensified across the country through November and into December, Quebec is still doing significantly better in the second wave than it did in the first.

Second Wave Interim Report

As of January 14, 2021, there were 789 active cases in Quebec's long-term care homes, with 8 long-term care homes that have more than 25% of their residents infected with COVID-19 and 7 long-term care homes with more than 15%.[36] For context, there are currently 437 long-term care homes in Quebec.[37]

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[30] Luft, Amy. CTV News. *Quebec's nine-point plan to prepare for possible second wave of COVID-19*. August 18 2020. https://montreal.ctvnews.ca/quebec-s-nine-point-plan-to-prepare-for-possible-second-wave-of-covid-19-1.5068848?cache=enzvogqbavvrgvzn%3Fot%3DAjaxLayout

[31] Lowrie, Morgan. The Canadian Press. *Quebec moves to shore up long-term care homes ahead of potential second wave of COVID-19* August 18, 2020 https://www.theglobeandmail.com/canada/article-quebec-moves-to-shore-up-long-term-care-homes-ahead-of-potential/

[32] Boshra, Basem. CTV News. *COVID-19: All 2,600 seniors' residences in Quebec will be inspected, Premier Legault says.* April 13 2020 https://montreal.ctvnews.ca/covid-19-all-2-600-seniors-residences-in-quebec-will-be-inspected-premier-legault-says-1.4893917

[33] Montpetit, Jonathan. CBC News. *Quebec announces plan to deal with second wave of COVID-19, avoid fatal failures of the spring.* August 18 2020. https://www.cbc.ca/news/canada/montreal/quebec-government-second-wave-covid-19-plans-1.5690603

[34] Gordon, Sean. CBC News. *Quebec thought it had learned from the 1st wave of COVID-19, so why is it facing another lockdown?*. January 6 2021. https://www.cbc.ca/news/canada/montreal/quebec-lockdown-second-wave-lost-1.5860741

[35] Serebrim, Jacob. Global News. *Long-term care homes in Quebec better protected during second COVID-19 wave: report*. December 17 2020. https://globalnews.ca/news/7529166/long-term-care-homes-in-quebec-better-protected-during-second-covid-19-wave-report/

[36] Province of Quebec. *Situation of CHSLD.* January 14 2021. https://cdn-contenu.quebec.ca/cdn-contenu/sante/documents/Problemes_de_sante/covid-19/etat_situation_chsld.pdf

[37] CIHI *Long-term care homes in Canada: How many and who owns them?* September 24 2020. https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

From September 1, 2020 to January 11, 2021, there have been 1,254 deaths in long-term care in Quebec, compared to 3,890 in the first wave.[38]

Vaccine Roll-Out

Quebec's vaccine roll-out in long-term care began much earlier than Ontario's and has moved more quickly. It has, however, been controversial. In mid-December the Quebec government began administering the COVID-19 vaccine among their long-term care residents and staff members. As of January 18, 2021, Quebec reported that 75% of their 40,000 long-term care residents had received either the Pfizer or Moderna vaccine.[39] Since administering the vaccine, the province has faced higher levels of community spread and rising hospitalization rates and decided to delay the second dose of the vaccine in long-term care homes so that they can administer first doses to senior citizens living independently or in retirement residents sooner. Both vaccines are only partially effective until the second dose is administered. The Quebec government decided to increase the delay for the second inoculation to up to 90 days for both the Pfizer and Moderna vaccines.[40]

CHSLD (French acronym for LTC home) Saint-Antoine in Quebec City began administering the vaccine on December 14, 2020, however the outbreak at that home has continued to grow significantly throughout January, even among some residents who have tested positive or developed symptoms had previously received the Pfizer vaccine .[41] Experts advise that the positive cases among some inoculated residents does not indicate a lack of efficacy in the vaccine, rather that the residents and staff may have been vaccinated after already being exposed to a significant viral load. There is the potential that those who were first vaccinated may have already been positive and/or exposed,[42] they reported and noted that the vaccine takes two weeks to build up immunity from COVID-19, during which time there is potential for further spread of the disease.[43] As of the most recent update we found, media reports stated that the residents and staff would get their second dose of the vaccine as scheduled (with the delay). Studies on the Pfizer vaccine show that the first dose of the vaccine alone has an efficacy of around 52% which increases to 95% after the second dose has been administered and the recipient has had time to build antibodies.[44] Physicians have speculated that the post-vaccine cases of COVID-19 should be less serious but there is no data so far on this.[45]

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[38] Province of Quebec. *Data on COVID-19 in Québec*. January 18, 2021. https://www.quebec.ca/en/health/health-issues/a-z/2019-coronavirus/situation-coronavirus-in-quebec/#c53633

[39] VAT News. *75% des résidents vaccinés dans les CHSLD*. January 18 2021. https://www.tvanouvelles.ca/2021/01/18/75-des-residents-vaccines-dans-les-chsld

[40] Wilton, Katerine. Montreal Gazette. *Quebec confirms it will delay second vaccine dose for CHSLD residents and staff.* January 15 2021.https://montrealgazette.com/news/quebec-releases-details-of-its-vaccination-plan

