BRIEFING SUMMARY AND ANALYSIS

TESTIMONY BY ONTARIO LONG TERM CARE ASSOCIATION

To the COVID-19 Long Term Care Commission

September 30, 2020

http://www.ltccommission-commissionsld.ca/transcripts/pdf/Ontario_Long_Term_Care_Association_Transcript_September_30_2020.pdf

BRIEFING SUMMARY AND ANALYSIS

Introduction

The Ontario Long Term Care Association (OLTCA) is the lobby group representing the interest of the 58% of for-profit institutions in Ontario. It was formed in 1959 originally as Associated Nursing Homes Incorporated of Ontario, later became the Ontario Nursing home Association in the 1970's then OLTCA in 2001. Its members "serve" over 70,000 residents of these facilities. It claims to "promote safe, quality long-term care to Ontario's seniors. We strive to lead the sector in innovation, quality care and services, building excellence in long-term care through leadership, analysis, advocacy and member services."

https://www.oltca.com/oltca/OLTCA/AboutUs/OLTCA/Public/AboutUs/Main.aspx?hkey=f0c607d1-cab4-470a-9874-df87f0259ae0

These points come from the testimony of Donna Duncan, to the Commission.

STAFFING

"So we knew that 80 percent of our homes were having difficulties with human resources." (Pg. 11).

"we know that many staff were working across multiple sites. Further, we have homes especially in rural areas where they're almost entirely dependent on agency staff, so there is no local labour pool for them to tap into. So especially for RPNs and RNs, but also PSWs, it's -- we have a massive shortage, just leading into this." (Pg. 12)

"The legislation has not allowed for the evolution of the staffing model. And, in fact, it constrains nurses and RPNs and others as to what their scope of practice may have been when the legislation came into effect in 2007 to 2010. So we've kind of hampered our homes, and then the funding model over top of that doesn't allow for the evolution of the model around – that would actually align with the evolution and the escalation of the care needs of our residents."(Pg. 13)

"And you Ruth [McFarlane] was a co-chair of a red-tape task force that had enormous elements and components around HR and the need for flexibility"(Pg. 14)

Analysis

The case is being made here to disregard provincial legislation which could open the door to hiring staff with fewer qualifications in order to address HR needs. The Ford government did loosen staffing restrictions and unions are claiming that cleaning staff are now providing personal care to residents. It also, once again, implies that funding is not sufficient.

This also confirms that a representative of OLTCA – a lobby group for for-profit facilities co-chaired a red tape task force for the Ford government. It has been claimed that it was this task force that eliminated comprehensive yearly inspections of these facilities as "red tape" in the year before COVID struck. OLTCA has long advocated for an end to compliance oriented inspections (see Pg. 2 https://www.oltca.com/OLTCA/Documents/OLTCA%20-%20Short%20Term%20Red%20Tape%20Submission%20-%20Final.pdf)

Without compliance and enforcement inspections, the existing long term care legislation would be useless.

CAPITAL FUNDING

"32,000 of our beds were built to 1970s standards. Our association had a say at a capital redevelopment task force, and we have done a lot of very in-depth work through the fall and into early winter. And we're working with government to try to find a way to expedite a capital redevelopment program, again, one that's not highly prescribed but one that allows for the innovation that we need and allows for the flexibility to adapt to a different resident population but one that could be done quickly. And certainly yet, you know, we identified a lot of process issues, a lot of policy issues. But certainly, as the pandemic bore out, we realized that infrastructure issue clearly was one of the root causes. HR crises, ancient infrastructure, root causes, certainly the red tape, and the staffing -- a couple of those buildings really pushed us, in the association, very early in the pandemic to rush to government to get an emergency order so that we could allow for that flexibility that Ruth was speaking of. We did not have that flexibility during the pandemic" (Pg. 15)

Analysis

So once again we have confirmation of OLTCA representation at a capital redevelopment task force of the Ford government. Their goal - to get a lot of taxpayer funded capital investment to for-profit facility membership in a way that was flexible. Translated this means lacking in public accountability. This is confirmation that OLTCA lobbied the government for emergency money to essentially put very expensive lipstick on a pig – an outdated institutional model that was not working. The Ford government gave it to them in the millions with more funds apparently slated to come.

