Long-Term Care COVID-19 Commission meeting

Commission Interview of Dr. Sinha
on Wednesday, September 2, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Microsoft Teams Meeting, with all participants attending remotely, on the 2nd day of September, 2020, 8:00 a.m. to 10:00 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

Dr. Samir Sinha, MD, DPhil, FRCPC, AGSF

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

Lisa Di Felice, Administrative Assistant, Long-Term Care Commission Secretariat

-- Upon commencing at 8:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning. My name is Frank Marrocco, Doctor. I am the Chair of the Commission, and the other two Commissioners are Ms. Angela Coke and Dr. Jack Kitts, whom I think you know from a previous or his previous life before the Commission took over his life.

Doctor, thanks in advance for agreeing to come and speak to us. You are for all practical purposes the first witness, so we are very grateful for your participation.

So why don't we just get started. We would appreciate it if you would tell us whatever you think we need to hear, and then the three of us may ask some questions after.

DR. SAMIR SINHA: Sure, okay.

And I have been working with Alison before this. I know she did tell me that I am the first person to come before you.

So I actually did create a statement for the HUMA Committee federally when they asked me to testify, and I actually just spent the last 20 minutes adapting it, so I thought maybe I would

start with that.

I have the specific questions that you have as well, and then that might just give you the context. That might be helpful, if that is okay.

COMMISSIONER FRANK MARROCCO (CHAIR):

That is just fine. And, Doctor, you shouldn't feel constrained by the questions.

DR. SAMIR SINHA: Okay, absolutely.

And to Alison and team, I will forward this to you right after, if that is okay.

COMMISSIONER FRANK MARROCCO (CHAIR):

That is just fine.

DR. SAMIR SINHA: Okay, perfect.

I am just going to get it up here, and then I will...

So I just wanted to say my name is Dr. Samir Sinha. I have a few roles. I am the National Institute on Aging at Ryerson University's Director of Health Policy Research, but I am also the Director of Geriatrics at Sinai Health System and the University Health Network in Toronto. And I have been advising the Government of Ontario as an advisor on health and long-term care, especially around seniors, since 2012 when I helped develop its first seniors strategy.

I want to first of all take a moment to acknowledge the nearly 2,072 older Ontarians who have died thus far of COVID-19 in our long-term care and retirement homes, as well as their families and caregivers, and one of the things I am going to say throughout this is I wanted to also mention retirement homes. I know it is not the focus of the Commission, but so much of this work and so many of the issues that I will be talking about today are related to what also happened in our retirement homes, but by treating them separately, I think we have also done ourselves a bit of a disservice.

So while I hold many titles, I want to speak to you first and foremost as one of Canada's only 305 geriatricians that work with older adults and their families challenged by complex health and social care issues like navigating their long-term care needs.

The aging of Canada's population should be seen as a triumph, as we have extended our life expectancy from 51 years in 1900 to 82 today, and when we established Medicare, the average Canadian was only 27 and would not live beyond their 60s, so it is understandable why the provision of long-term

care was not an original priority.

While other countries acted clearly and decisively to address these shortcoming as they aged, Canada didn't. Our inaction cumulatively helped to sow the seeds of the tragedy we have been witnessing where 81 percent of Canada's deaths to date from COVID-19 have occurred in long-term care settings and where Canadians as well, in a forthcoming paper we have coming out in the Journal of the American Medical Directors Association, show that Canadians actually had a 77-fold greater chance, older Canadians had a 77-fold greater chance of dying from COVID-19 in a long-term care or retirement home than if they were living in their own homes in their community.

So some thought I was being alarmist on April 2nd when I was quoted in The Globe & Mail as saying if my mom was in long-term care, I would pull her out, most Canadians have now come to also appreciate that our long-term care system was utterly ill-prepared to deal with this pandemic.

Currently there has been some recent polling that has been done that shows 90 of Canadians are aware of what has actually happened in our long-term care homes, and next week we'll be

releasing some polling results we have done through the National Institute on Aging showing that now 60 percent of Canadians have told us that they are reconsidering their decision about whether they would want to actually live in a long-term care retirement home.

So right now we know that 430,000 Canadians have unmet home care needs, while over 40,000 are on wait lists for long-term care homes even before COVID. And as the Commission is probably well aware, currently our long-term care wait list in Ontario is about 38,000 people.