[41] Lowrie, Morgan. Global News. *Coronavirus outbreak grows in vaccinated Quebec City care home, expert says it was to be expected.* January 7 2021. https://globalnews.ca/news/7560584/quebec-city-long-term-care-home-coronavirus-outbreak/

[42] Lowrie, Morgan. Global News. *Coronavirus outbreak grows in vaccinated Quebec City care home, expert says it was to be expected.* January 7 2021. https://globalnews.ca/news/7560584/quebec-city-long-term-care-home-coronavirus-outbreak/

[43] Gordon, Sean. CBC News. *COVID cases among CHSLD residents not a reflection of vaccine effectiveness, experts say.* January 14 2021. https://www.cbc.ca/news/canada/montreal/covid-cases-vaccinated-chsld-residents-1.5872239

[44] Gorvat, Zarya. BBC. *How effective is a single vaccine dose against Covid-19?* January 14 2021. https://www.bbc.com/future/article/20210114-covid-19-how-effective-is-a-single-vaccine-dose

[45] Lowrie, Morgan. Global News. *Coronavirus outbreak grows in vaccinated Quebec City care home, expert says it was to be expected.* January 7 2021. https://globalnews.ca/news/7560584/quebec-city-long-term-care-home-coronavirus-outbreak/

3. Power, Influence, Care & Accountability in Ontario's For-Profit Dominated Long-Term Care Sector

Ontario has, by far, the most for-profit long-term care ownership of any province in Canada with 57 percent of our province's long-term care homes operated by for-profit companies.[46] As the pandemic spread across our province, the fact that for-profit long-term care homes had worse outbreaks and worse death rates than non-profit and public homes began to capture the public's attention. Thereafter, a much-needed public debate about ownership and control of our long-term care has grown. Though there is a strong moral element to the debate, the issue is not only ideological. There are well-studied differences in outcomes and processes of care in for-profit homes as compared to public and non-profit homes. Lesser studied, but vitally important, is the influence that the for-profit industry has on public policy regarding long-term care homes.

The for-profit long-term care industry is manifestly well connected. It is organized and sophisticated, operating through the influence of chain companies and the industry association, called the Ontario Long-Term Care Association (OLTCA).[47] Despite irrefutable evidence that both the infection rates and death rates in for-profit long-term care homes throughout the pandemic have been far higher than in public and non-profit homes, and that prior to the pandemic across a whole array of process and outcome measures the for-profits showed poorly in comparison to their non-profit and public counterparts, the industry and its spokespeople have developed a set of arguments to distract from the significant differences in care, outcomes and choices about how they use their resources. Their spokespeople have widely used a Canadian Medical Association Journal study to support their claims. Their power is evident in the high-profile publications that have run recent editorials in favour of slight regulatory changes, while ignoring the very egregious practices in staffing, care levels, and attempts to win deregulation by the industry.

Any attempt to reform long-term care must grapple with the disproportionate and negative impact of the for-profit long-term care industry in Ontario on public policy regarding improving care. The following section outlines the evidence regarding the spread of COVID-19 and deaths that have resulted in for-profit versus non-profit and public long-term care homes in Ontario. It addresses the significant methodological problems and other flaws in the study that has been used to claim that facility design and not ownership accounts for these differences. It sketches the revolving door between the highest levels of policy decision-making and the industry and gives a summary of what the industry had advocated in its lobbying. Finally, we include some recommendations and cautions for your Commission both regarding the industry's claims and regarding ideas to assert the public interest going forward with recommendations for reform.

a. COVID-19 Infection and Death Rates in For-Profit Long-Term Care

Every study of COVID-19 infection and death rates in Ontario's long-term care homes through the pandemic has found significantly higher rates in for-profit compared to public and non-profit long-term care homes. We did our own study in May, looking at the first wave to May 5, 2020.

[46] https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them#:~:text=Canada%20has%20a%20total%20of,%25%20not%2Dfor%2Dprofit.

[47] Today, the OLTCA claims it represents 70% of Ontario's long-term care homes. (57% of all LTC homes in Ontario are for-profit and a number of others are managed by for-profit companies.) It must be noted that there is an association for the public and non-profit homes currently called AdvantAge Ontario. The OLTCA was born from the former nursing home association (the nursing homes are for-profits) and changed its name in 2001. Of the 12 Directors on the Board 10 are from for-profit corporations.

We looked at long-term care homes that had outbreaks resulting in death. In summary we found, that the rate of death, as measured by the proportion of deaths over the total number of beds in homes with COVID-19 outbreaks resulting in death, was:

- 9 per cent in for-profit homes
- 5.25 per cent in non-profit homes, and
- 3.62 per cent in publicly-owned (municipal) homes.[48]

CBC's Marketplace released an analysis in December, confirming our earlier findings. They looked at long-term care homes with outbreaks from the beginning of the pandemic to December 13 and measured the death rates by ownership and then broke down their findings by chain company. They found much higher death rates in the for-profit homes, with the following chains ranging from more than double to more than 6 times the death rates of municipally owned (public homes):

- Southbridge Care Homes had 9 resident deaths per 100 beds
- Rykka Care Centres had 8.6 deaths per 100 beds
- Sienna had 6.5 deaths per 100 beds
- Revera had 6.3 deaths per 100 beds
- Chartwell had 4.6 deaths per 100 beds
- Extendicare had 3.6 deaths per 100 beds.