It should be noted that these facilities receive millions of dollars annually in resident co-payments through the Accommodations funding envelope. This has historically been intended to allow them to renovate and upgrade their facilities. Instead, it would appear that this money was used to pay shareholders a good return on investment, and senior executives at the same time that many facilities did not even have air conditioning and continued to have 4 bed wards – a problem the Association lays at the feet of

Government instead of its own membership and the Ford government responds with millions of dollars in public funds as a bailout.

OLTC INFLUENCE ON PUBLIC HOSPITALS

"And certainly I sit on a hospital board, and I chair their Quality Committee and Patient Experience Committee. And as I think about how we go through our quality reviews or our critical incident reviews, it really is anchored in the programmatic model and the clinical outcomes and certainly international best practices and data."(Pg. 19)

Analysis

So the head of OLTCA - group that represents the for-profit long term care institutions some of which were found to have the highest death and infection rates in Ontario as documented in a major study published in the Canadian Medical Association Journal and numerous press reports chairs a Quality Committee and Patient Experience Committee of a hospital? The irony of this will escape no one.

CARE PLANS

"And then we create what's called a "care plan." And then that care plan is actually translated into our staffing models, and that is ultimately what we want to do is provide that really individualized, custom care that drives resident and family satisfaction but also, you know, drives staff satisfaction." (Pg. 19/20)

Analysis

Again the irony of this is stunning when you consider the Inspection Branch testimony showing that almost 2000 complaints come into the Branch monthly, and that the complaint that tops that list has to do with care planning and how care plans are not met in these facilities.

AN ATTACK ON INSPECTION AND OVERSIGHT

"I believe it was in March that we advocated for the emergency order, but we were also advocating early on to free up the inspectors, especially the nurses, to support our homes in doing assessments around protection, prevention, and control, as well as ensuring that they had sufficient personal protective equipment, recognizing where the shortages were." (Pg. 29).

COMMISSIONER KITTS: Can I just follow on that? In terms of the inspectors, so you realized that long-term care homes were at risk, and you asked government to free up inspectors to help inspect homes to see what their readiness for the pandemic is. When was that, and were the inspectors freed up to come into the homes?

DONNA DUNCAN: So we certainly asked for the freeing up of the inspectors in -- at the end of January or into February. I believe it was in late January we asked for the suspension of the inspections so that we could mobilize the inspectors for other purposes. We continued that advocacy and into March were advocating together with the Ontario Hospital Association as well as the chair and co-chair of the Ontario Health Toronto Region.

COMMISSIONER FRANK MARROCCO (CHAIR): And it just strikes me as odd. At that period in time, responding to the crisis, there are lots of times to do inspections. But at that particular moment, presumably everybody's focussed on the immediate crisis that you have to deal with. Maybe not the best time for an inspection.(Pg. 29/30)

DONNA DUNCAN: M-hm, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Because you're distracted by the inspection then. I don't even know how you would balance the two, really. I'm just speaking, but it's not a conclusion. If it's not correct, I'd like to know. DONNA DUNCAN: No, that certainly was 4our view. When you consider those four foundational pieces, if you were doing a risk assessment, our human resources, our physical plant, our regulatory framework, and our funding would all be red for the sector as we were going into this." (Pg.30/31)

RUTH MCFARLANE: And I might add that I think we wanted to go from the compliance inspection process to having a partnership with the Ministry -- working in partnership with the Ministry to be able to better manage what was coming because we were worried about what was coming, and we needed to have their support. And to have the knowledge about what we were actually struggling with, we could move back forward.

COMMISSIONER FRANK MARROCCO (CHAIR): Which Ministry? When you say "the Ministry," to which Ministry are you referring?