Of course, most people have the right to pay privately for their own services, but this isn't an option for the majority of Canadians who do not retire with a workplace pension and on average only $3,000 in savings in the bank by the time they retire.

So public long-term care funding has also been inadequate. Its nurses or personal support workers, for example, make far less than they would in publicly funded hospitals.

With 80 percent of Ontario's homes before the pandemic reporting trouble recruiting or retaining staff, the majority of workers they could

recruit were often racialized women who didn't really have many other options.

So we owe a debt to them and the 3,451 to date who have contracted COVID-19 and the nine who have died so far in Ontario because they are caring individuals trying to make ends meet who are willing to keep doing this dangerous work. But if we think our usual staffing approaches are the right way to enable a system that we may all need in the future, then we are deluding ourselves as well.

Indeed, to contain costs and ensure flexibility, most homes employ these workers on a part-time basis, so many would work across multiple settings, placing them at increased risk of contracting and spreading COVID-19.

After SARS, many countries around the world ensured their homes only offered single-room accommodation, and until recently we still had Ontarians receiving care in two, three, and even four-bedded rooms.

And altogether these staffing and physical plan deficiencies have become known as our systemic vulnerabilities that led to the rapid introduction and spread of COVID-19 in and between

our homes.

During a pandemic, quickly applying definitive actions to prevent the introduction and spread of a novel infection based on rapidly emerging evidence is key. This is why I say that BC gets top marks for implementing key preventive measures well ahead of any other province. They stemmed their outbreaks to 12 percent of their homes, while in other provinces like Ontario, 34 percent or 480 of our long-term care and retirement homes have now experienced outbreaks. Ontario has the highest rate or proportion of its homes experiencing outbreaks in Canada.

Our NIA, our National Institute on Aging, issued its evidence-informed "Iron Ring" guidance on March 27th which informed the Federal Government's April 8th federal guidance, and yet some provinces still hesitated to act on these recommendations for at least another week.

Ontario and Quebec, for example, tried to stabilize their situations with the help of hospitals, the armed forces and even school board employees, but this is not seen by anyone as a stable solution for a system that has lost the faith of many of its residents, families and

workers that their care needs and safety can be ensured.

So where do we go from here?

Most experts agree that we'll be living with COVID-19 for awhile. We did better than many other countries in implementing our lockdowns early, allowing us to keep our community dwelling population and elders relatively unscathed, but as we anticipate future waves, we need to take the early lessons we have learned and apply them to further protect the 144,000 Ontarians living in our 626 long-term care and 770 retirement homes who have not yet been infected or killed by COVID-19.

Our province needs to act more definitively to apply current evidence-based recommendations. We still have inadequate public health data collection and reporting systems to help us understand how and in what ways COVID-19 is affecting our long-term care settings and makes them more vulnerable.

The NIA created an LTC tracker for this purpose. This is where the data that I am presenting you today has been collected, all independent of the support of our Ministries of Health and Long-Term Care.

While it is good that our Prime Minister and our Premier and our Ministers in Ontario have agreed that long-term care is broken, we need to ensure that we pair our immediate actions with efforts to determine how to best fix, develop and fund long-term care systems that Ontarians should look forward to as we age.

In this regard, I am glad that our NIA has been helping to ensure that we can define issues properly, ask the right questions, find the right answers and ways of implementing them as quickly as possible.

Much of what we need to do has been well-known for years and luckily isn't rocket science, but it will take political will and a federal and provincial and territorial coordination of effort. My only fear is that with, hopefully the worst of things behind us, we still have key things that we have not yet done to get us to a better state of affairs to handle a potential second wave but also ensure the integrity of our system as sound in moving forward.

So I just wanted to open with that statement, but then I wanted to just quickly highlight that what I would like to talk to you

about, and we can certainly go to a Q&A format, is in terms of the issues that I think we need to still rectify or resolve right now, there still are current staffing issues that we haven't appropriately addressed. There are still significant issues related to data collection and data transparency that are important. There are still important issues we need to think about from the coordination of efforts that can occur between our long-term care homes, but also local hospitals, Public Health Units, the LHINs and the authorities that they work with so that we can better coordinate response efforts should future outbreaks occur.

