McMaster University | Health Forum

Dialogue Summary

Building capacity in Ontario's long-term care sector to safeguard residents' well-being during infectious disease outbreaks

17 & 18 November 2025

Background

On 17 and 18 November 2025, the McMaster Health Forum convened a stakeholder dialogue on building capacity in Ontario's long-term care (LTC) sector to safeguard residents' well-being during infectious disease outbreaks. Eighteen participants (described in the figure below) deliberated about the problem, elements of a potentially comprehensive approach for addressing it, implementation considerations, and possible next steps for different constituencies. Box 1 provides additional background to the stakeholder dialogue.

Box 1: Background to the stakeholder dialogue

The key features of the stakeholder dialogue were:

1) it addressed an issue currently being faced in Ontario
2) it focused on different features of the problem, including (where possible) how it affects particular groups
3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the issue, as well as insights from a citizen panel convened on the same issue in October 2025
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and elements of an approach to addressing it
6) it brought together many parties who would be involved in or affected by future decisions related to the issue
7) it aimed for fair representation among policymakers, stakeholders, and researchers
8) it engaged a facilitator to assist with the deliberations
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"
10) it did not aim for consensus (because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors, and others about detailed commitments).

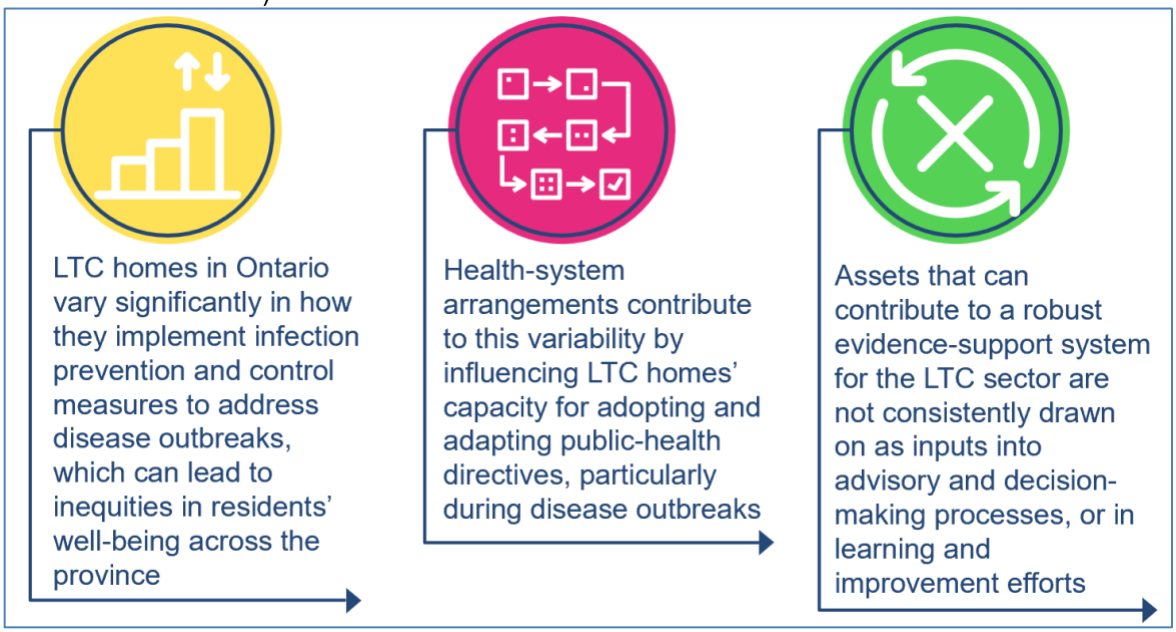
Participants' views and experiences and tacit knowledge were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary.

Summary of the deliberation about the problem

While participants mainly agreed with the points raised in the evidence brief, they also highlighted four additional dimensions of the problem that were important but not covered, including:

1) resident transitions and admissions processes introduce additional dynamics among interest holders (e.g., Ontario Health and social workers, as well as care providers from different sectors) and have their own unique set of complicated decisions related to IPAC efforts, including how to assess residents' risk of infections caused by carbapenemase-producing organisms/Enterobacteriaceae, how to deal with the stigma associated with these infections
2) gender dynamics need to be acknowledged as part of the conversation, given the high proportion of women who are residents, front-line staff, and caregivers in LTC homes
3) there is a high prevalence of dementia among residents, and this shapes what is locally feasible in LTC homes as mandated IPAC measures are interpreted, adopted and implemented
4) there are power imbalances between those making final decisions about IPAC measures and those having to follow them that aren't acknowledged or addressed, which undermines relationship building and trust within and across organizations in the LTC sector.