DONNA DUNCAN: So Ministry of Long-Term Care.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay." (Pg.32)

"You know, government does talk about, you know, their inspection plan. And one thing I would add on that, the inspection should be about how do we come in and help you improve."(Pg. 73)

"I do think it's, as we know, what happens and happened in Wave 1 with these homes that are at risk. It really needs to be about a building up and a supporting and figuring out what do you need and how do we help you get there. And I think that tone and approach is going to be profoundly important. I think we can make progress on this. The government has a plan. Let's start."(Pg. 74)

"This notion -- and this is my opinion based on my personal experience working in those other sectors -- is this notion that we should have to surprise a home rather than give them the advance notice. And let's -- you know, and certainly we know that when homes submit critical incident reports, they know that they will have an inspection. There will be an investigation because they've invited it with the fact of the report. But this notion that it has to be a shock and awe surprise, again, speaking to tone and culture, is -- you know, why would you not want to work with them to help them prepare and address an issue in the moment rather than to come in and try to catch them out. I do think that speaks to the culture and the challenges that we have around human resources because, you know, the investigation is about what had happened at that moment of the complaint, and it takes into consideration nothing that you might have done to remedy the situation at all. And the report that you're going to get is going to be a report on failure. "You failed; you failed; you failed."(Pg. 78)

"***In our school system, we support our students to do the very best we can. We recognize and support them to do better. And yet in our long-term care homes, the people who work in them can only fail. So why would you want to work in a sector where you know that as soon as the inspectors are coming in, you have already failed, just the fact that they came into your home." (Pg. 79)***

"But that tone and approach and that culture and not blaming operators or finding faults and really trying to focus on the people in this, I think, is going to be really important for us if we are going to stabilize the workforce we have, protect our residents and our seniors, and attract a new workforce because we do know that the hospital workforce is not there."(Pg. 81)

Analysis

In this testimony, OLTCA provides proof that the for-profit long term care lobby advocated for inspectors to stop being inspectors seeking compliance with the Act and Regulations during COVID, and instead be redeployed to "support" the facilities – something that was confirmed as having happened by the Inspection Branch testimony.

This represents a complete abdication of government responsibility to provide oversight and inspection during a crisis and changed completely the role of the inspectors from an inspection to a support role for facilities. This created blurring of the role of inspectors, and resulted in complete lack of oversight and no requirement of compliance with the legislation or enforcement action.

The Chair of the Commission, during this exchange appears to agree with the head of the OLTCA that eliminating the inspection and oversight role during the pandemic seemed perfectly reasonable.

Further testimony goes on to suggest that these facilities should not have inspections at all but rather have a consulting role in relation to companies, operated for-profit making millions who it would appear are unable to purchase their own expertise and must rely on government-funded inspectors as consultants and supporters.

The OLTCA appears to be suggesting that not only should inspections no longer be inspectors but rather consultants and supporters. They should also not conduct unannounced inspections so that the facility has time to prepare for the inspection.

Essentially the argument is "we do not want to be held accountable at all" through inspection and enforcement, even though this sector is receiving millions of public dollars each year.

OLTCA actually compares the for-profit long term care sector to students in school seeming to suggest that staff do not want to work there because the sector is inspected.

Essentially this means that OLTCA is of the opinion, as an example, that it is the responsibility of the Inspection Branch and the government to help facilities like Orchard Villa that are owned by a large chain, Southbridge, and managed by another large chain, Extendicare Assist, to help them to improve rather than revoking their licenses for repeated violations of the Act and Regulations.

This raises the question why was Extendicare Assist unable to prevent a high infection and the highest death rate in the province in a facility that it was hired to manage? Why did it not bring sufficient infection control and other expertise to the table? How could it have paid out millions to shareholders while not having this kind of expertise available?

MINISTRY OF LABOUR INSPECTIONS

"DONNA DUNCAN: M-hm. So we actually have a good working relationship with the Ministry of Labour. And certainly, you know, we have a lot of inspections in long-term care homes, and labour was certainly a partner and, you know, certainly mindful of what some of the risks were, and they were going into homes and supporting as well."