All of those companies had death rates higher than the non-profit and municipal categories. Non-profits had an average of 2.8 deaths per 100 beds while publicly-owned municipal homes averaged 1.4. The average death rate in for-profit homes is 5.2.[49]

These numbers represent thousands of human lives.

b. Fact Check– Addressing the Claims of the For-Profit Industry

Unable to deny the fact that for-profit long-term care homes have extraordinarily higher infection and death rates in the pandemic, and unable to deny the fact that for-profit long-term care homes have, for years, paid their staff less, hired less full-time staff, provided less benefits and fewer hours of care per resident, the proponents of for-profit long-term care have shifted their arguments and engaged in an array of contortions and misrepresentations.

For-profit proponents claim that almost all of Ontario's older nursing homes are for-profits blaming the age and design of the homes for infection and death rates, saying "these old homes have multi-resident rooms where four seniors could transmit the virus through the air they were sharing". They claim that most of the private LTC companies have applied to redevelop those homes.

To put these claims into context, long-term care homes that have rooms shared by 4-residents are not up to building standards set in 1998, at minimum, 23 years ago. In 1998 the Mike Harris government created a capital development plan to build new long-term care homes and renovate old homes to come up to new standards. For the first time in Canadian history, public tax dollars would be used to fund for-profit companies to build long-term care homes that they would then operate for 20-year leases (subsequently extended to 30-years) for their own profit.[50] The provincial government would use public money to pay these companies a per deim rate per bed per day to cover their costs for the duration of the lease deal. In addition, the

[48] https://www.ontariohealthcoalition.ca/index.php/death-rates-in-long-term-care-by-ownership-release/
[49] https://www.cbc.ca/news/canada/nursing-homes-covid-19-death-rates-ontario-1.5846080
[50] https://collections.ola.org/mon/4000/10307915.pdf

companies get operating funding from public tax dollars and residents' fees. At the end of the lease term, the private companies would own the assets for which we, as tax payers, paid.

This capital fund was enriched in 2007 by the McGuinty government then revised the program due to low uptake and announced a new program in 2014,[51] then again in 2019 by the Ford government[52] and again in 2020 by the Ford government.[53] Long-term care corporations that bought older cheaper homes and chose not to redevelop their beds under the repeated voluntary incentives programs for redevelopment, made a financial and operational choice not to do so. Those who were laggards benefitted by not voluntarily renovating their beds earlier. Since wait lists for long-term care in Ontario have numbered more than 30,000 for years and more than 20,000 for decades, it is a seller's market. Homes run with high occupancy rates no matter how small and cramped. The fact is that for-profit ownership is strongly correlated with the choice not to redevelop beds to come up to standard.

The bottom line is that given the decades of financial incentives given to operators of old long-term care homes, except for those that are land-locked and cannot find a reasonable way to move their residents out to rebuild, they really cannot now claim they are not responsible for the poor outcomes that have resulted from their financial decisions.

It is also important to understand also that the long-term care chain companies that bought cheaper and older homes, which they have run for profit for decades, are now advocating that the public pay for their renovations and rebuilds and that those funds place competing demands on funding for care.

For-profit proponents claim that private employers do not keep workers' wages low and reduce hours of care in order to increase profits. They claim that the wages are duly negotiated with unions. This obscures the fact that long-term care workers do not have the right to strike, even if the dedicated women who work in the homes could see their way to removing their labour from the residents for whom they care to go out on strike. Nor does it recognize that for-profit long-term care homes have chosen to set bargaining demands for lower wages than their public and non-profit counterparts.

For-profit proponents claim that the hours of care are not determined by employers. It is irrefutable that the employers determine how many staff per shift, whether or not they replace empty shift lines (which they often do not).

From a Toronto Star article, this account:

> "Southbridge Care Homes, a private company that bills itself as Ontario's sixth largest long-term-care home operator, has an investment agreement with a Toronto-based money management firm called Yorkville Asset Management.

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[51] http://www.health.gov.on.ca/en/pro/programs/ltcredev/docs/construction_funding_subsidy_policy.pdf This describes the changes that enriched the program in the Enhanced LTC Home Renewal Strategy. It increased the construction funding subsidy, extended licenses from 25 to 30 years for homes that redeveloped under the strategy, it increased the preferred accommodation premiums homes are allowed to charge, it established a committee to review variance requests from design standards:
http://www.health.gov.on.ca/en/pro/programs/ltcredev/docs/enhanced_strategy_overview.pdf

[52] http://health.gov.on.ca/en/public/programs/ltc/docs/policy_funding_constructioncosts.pdf

[53] https://www.ontario.ca/page/long-term-care-home-capital-development-funding-policy-2020 The new policy provides capital grants of between 10 and 17 percent of total project costs, depending on location, increases the operating funding for basic accommodation, a significant increase in the construction subsidy and grants for transition.