Participants also raised several issues related to the three specific aspects of the problem outlined in the evidence brief (summarized in the visual below).



In discussing the first component of the problem, participants raised five issues that further contribute to variation among LTC homes in Ontario, including:

1) outbreak management covers several types of infections, which are often 'rolling' or overlapping to different degrees in different settings, and draws from a wide array of interventions, which can contribute to communication and implementation challenges in LTC homes
2) inconsistencies across LTC homes can manifest in multiple complex ways that have implications for IPAC (e.g., different rates of staff turnover, varying capacity for, awareness of, and skills to practice IPAC, no sustained funding for IPAC hubs, and a rotating roster of ministry inspectors)
3) there are ongoing tensions associated with reconciling 'black and white' guidance with the need for contextual adaptation (and variation in IPAC approaches), and a lack of capacity in homes for conducting 'risk assessments' that can be used to balance guidance with local needs
4) demographic shifts are set to make it even more challenging for decision-makers to 'meet the moment,' with trends towards an increase in the number of Ontarians who need to live in an LTC home, too few beds to accommodate

those in need, and resident populations with increasing medical complexity (e.g., multiple chronic conditions and advanced dementia).

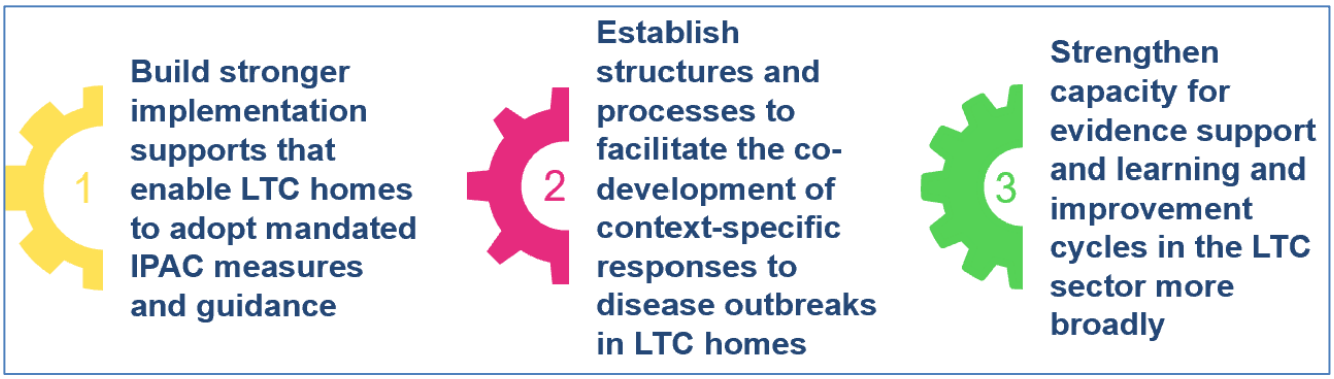
When discussing the second component of the problem, five issues related to health-system arrangements were noted as particularly important by participants, including:

1) legislation and regulatory structures in LTC are designed to identify the 'worst' actors deviating from mandates in ways that might be harmful, with the downside of overemphasizing enforcement and creating a 'culture of fear' in which most home operators are focused on reducing their own liability at the expense of identifying ways to balance mandates with the needs of residents and their families
2) government inspectors do not always visit the same LTC homes, resulting in a lack of continuity, institutional knowledge, and contextual awareness
3) funding commitments from government are inconsistent and create uncertainty for organizations with important roles to play (e.g., IPAC hubs, which some participants considered to be the 'wobbly stool' of the system because their ongoing role isn't clear) and for those in key roles (e.g., IPAC leads within homes)
4) there is a 'collision of interpretation' caused by the high number of organizations and individuals with 'skin in the game,' which creates communication and trust challenges (e.g., between government ministries and homes, IPAC leads and Public Health Units)
5) communication consistently breaks down across various levels of the sector (e.g., from government and Public Health Units to home operators, between home operators and their IPAC leads, and between health professionals working in different settings).