<u>Analysis</u>

OLTCA confirms that the Ministry of Labour inspectors had also become "partners" with these for-profit facilities raising the question of whether their roles had also changed from being inspectors to being support people. This would have occurred at a time when union members were alleging that some of these facilities were stockpiling PPE and not providing it to their front line staff – something that would seem to be a significant violation of Health and Safety protocols.

CASE MIX INDEX AND HIGH ACUITY ARGUMENT

"RUTH MCFARLANE: So the Case Mix Index is supposed to -- demonstrates the acuity of your residents. Where the challenge comes in is that there is a certain amount of funding that is available, so there's a pie of funding. And the Case Mix Index, well, it enables people to -- or it enables us to take a look at how acute our residents are and what type of, you know, care we have to provide for them.

What it does is it divides that same pie up amongst our staff. It doesn't actually increase the funding when the general acuity of all residents is going up. And it is also a very interesting, you know, demonstrator of acuity, but sometimes it doesn't actually reflect what's happening on the floor with respect to dementia care and behaviour care. So it doesn't actually capture that amount, and there's a lot of staffing resources that are expensed on those type of, you know, every day supports. And so while the CMI is reflective of that, it only divides up an already-set pot amongst the sector……

WIESIA KUBICKA:….It's a tool to distribute available funding and not necessarily the tool that helps us inform the pace of the increases in acuity and how we need to then increase the resources to support our homes to meet those needs."(Pg. 35).

COMMISSIONER KITTS: We've heard the acuity going up with dementia and multiple chronic diseases and behaviour, et cetera. Do you ever compare your sickest or most acute residents with the hospital -- patients in the hospital who are less acute than others? Does acuity come in close there or not?

DONNA DUNCAN: … our recognition is these are ALC hospital patients coming into our homes. So, you know, the data are not aligned, and I think we've got to find a way to better align that. And certainly we're hopeful that as we work more closely with the healthcare system and some of the new integration opportunities, there will be opportunities around data." (Pg. 36)

"I think that it also provides an opportunity for us to educate and maybe update the acute care sector on what type of care and supports we provide our residents. Because it is a very different model from the acute care model and what we do and how we do it." (Pg. 39)

Analysis

This is critical testimony and appears to reinforce SSAO's position that the "higher acuity" argument is faulty.

There is incentive for for-profit facilities to ensure that their Case Mix Index (CMI) is high to give them access to the largest possible share of the finite pot of funding available.

The argument here also appears to be that the CMI does not reflect the true level of "acuity" – a term that is used incorrectly in the context of long term care since it generally refers to critical care patients in hospitals. This sector would naturally try to make the argument that the assessment tool does not reflect the needs of residents in order to support its argument that it needs more funding – even though large nursing home chain operations in Ontario were seeing healthy profits before the pandemic hit.

Here OLTCA also admits that their data is not aligned with hospital data concerning "acuity", therefore raising the question of what baseline OLTCA is using to establish "high acuity" if the CMI does not accurately reflect "acuity" and they have no data aligning with hospital data.

OLTCA has repeatedly made the argument for more money while also trying to convince shareholders to invest by showing excellent return on investment.

These two arguments contradict one another.

Ironically OLTCA also appears to believe that it is in a position to "educate" the hospital sector when it is that sector that had to come to the rescue of OLTCA members during the pandemic. This would seem to lend credence to a public model working and a for-profit model not especially since non-profits performed better during the pandemic.

PROBLEMS OBTAINING INSURANCE

"***…homes were asked prior to infection prevention and control assessments to sign a contract, a clause within which was that they were required to increase their liability insurance And this is at -- so we're in March now, and at that point, all of our homes are actually insured by global reinsurance funds, and insurance for long-term care had been frozen. So there was no opportunity to meet the test that they were being asked to provide -- asked to meet in terms of ensuring that the -- that any hospital employers were indemnified."(Pg. 41)***

<u>Analysis</u>

These institutions appear to be having difficulty obtaining insurance raising the question of corporate and facility liability in the event of another outbreak.

Is government allowing these facilities to continue to operate uninsured?