> Among the homes in the Yorkville portfolio is Orchard Villa, in Pickering, where 71 residents died during the first wave of COVID-19. In a fund review for the quarter ending June 30, the quarter when more than 200 Orchard Villa residents were diagnosed with COVID-19, Yorkville wrote that Southbridge management was "continuing to reduce costs outside of care." Three months later, in another update, Yorkville wrote that it was pushing "for a reduction in structural costs within the business model" at Southbridge. Neither update mentioned the death toll at Orchard Villa or any other Southbridge home."[54]

For-profit proponents claim that we cannot afford to end for-profit care. They say that 36,000 beds need to be rebuilt and we cannot afford to do so without the for-profits. They neglect to note that we, as taxpayers and residents, are paying for the rebuilds and the new beds regardless of who owns them. We are paying in per deims of $150,000 plus per bed for 20-year licenses, $224,000 per bed for 30-year licenses, plus capital grants, plus operating costs, plus capital repairs subsidies etc., plus underwriting their mortgages through the Canadian Mortgage and Housing crown corporation.

c. Analysis of the CMAJ Study on For-Profit LTC Infection & Death Rates

For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths.
Study published in the CMAJ, August 17, 2020, Volume 192, Issue 33
Authors: Nathan M. Stall MD, Aaron Jones MSc PhD, A. brown MSc PhD, Paula A. Rochon MD MPH, Andrew P. Dosta PhD.

This analysis looked at the relationship between ownership and the occurrence, size and mortality rates in Ontario's long-term care homes as a result of COVID-19 in the first wave of COVID-19 from March 29 to May 20, 2020. The study authors found that all different types of homes had outbreaks but that once an outbreak occurred, for-profit homes had larger outbreaks and higher death rates than non-profits and even more significantly higher than publicly-owned homes. They also found that chain ownership carried a higher risk of infection and death. They then took the overall findings of significantly higher infection and death rates in for-profit long-term care homes with outbreaks and adjusted them by multiple regression analyses using other factors that may have contributed to the spread of COVID-19 in the homes. When adjusting for facility design, they found that the impact of for-profit ownership was negated. However, there are some problems with this analysis.

If considering this article as evidence, we ask your Commission to review a brief critique of this article here:

COVID-19 and long-term care facilities: Does ownership matter?
Margaret J. McGregor and Charlene Harrington
CMAJ August 17, 2020 192 (33) E961-E962; DOI: https://doi.org/10.1503/cmaj.201714

The main points are as follows:

- Research has shown that for-profit ownership of long-term care (LTC) homes has been relevant to patterns of coronavirus disease 2019 (COVID-19) outbreaks and

[54] https://www.thestar.com/business/2021/01/26/the-problem-with-profits-as-ontarios-long-term-care-homes-stagger-under-a-covid-death-toll-of-more-than-3000-some-say-its-time-to-shut-down-for-profit-homes-for-good.html

deaths in Ontario; this is related to building characteristics and chain status of owners.
- For-profit ownership has been related to lower LTC staffing levels in research comparing for-profit and non-profit facilities. The study did not including staffing levels across different ownership groups.
- Recent research has shown an association between lower nurse staffing levels and worse COVID-19–related outcomes in LTC facilities.
- Long-term care policy should prioritize funding and mandating sufficient staffing levels based on the available evidence.

In addition to the findings of McGregor and Harrington, we had notes of concern regarding the methodology of this study as follows:

- Study authors report that the cumulative incidence of COVID-19 in the public health unit surrounding the LTC home was highest for the non-profits (1.06 per 1000), middle in the for-profits (1.00 per 1000) and lowest for the municipal homes (0.89 per 1000) and that the odds of an outbreak in a LTC home as a proportion of all LTC homes in the province was "associated with the incidence of COVID-19 in the public health unit region surrounding the LTC home, the total number of active residents, and older design standards, not not for-profit status". All of this was achieved through using different regression analyses.

- The analysis used public health data for rates of COVID-19 infection in the communities surrounding the homes. However, testing was very low through the first wave. For example, on March 31 Ontario had the lowest testing rates in the country overall and local Public Health Units were only testing "3 to 4" residents in long-term care homes with outbreaks.[55] By the end of April, Ontario was still only conducting approximately 10,000 tests per day[56] throughout this time, general community members could not get tested and testing criteria was very tight (known travel or close contact with travel, active symptoms including fever, sore throat, dry cough) so there is no real measure of COVID-19 rates in the community. Furthermore, regular surveillance testing of all residents had not been implemented in the period studied. Thus, there is not good data on what the rate of infection was in the communities surrounding the homes nor was there good data for a significant portion of the time studied on infection rates in the homes.

- The analysis was conducted at the LTC home level rather than at the resident level. But every home, regardless of whether it has 4-bed shared rooms also has up to 60 percent of its rooms as private and semi-private. (In the older homes 1 or 2 people per room respectively). Thus, residents who contracted COVID-19 who were and were not in 4-bed shared rooms was not actually calculated. It is hard to see how a definitive link between 4-bed shared rooms and COVID-19 incidence is possible without looking at which residents in each home actually contracted COVID-19. At no point in the study do the authors report what percentage of residents in 4-bed shared rooms were infected or died.