Participants noted three general issues when discussing the third component of the problem:

1) discussions around evidence as an input into advisory and decision-making processes at all levels of the sector are not where they need to be, and often not framed in a way that is appropriate for LTC (e.g., focusing on randomized controlled trials rather than large population-based studies using administrative data, which are more feasible in LTC)
2) there is a lack of technical support for those working in LTC homes to conduct risk assessments that allow them to balance the best-available evidence (and best practices) with the unique needs of their residents
3) despite efforts in the past (e.g., town halls and other community outreach efforts during and in the immediate aftermath of the SARS outbreak in 2003 and 2004) there are no mechanisms to support an 'iterative feedback loop' where insights from residents (and their families and caregivers) and home operators or staff feed into learning and improvement cycles.

Summary of the deliberation about elements of a potentially comprehensive approach to address the problem



During deliberations about the elements presented in the evidence brief (represented in the visual above), three cross-cutting approaches emerged as priorities among participants, including:

1) clarifying the roles of the many contributors to IPAC efforts in LTC in Ontario (and particularly IPAC hubs)
2) building relationships by drawing on previous experience in the sector (which many participants agreed was foundational to establishing a relational IPAC culture underpinned by strong IPAC practices in the sector)
3) establishing principles that can be used to set expectations for decision-making in the sector, and that underpin relationship building, such as:
   - anchoring everything in the lived experience of residents, their families and caregivers, and staff
   - creating an 'LTC culture in IPAC' (rather than an 'IPAC culture in LTC')
   - promoting clarity and transparency around legislation, regulations, and mandates
   - continuously learning and improving, and using the best-available, context-appropriate, and practice-relevant information and research evidence.

Several participants expressed views that suggested these cross-cutting approaches are necessary precursors to the more specific elements included in the evidence brief. However, during deliberations, participants did provide additional insights about each of the three elements, which are summarized below.

When discussing the first element, participants noted two targeted efforts that are needed to move forward, including:

1) improving communication across the many different individual roles and organizations that need to share information in the sector
2) developing and establishing principles – grounded in ethical frameworks – that can be used to guide flexible implementation efforts (versus continuing with the current framework of rigid requirements that can be difficult for some homes to meet as they attempt to balance the unique needs of their residents).

When discussing the second element, participants put forward four concreate actions needed to make progress, including:

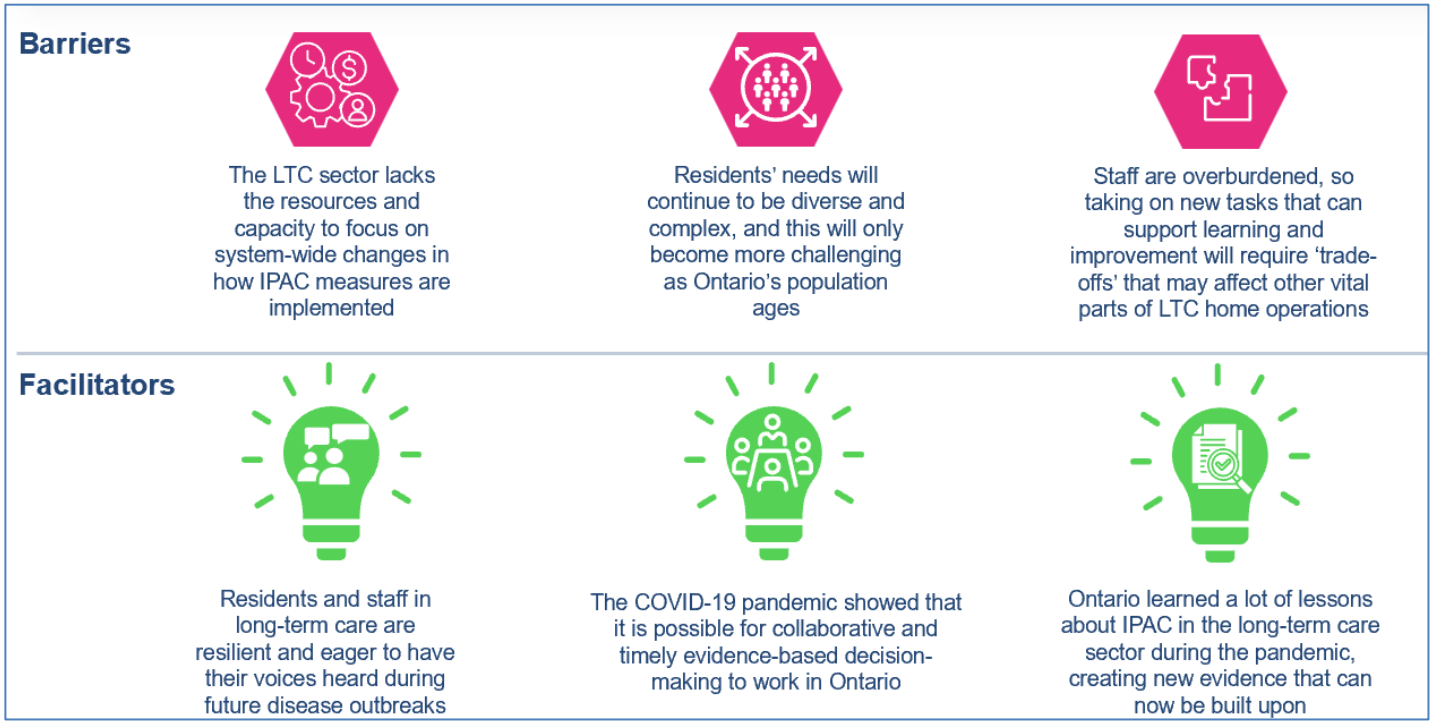
1) mandating full-time positions for IPAC leads in all LTC homes (and moving away from size-dependent allocations of funding and staffing requirements for these key individuals)
2) strengthening communication between LTC operators and their IPAC leads regarding the use of government funding, to improve transparency and understanding of how they can be allocated to improve the lives of residents and staff
3) building consistent, trusting, and reciprocal relationships between ministry inspectors, home operators, IPAC leads, staff, and residents
4) adjusting health professional education and staff-training programs to ensure those working in LTC have the requisite knowledge and skills required to contribute meaningfully to IPAC advisory and decision-making processes.

When discussing the third element, participants focused on the high-level aspects of creating a learning and improvement culture in LTC (rather than on how to strengthen capacity for evidence support more specifically), describing the following five efforts as important:

1) documenting, evaluating, and learning about what works in Ontario for building a strong relational IPAC culture, drawing on lessons from the past (e.g., the Campbell Commission and the creation of the Provincial Infectious Diseases Advisory Council (PIDAC) in the aftermath of the SARS outbreak), the near present (e.g., the COVID-19 pandemic and the efforts of the Ontario Science Table), and present (e.g., evaluating pockets of excellence in how the IPAC hub model has been used to foster connections and build capacity, and the approaches used in certain regions to share lessons learned pre-/post-respiratory virus season)
2) conducting network and stakeholder mapping to help facilitate linkages among those who can play a role in evidence support and in learning and improvement cycles
3) ensuring guidance and evidence support is attentive to the realities of those living and working in homes (e.g., creating 'bite-sized' resources and tools that provide insights for how to better accommodate the needs of residents with advanced dementia)
4) establishing and supporting a culture of advocacy

5) prioritizing the lived experience of residents (and their families and caregivers) and LTC staff across all aspects of learning and improvement.

Summary of the deliberation about implementation considerations



When discussing implementation considerations, participants raised barriers and facilitators that were consistent with those included in the evidence brief (outlined in the visual above). However, they also identified six additional barriers:

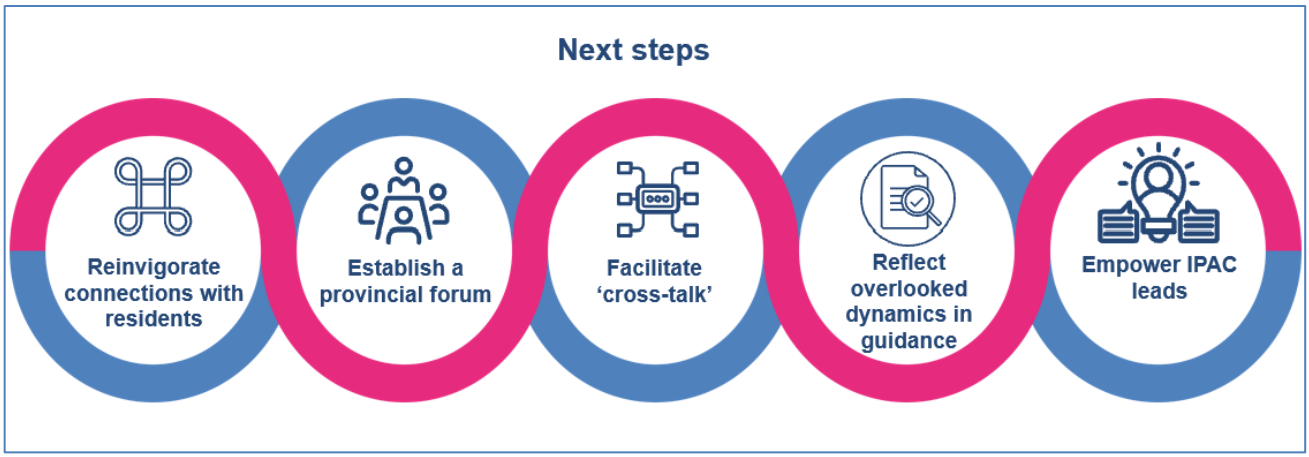
1) key individuals (including physicians) and organizations with decision-making authority (such as Crown agencies and important government ministries like the Ministry of Seniors and Accessibility) aren't consistently at the table for these discussions
2) the sector is stuck in a COVID-era operating framework focused on enforcement
3) some segments of society undervalue older adults, and ageism can contribute to the issue not being prioritized as much as it should be
4) organizational make-up varies across the province and within regions (e.g., not all Public Health Units have dedicated IPAC staff) making it difficult to plan an approach that will work for all contexts and settings
5) while residents (and their families and caregivers) and staff are the most crucial interest-holders, they may not 'buy in' to transformative change if it is perceived as disruptive to their daily lives
6) there is a lack of flexibility in how homes can allocate funds (e.g., per-bed funding allocation that means some homes aren't able to hire a full-time IPAC lead).

Participants also identified four additional facilitators:

1) large investments have recently been made in the LTC sector in Ontario, which is in a 'rebuilding' phase with opportunities for sustained and transformational change
2) LTC homes provide an opportunity to create 'living classrooms' for a range of issues that can lead to improvements in the sector, including for IPAC
3) advances in how IPAC is approached in acute-care settings offers insights about how to be successful
4) there are signs that challenges with staffing are beginning to stabilize.

Summary of the deliberation about next steps

Dialogue participants suggested several next steps, with the majority falling into one of the following five types of action.



1) **reinvigorate connections with residents** and their families, and introduce processes that can direct feedback from them – and staff – to government policymakers and other system and organizational leaders who can affect change
2) **establish a provincial (or regional) forum** with the goal of building stronger relationships, fostering trust, and sharing lessons learned among all relevant system partners (including resident and family representatives, LTC staff, Public Health Units, Ontario Health, and other relevant parts of government including the Ministry of Seniors and Aging), ideally in ways that are linked to shared IPAC priorities like planning for outbreak season, and that take advantage of existing interactions (e.g., monthly meetings of regional IPAC hubs in the Greater Toronto Area, quarterly meetings held between Ministry of Health and IPAC hubs, communities of practice)
3) **facilitate 'cross-talk' among parallel initiatives** that could mutually benefit from more integrative thinking (e.g., IPAC planning and resources development with the efforts of Behavioural Supports Ontario, and vice versa)
4) **reflect overlooked dynamics in IPAC guidance provided to** LTC homes (e.g., the high burden of residents with dementia and the greater proportion of women working and living in these settings)
5) **empower IPAC leads** within homes to be leaders, teachers, and advocates, and standardize competencies related to key IPAC domains for all LTC staff in Ontario.

Moat KA, Ali A, Dass R, Whitelaw H. Dialogue Summary Building capacity in Ontario's long-term care sector to safeguard residents' well-being during infectious disease outbreaks. Hamilton: McMaster Health Forum; 17 & 18 November 2025.

This dialogue summary was funded by the Canadian Institutes of Health Research (CIHR) through a grant to the Health Services and Policy Research Institute (HSPRI) at Queen's University. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the dialogue summary are the views of the authors and should not be taken to represent the views of the funder or McMaster University.

ISSN 1925-2234 (online)