MORE EVIDENCE OF OLTCA INFLUENCE

"So we had about 120 of our members sitting on different tasks forces and committees really driving toward solutions, multiple member meetings. You know, for us it was about stabilizing our funding reform; taking measures around the HR emergency, and we've talked about that already; certainly addressing the capital program and expediting that and really

looking at some of that regular burden that was contributing to quality but, in many cases, was creating a barrier to quality and innovation. And so this was part of our budget submission that we presented to the Legislative Assembly Finance Committee in early February. So again, you know, what strikes us today is that these recommendations still hold."(Pg.41/42)

Analysis

120 members of the for-profit long term care association were having input into task forces and committees pursuing their agenda for better funding, getting government assistance with staffing issues that they have been unable to manage themselves, and obtaining more money for capital that their members had failed to invest in with resident co-payments. Historically the justification for having privatization in long term care was because they could do the job cheaper and brought their own capital. Since the threat by the Ontario Nursing Home Association to sue for funding parity in the 1980's which resulted in parity between for and non-profit institutions, and now the government providing millions in capital to allow upgrading of their facilities, both arguments appear to be non-starters. This raises the question of why government continues to allow privatization in the long term care sector.

The government has literally delivered on most of what OLTCA has requested.

Meanwhile individuals, their families and advocates' calls for alternatives to the institutional system and elimination of profit as well a strengthening of the Inspection Branch were not just ignored by the government. The government literally did the opposite. It threw millions of taxpayer funds into an outdated and inhumane system, provided money and other support for staffing in a system that staff no longer wanted to risk working in, and redeployed inspectors who were supposed to provide oversight during a pandemic to provide support instead to this privatized sector.

The implications of this – the waste of taxpayer funding that could have gone into alternative residential options in the community to allow the government to shut down the most dangerous facilities (23 as identified by OLTCA as being most in trouble) – that opportunity was completely lost and the money wasted after "input" on numerous task forces and committees by OLTCA. The government largely complied with OLTCA's wishes – with public funds – diverted into private hands.

PUBLIC SECTOR TO THE RESCUE OF THE PRIVATE SECTOR

"But once long-term care homes were prioritized for personal protective equipment, for testing of residents and staff at the beginning, certainly the IPAC supports from the hospitals, the mobilization of workers into the homes from Ontario Health from hospitals from the CAF, unfortunately, as well as, you know, certainly taking some of the steps around really enhancing our prevention supports but also the containment in the community as well as -- you know, unfortunately, the fact that we were closed." (Page 43)

"Certainly where we saw the first cases, in many cases, staff left. We saw homes in dire need of staff. In the most tragic situations where we saw those untold losses, staff, in some cases, had been reduced to 20 percent of their compliment." (Pg. 44/45)

Analysis

OLTCA testimony provides proof that the public hospital sector came to the rescue of the private nursing home sector during a time of crisis and that the private sector was completely unprepared without that assistance This means that very likely, many more would have died had there not been intervention by hospitals, the military, and Public Health. \

PPE should have been readily available in these facilities in the event of outbreaks, but was apparently not. Infection control procedures should have been in place, but were apparently not. Staffing should have been in place, but apparently was not. A containment plan should have been in place but apparently was not.

This raises the question – what were Ontario taxpayers and residents paying for if not for staffing and for supplies?

If these facilities were this unprepared and there were not enough staff and supplies, why did government not reduce their beds and institute Cease Admission orders? If some facilities were staffed at only 20% was government still funding them the full per diem payments with residents not receiving care – some dying because of it as alleged in class action lawsuits?

If ever there was a case to be made for Cease Admissions orders, this would have been it – staff reductions to 20% of their necessary complement during a pandemic?

But the inspectors had been redeployed to "support" these facilities instead of inspecting them.

The fact that staff left in droves also proves how unworkable large institutions like this are, and how smaller, more home-like non-profit community homes would also have been safer and able to keep staff.

The OLTCA is essentially making the case for its own elimination here.

OLTCA tries to suggest that a staffing shortage and 4 bed wards were "root causes" (Pg. 46). In fact they were not. The "root cause" was that for-profit companies had, for years, been using part-time staff, paying them very little, and not supplying them with benefits – forcing them to work at several facilities to make ends meet.