[55] https://www.ontariohealthcoalition.ca/index.php/release-why-are-so-few-ontarians-being-tested-and-tracked-health-coalition-raises-questions-about-covid-19-numbers/
[56] https://files.ontario.ca/moh-covid-19-report-en-2020-04-29.pdf

- Among LTC homes with a confirmed COVID-19 outbreak, for-profit status was associated with a 1.96 fold increase in the extent of the outbreaks and a 1.78 fold increase in the number of resident deaths due to COVID-19 compared with non-profit homes. In this section, study authors did not give the numbers in comparison to municipal homes. Instead they reported, "All comparisons favoured municipal homes, which generally operate with the support of municipal contributions and benefits that allow for greater staffing levels and capital expenditures." No similar sentences that attribute spending and funding causality to home performance are in this study regarding any other ownership type. For example, the study does not state that for-profits choose to allocate costs away from the accommodation (profit-taking) envelope in order to make more room for profit taking, and make other financial decisions that impact on care levels, choose to schedule staff in such a way as to result in more part-time and precarious staffing etc. The study does not look at funding or spending and does not contain any evidence to support any contentions regarding these. In fact, this sentence is footnoted to two other studies which do not contain any supporting evidence for this contention as follows:

    The studies cited to support that sentence which appears to have written off the better practices of municipal homes as a result solely of better funding and "benefits" are: 1) a B.C. study looking at only B.C. LTC homes comparing non-profit and for-profit (not municipal) homes, and; 2) a 2015 comparative study (ON, BC, Alta, Man) looking at size and market consolidation as well as regulatory trends.

    Study 1 which looks solely at British Columbia non-profit and for-profit ownership does not contain anything about municipal homes having municipal contributions allowing for greater staffing levels and capital expenditures. Study 2 also does not contain anything to support this contention. In fact, it says that the Harris government changes shifted capital funding to favour the for-profits and eliminated capital grants for municipalities.

    Using this sentence, the authors discount the better performance of municipal homes regarding the number of resident deaths due to COVID-19 as attributed to causal factors and financial decisions that are not based on any evidence provided or studied or cited, and with regards to capital funding, are not necessarily true. They do not similarly assess the decisions of for-profits with regards to funding staff and capital.

    The next paragraph attributes staff infection as a likely source of outbreaks. It mentions scarce sick benefits, part-time and multi-facility work, as linked to COVID-19 transmission among facilities. It does not mention that fewer benefits, part-time and casual status are more prevalent among for-profit homes and it does not mitigate its adjustment of the impact of community transmission on ownership status accordingly.

- The next paragraph states that outdated design standards and chain ownership together mediate for-profit status link to death rates. These are two totally different things. Chain ownership is inextricably linked to for-profit status. How could it be used as a mitigating factor to adjust death rate outcomes? As for design standards, which likely have an impact, for-profit ownership is strongly correlated with failure to redevelop beds. Tens of thousands of beds were rebuilt with provincial funding

provided equally to all home operators that chose to rebuild and increasing incentives were given over the years to rebuild. Those homes that bought cheaper older homes chose to do so. Those operators who chose not to avail themselves of provincial funding to redevelop beds made that financial decision.

- The authors attribute design standards to better infection control, using as an example less crowded common areas as well as room design. However, they did not look at the homes with outbreaks to assess whether residents were sequestered or moved from their rooms, whether they were isolated, whether common rooms were used at all during the outbreaks. Poor compliance with cohorting/sequestering infection control standards has been repeatedly demonstrated in the for-profit homes studied. This was not mentioned.

d. Connections Between For-Profit Long-Term Care Corporations & Government

For many years, public interest advocates have tried to win improved care levels in regulation or legislation, and meaningful accountability and enforcement in long-term care. With only a few exceptions, these efforts have been opposed by the for-profit long-term care industry. While governments pursuing policies of austerity can partially explain (though not excuse) the failure to implement care standards and improve care levels, the failure to create meaningful accountability and enforcement is not a cost issue. It can, however, be explained by the revolving door between the for-profit long-term care industry and key positions in government. The following list gives just some examples of connections between the current government, key figures associated with the current government, and for-profit long-term care interests.

PREMIERS

Mike Harris

- Former Progressive Conservative Premier, his son Mike Harris Jr. is currently a MPP
- Chair of Chartwell

Ernie Eves

- Former Progressive Conservative Premier
- Board member of Central Park Lodges between terms in office

Bill Davis

- Former Progressive Conservative Premier
- Board Member of Revera Inc

MINISTERS' & LEADERS' OFFICES

Donna Duncan

- Former Policy Advisor to John Tory from 2006-07 when he was leader of Ontario PC
- Current CEO of OLTCA

Christopher Chapin

- Ties to MPP Caroline Mulroney (Minister of Transportation), Vic Fedeli (Minister of Economic Development) and Christine Elliot (Minister of Health)
- Senior Campaign Advisor for Caroline Mulroney's leadership campaign (Jan. to Mar. 2018)
- Deputy Digital Director, PC Party (June 2017-Jan. 2018)
- Digital Comms Advisor, Office of the Leader of Opposition, Patrick Brown (Now Mayor of Brampton) and Vic Fedeli (Current Minister of Economic Development) (June 2015 to Jan. 2018)
- Digital lead, Christine Elliott's leadership campaign (2014-15)
- Senior Campaign Advisor for Caroline Mulroney's leadership campaign.
- Lobbyist for Caressant Care as part of Upstream Strategy Group from August 2018-April 2020

Andrew Brander

- Ties to MPP Rod Phillips (Minister of Finance)
- Former Director of Communications for MPP Rod Phillips who is currently Finance Minister under Ford Government. Worked for a decade in the Harper administration.
- Lobbyist for OLTCA from April 2020 to Present

Carly Luis

- Ties to MPP Vic Fedeli (Minister of Economic Development) and MPP Christine Elliott (Minister of Health)
- Director of Strategic Communications, Office of the Leader of the Ontario PCs from January 2017 to March 2018 (Vic Fedeli)
- Strategic Communications Advisor, Office of Leader of the Ontario PCs from Mary 2015 to January 2017 and Manager of Stakeholder Relations for Ontario PC in 2014.
- Is currently Director of Communications for the Minister of Health, Christine Elliott
- Lobbyist for Chartwell from March to June 2020
- Lobbyist for OLTCA from October 2019 to May 2020

Jessica Trepanier

- Ties to MPP Doug Downey (Ontario Attorney General), MPP Caroline Mulroney (Minister of Transportation) and MPP Lisa Thompson (Minister of Government and Consumer Services)
- Press Secretary and Issues Manager at the Office of the Ontario Attorney General, (Doug Downey) from July 2018 to February 2019.
- Communications Advisor for Caroline Mulroney's Campaign from February to June 2018 and Legislative Assistant for Ontario PC MPP Lisa Thompson from August 2015 to February 2018.
- Public Relations position for Southbridge Care Homes working under Smith Com.

Michael Wilson

- Ties to MPP Doug Downey (Ontario Attorney General)
- Chief of Staff for Doug Downey, Ontario Attorney General from June 2018 to January 2020
- Lobbyist for Sienna Senior Living from May to June 2020

CLOSE ADVISORS TO PREMIER DOUG FORD

Melissa Lantsman

- War Room Director and Spokesperson for Doug Ford's campaign from February to June 2018.
- Former (to early 2020) Vice President Conservative Party of Ontario
- Campaign Director, Caroline Mulroney's leadership campaign.
- Director of Communications for the Minister of Finance (Jim Flaherty) in federal government from December 2013 to November 2015.
- Lobbyist for Extendicare from April 2020 to present.

Patrick Tuns

- Former Deputy Campaign Manager for Doug Ford's leadership race and 2018 election campaign
- Lobbyist for Caressant Care as part of Upstream Strategy Group from July 2018 to April 2020

Hazel McCallion – Former Mayor of Mississauga

- Endorsed Ford's campaign in 2018
- Chief Elder Officer (a newly formed position) at Revera Inc.

Lauren McDonald

- Ties to MPP Sylvia Jones (Solicitor General of Ontario)
- Director of Marketing in the Ontario Office of the Premier, Doug Ford from July 2018 to August 2019
- Special Assistant to Ontario PC MPP Sylvia Jones (now Solicitor General) from June to September 2014
- Constituency Assistant for Conservative MP David Tilson from May to September 2013
- Lobbyist for Revera as part of Proof Inc. from May 2020 to September 2020

Brayden Akers

- Ties to MPP Greg Rickford (Minister of Northern Development, Energy, Mines and Indigenous Affairs)
- Former Director of Communication to Greg Rickford, Ontario's Minister of Northern Development, energy, mines and Indigenous affairs
- Senior Political Staff Member in Harper Government
- Lobbyist for Sienna Senior Living as part of Navigator LTD from June 2020 to Present

SUPER AGENCY APPOINTEE

Shelly Jamieson

- Was Executive Director of Ontario Nursing Home Association and VP/President of Extendicare then was appointed to Harris' government Health Restructuring Commission (1995) where they ordered the closure of thousands of chronic care hospital beds from 1997-2000. Then the Harris government tendered 20,000 new long-term care beds to replace them. The majority of the beds went to for-profit providers including Extendicare. Ms. Jamieson then became President of Extendicare.
- On the Board of Ontario Health (New Super Agency), appointed by the Ford Government.

e. What For-Profit Long-Term Care Homes are Advocating

Space does not permit a full list of all of the policy changes that for-profit long-term care homes had advocated but a brief summary of some of the recent key issues is illuminating. In a document titled *Cutting Ontario's red tape in long-term care: Immediate solutions to unleash capacity now and for the future* the OLTCA lays out a series of claims about over-regulation and "red tape" and calls for a series of measures, couched in euphemisms, including:[57]

- To replace the regulated requirement for one RN 24/7 per home to replace RNs with less costly RPNs (page 3).
- To replace PSWs with lesser or untrained staff. Currently PSWs must have a diploma and must provide the care set out in the Act and its regulations (page 3).