The other "root cause" is that instead of using resident co-payments to upgrade their facilities – (in some cases just putting a partition in a 4 bed ward to make the rooms semi-private), there were payouts to shareholders and senior executives of the chains that operated the facilities.

So the "root causes" were actually institutionalization and profit taking, not the symptoms of both described by OLTCA which admits that 1/3 of the deaths occurred in "newer homes". This raises the question of why that was the case if only 4 bed wards were the problem.

The numbers tell the story. "***About 344 homes or about 55 percent of all homes have experienced an outbreak, and 32 homes or 5 percent of all homes are currently in active outbreak with 69 residents and 85 staff with confirmed cases". (Pg. 47).***

JUST HIRE ANYBODY AND PROVIDE MINIMAL TRAINING

"You know, people from the accommodation and hospitality industries have, unfortunately, lost their jobs. How do we take that new role that we have through that flexibility, that resident support worker, bring people in, and, in real time, allow them to take their theory for a PSW online and then, in real time, mapped against that module, work with a preceptor of a home to do their practical training. We could -- we could train -- we could train a workforce pretty quickly. So we've been talking about this, again, for a number of months, but let's start. You know, we think the possibilities are endless here for this."(Pg. 81)

Analysis

Here OLTCA is actually advocating that waiters, waitresses and cooks who have lost their jobs could be redeployed as PSW's after online training and doing a practicum because of the flexibility the province is now allowing them. Unions are reporting completely untrained people doing PSW jobs. https://www.cbc.ca/news/canada/ottawa/ontario-seniors-centres-1.5517075 https://www.rankandfile.ca/ltc-critical-staffing-challenges/

NOT READY FOR A SECOND WAVE

OLTCA admits that they are not ready for a second wave. ***"So we -- are we ready? We're concerned that we're not. But we have to get on a better path to readiness.." (Pg 64).***

One wonders what happened to the so-called nimbleness and innovation argument of the private sector in light of these comments.

Because of the poor preparedness of this sector, many problems continue to be present that could raise serious issues in a second wave. They are described here:

"And so our homes, in many cases, have lost insurance, or they no longer have coverage for infectious diseases. They're subject to class action lawsuits in many cases. We still have an acute staffing shortage. They are subject, in many cases -- and it's more on the small homes and small non-profit homes, in particular, where we're certainly hearing that agencies who are supplying staff are asking for cash on delivery -- so upfront payments. PPE continues to be a cost, and the agency costs are significantly inflated. They're approximately twice what a normal compensation level in a home would be for a nurse, an RPN, or a PSW. Certainly PPE

costs are inflated, and again, it's where they're doing their own procurement. You know, we're hearing from our regular suppliers for this system that the system is largely stable right now, and homes are able to go through their regular resources, but there are still some weaknesses in that system." (Pg. 70)

THE FOR-PROFIT LONG TERM CARE SECTOR IS NOT SUSTAINABLE

it would appear that the for-profit institutional system is not financially sustainable according to its own admission.

"And certainly the government's commitment for funding yesterday -- well, stabilizing, in some respects, may well not be enough to ensure that homes are able to continue to be sustainable from a financial perspective. They run with financing. They have debt service requirements. Many of our homes are in breach of those debt service requirements. They can't get additional financing. They can't get additional insurance……The vulnerability of our sector creates significant vulnerabilities for the rest of the healthcare system and certainly vulnerabilities for the people we are here to serve" (Pg. 71/72)

Analysis

In other words, this system is on the brink of collapse and government had better move quickly with a plan to take over these facilities and put them under public management as the Official Opposition has suggested rather than just bail out this antiquated for-profit system – again, with public dollars.

With the public hospital and Public Health sectors and the Canadian military having had to come to its rescue, with numerous press reports and a study published in the Canadian Medical Association Journal showing that residents in the for-profit sector fared worse during the pandemic, and with OLTCA's own admission that it is unable to function without significant infusions of public funds, it is time that the Ontario government abandoned the privatization model and moved to a full funded non-profit, non-institutional mode of long term care.