Note: the homes won these deregulations under the emergency orders in the pandemic. So just as COVID was sweeping through long-term care homes and residents needed more and better trained staff, not less, the only existing care standards for daily care staff were deregulated.

- Reduce the requirement for the frequency of police checks for staff (page 4).
- Adopt risk-based inspections, reduce inspections, do not use an enforcement approach (page 5).
- Reduce requirements to report critical incidents and complaints, refer them to a complaint resolution process (page 6).
- Reduce reporting requirements (page 6 and throughout).
- Reduce mandatory training requirements (page7).
- Provide greater flexibility in the use of funding (page 8).
- Repeal the Pay Transparency Act (page 9).

f. Case Study: Regulating Inspections of Long-Term Care Homes

For many years we have struggled to achieve regular comprehensive unannounced inspections in long-term care homes. The power of the industry lobby is apparent in this history. Repeatedly, advocates in the public interest have won annual surprise inspections and repeatedly they have been taken away behind the scenes. The following is the history:

Types of Inspections:

There are multiple different types and intensity of inspections. Following the CBC investigative report here: https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585 on the Ford government's failure to conduct annual unannounced comprehensive inspections on all homes since it took office, Merrilee Fullerton, Minister of Long-Term Care, has declared that the province has performed thousands of inspections. The fact is that the government only conducted 9 comprehensive inspections in 2019.

The annual unannounced inspections that the Ontario Health Coalition, the Advocacy Centre for the Elderly, Concerned Friends of Ontario Citizens in Care Facilities, unions and other public interest advocates have been advocating for are currently called Resident Quality Inspections (RQIs). As per the CBC report, most of the province's 626 long-term care homes received full RQIs in 2015, 2016 and 2017, but that number dropped to half in 2018 and only 9 were done in

[57] https://www.oltca.com/OLTCA/Documents/OLTCA%20-%20Short%20Term%20Red%20Tape%20Submission%20-%20Final.pdf

2019. The provincial election was half-way through 2018 (June 7, 2018). Since the election of the Ford government RQI inspections slowed to a trickle.

When the Long-Term Care Homes Act (2007) was enacted in July 2010, the Liberal government promised that an RQI would be performed annually on every long-term care home. The RQI required interviews with 40 residents, as well as family, staff and family and resident councils, and had mandatory areas of review. In 2016, the RQI was split into two tiers of inspections: intensive and not (the latter colloquially called RQI Lite). The Intensive RQIs were the original full inspections. The RQI Lite inspections interviewed fewer people and only inspected in areas that were "triggered". Under this new scheme, every home was to have an "intensive" RQI at least every 3 years, with those homes identified by the Ministry as being at risk having them more frequently.

Other inspections are not the same thing. They are based on complaints (usually made by residents or relatives of residents), or critical incident reports (which are reports required by the Act when certain incidents occur and which are supposed to be reported to the Ministry by the home). These inspections look at specific issues, and do not look at the conditions throughout the home and do not require interviews with residents, families, and staff as well as management, except insofar as these are needed to investigate the specific complaint or critical incident. They do not provide a comprehensive view of the home as occurs in a full RQI.

However, since 2018, the Government has indicated that any type of inspection done by the Ministry qualifies as an "annual" Inspection under the Act. To count complaint- and criticial incident- based inspections as being equivalent to comprehensive annual RQI inspections is misleading.

<u>The Long-Term Care Industry Lobby for Deregulation:</u>

The long-term care homes industry has lobbied against the full inspection regime. They have called for an end to the annual surprise comprehensive RQI inspections and enforcement. They have a set of language to cover for this, calling it "quality based" or "risk based" approach versus a "punitive" "inspection and enforcement driven" approach.

<u>The History of Regulation/Deregulation of Inspections in Ontario:</u>

1990 – 1994: NDP Rae government passed Long-Term Care Homes Statute Amendment Act to amend all three types of facilities – nursing homes (for-profit and non-profit), homes for the aged (public – municipally owned) and charitable homes (non-profit)– under the umbrella of the Ministry of Health, and under one administrative system and put into place stricter oversight. Among the most important features of this new regime were the Residents' Bill of Rights and the mandatory establishment of Residents' Councils in all long-term care facilities. These Councils had the power to advise residents of their rights, file complaints, monitor the operation of the facility, review inspection reports and financial statements including the allocation of government funds. Under the Long-Term Care Facility Program Manual annual inspections were required for every long-term care home.

The Conservative Harris government was elected in 1995. In the spring of 2000, NDP Health Critic Frances Lankin, who had been the Minister of Health previously, discovered that many nursing homes had not been inspected in two years, even though their licenses were renewed. For months, Lankin hammered the government in the Legislature and in the media to explain the gap in inspections and reinstate annual inspections. The Ontario Health Coalition and other

public interest advocates supported the call for the reinstatement of annual inspections. In the fall of 2000, the Canadian Press reported that documents obtained through a Freedom of Information request revealed that regular inspections had dropped close to 40% between 1996 and 1999. In some instances, facilities were not inspected for three years, a clear violation of government policy. When inspections did actually take place, they were not the three- to seven-day examinations mandated by the Ministry. Instead, they were quick and often cursory reviews. By 2001 Ernie Eves was the Conservative Premier and his government reinstated annual inspections.

The Liberal McGuinty government was elected in 2003. In 2007 they passed the Long-Term Care Homes Act rolling the three existing Acts (Nursing Homes, Homes for the Aged and Charitable Homes) into one, set up a system of Family Councils and created a new regulatory regime. The new Act required annual inspections the Ontario Health Coalition, Concerned Friends and other public interest groups advocated for residents, families and staff to be interviewed by inspectors, not only facility management. The new RQI system was born and annual inspections continued until 2012 when Health Minister Deb Matthews attempted to stop the annual RQI inspections. The Advocacy Centre for the Elderly (ACE) was instrumental in getting the inspections reinstated. Jane Meadus, a lawyer with ACE and a specialist in long-term care, brought the documents from the passage of the 2007 Act to the government, forcing them to acknowledge that the legislated requirement for an annual inspection was meant to require an RQI. OPSEU also intervened actively pushing for the hiring of more inspectors and reinstatement of the annual inspection regime. The Ontario Health Coalition also campaigned actively on this issue: see http://www.ontariohealthcoalition.ca/wp-content/uploads/ltcjune132012.pdf . Annual inspections were reinstated. Under Health Minister Eric Hoskins, new fines were created as penalties for homes that were not compliant with inspection orders. The legislation, The Strengthening Quality and Accountability for Patients Act (2017), was passed in late 2017 but was not enacted before the Liberals lost power and has not been enacted by the Ford government.

When the Ford government took power in 2018 the comprehensive annual unannounced inspections were ended.

g. Measures to separate government political and ministry staff from the influence of the for-profit long-term care homes industry

In order to address the disproportionate influence of the for-profit long-term care home industry has on policy, and to ensure that any improved regulations or policy measures in the public interest have a chance of lasting, it is critical that measures be taken to separate the industry from government. These measures could include: prohibiting politicians, public servants, political staff and advisors from lobbying for long-term care corporations for a period of 5-years after holding a position; requirements that government consult with families, workers and their organizations and public interest advocates on long-term care policy changes; requirements for improved disclosure of lobbying activities and stronger requirements of the Integrity Commissioner; and a review of best practices in achieving a full separation between the industry and the government, both political and civil service.

4. Response to the Long-Term Care COVID-19 Commission's Recommendations to Date

We deeply appreciate this Commission's recommendations to date. We are in full support of the following, and in some areas, respectfully recommend that the Commission strengthen and clarify some of your recommendations as indicated in the italicized notes.

- Increase the supply of PSWs, ensure an appropriate staff mix, increase the number of full-time staff, implement a comprehensive human resource strategy. *This cannot wait any longer as the staffing and care crisis is worse than ever.*
- Implement a minimum average of 4-hours of direct care per resident per day. *Progress needs to be made much more quickly than scheduled in the December 17, 2020 Staffing Plan released by the Ontario government. Residents, families and care workers alike cannot wait until April 2022 for the first 15-minute increment of improved care. Nor can they wait until 2025 for a four-hour minimum standard to be achieved.*
  Ontario can and should follow the example of Quebec in implementing a coordinated recruitment strategy with paid intensive training, improved pay and full-time work, as outlined in this submission, and get care into the homes as soon as possible.
- Ensure that families and caregivers have ongoing, managed and safe access to long-term care residents.
- Clearly define supports and surge capacity for each LTC home, put these in place so they can be quickly mobilized when an emergency situation arises.
- Ensure every LTC home has a trained, dedicated and designated staff person responsible for infection prevention and control. This individual must be on-site each day in a full-time position and be held accountable for resident quality of care.
- Send inspection staff the ministry and from the local Public Health Unit into homes to conduct timely, focused inspections to ensure homes are properly implementing proactive IPAC measures, and are responding effectively to their assessment results.
- Provide highest priority access to testing and quick turn-around of results for residents and staff. The government should also prioritize LTC homes for point of care and less invasive tests as they become available.
- Give residents an option to transfer to another setting such as a field hospital to avoid further transmission of the virus and help them recover. *We believe that this should also apply to residents when safe and adequate care cannot be provided in the long-term care home and care cannot be brought in.*
- Monitor and publicly report indicators in areas such as staffing (e.g. staffing mix, ratio of residents to staff and ratio of residents to staff with clinical expertise, level of staff engagement, etc.), PPE supplies and resident and family satisfaction with care at the home.
- Reintroduce annual Resident Quality Inspections for all LTC homes and require all reactive inspections occurring during the pandemic to include an IPAC Program review. This will ensure that all LTC homes receive an IPAC protocol review and assessment and that possible violations are identified whenever there is a MLTC inspection in the home during the pandemic.
- Improve enforcement. *We believe, based on decades of experience, must include meaningful fines for non-compliance and in serious cases license suspensions or revocations in order to be taken seriously by the home operators.*
- *Complete vaccinations of all long-term care residents, staff and essential caregivers as soon as possible.*