And finally, we need to really focus on fixing our visitation policies right now that have been rather piecemeal and still rather confusing for families to understand, especially as we look to re-open our homes, but also how do we actually start closing them again in a coordinated way, because that certainly has created a lot of problems for people who haven't actually even been affected by an outbreak but certainly have been affected by not being able to visit with their families and friends.

So I will just outline those as core issues I would like to talk further about, but I'll pause there.

COMMISSIONER FRANK MARROCCO (CHAIR): What I think we'll do is we may have some questions and this is a probably good point to find that out, but then, Doctor, if the questions don't take you to something you want to say, please say so and say it because I think we are anxious to receive your views as much as we are anxious to ask questions. So don't hesitate to do that.

DR. SAMIR SINHA: Sounds good.

COMMISSIONER FRANK MARROCCO (CHAIR): I guess I'll start. And we will ask questions and we won't ask them in a particular order. If somebody wants to ask a question, they'll ask a question and we'll go back and forth.

But what I guess occurred to me listening to you is how do you fix the staffing problem, in your opinion? You have, as you described, people earning perhaps less than they could -- well, earning what they are able to earn, which doesn't amount to a lot and they are trying to make ends meet. How would we recommend to the government that they should address that?

DR. SAMIR SINHA: Right. So thank you.

So from a staffing issue right now, this is one of our greatest challenges that we had prior to the pandemic, and it is going to continue on, especially in light of the pandemic.

I think one of the -- the staff that I shared with you is that prior to the pandemic, the Ontario Long-Term Care Association, for example, and others would report that 80 percent of homes were having trouble recruiting and retaining staff.

When you actually look at how staff are actually paid in long-term care homes, many are actually unionized. Many are actually, you know, receiving, benefits, for example, and supports, things like sick days, and I think that is important.

But when you actually fundamentally look at how we pay people in Ontario versus kind of other provinces, you'll see that we don't actually have something we have wage parity, so the idea that a nurse, for example, in a home in Saskatchewan is actually making the same as a nurse would actually make in a hospital.

And in many parts of the country, what we call wage parity has actually been achieved, and

by doing that, for example, you then have less of a situation where even if you recruit someone to work in a care home, you know, they are always looking over their shoulder to see when the local hospital actually has an opening.

And that is fundamentally because the care envelope, the funding that we actually provide to publicly funded hospitals, for example, is a far greater or a more generously funded care envelope than what we would actually provide to a long-term care home.

So when you actually look, for example, in Ontario, if you look at what the standard wage rate for someone working in a hospital would be - and I am just going to give you ballpark figures. I have been working on this with some labour employment lawyers and experts across Canada just to understand the issue a bit better and to kind of make sure that I understand the facts better.

But let's say the average person, for example, in a publicly funded hospital, a personal support worker was making about $27 an hour. What you will find actually is then you'll find wage rates, for example, in a long-term care home can be upwards of $5 less an hour. And of course, it

depends on if you are working in a private for-profit, if you are working in a not-for-profit, or if you are work in a municipally-funded home. And in some cases, you'll actually find that some municipally-funded homes are actually almost achieving wage parity with a local hospital. So you see funding differentials occurring between homes.

Where you actually see the lowest wage rates can actually be in retirement homes where a personal support worker might only be making $18 an hour, and then many homes actually rely on agency staff to fill in gaps. So if you were actually staffing short for a day or for a shift, for example, you are going to rely on an agency, and an agency in that case might actually be only paying their staff $15 an hour to come in.

So the idea that we, first of all, have these differential wage rates I think are a problem. Some people say or will argue and say, well, when we increase the funding for personal support workers doing home and community care fundamentally by $4 an hour, it really didn't stabilize the home care situation. So just giving people more money won't do that.

But I think the fact of the matter is when you are fundamentally having trouble recruiting people into the field in the first place and retaining them, I do honestly believe that wages are part of this, but wages are only part of the issue.

I think the other challenge is that we don't do a good enough job promoting work in long-term care and retirement homes to potential caregivers, and that could be a few different reasons.

Number one is that when many folks are training in say schools of nursing, for example, they may have acute care placements in a hospital setting but it is harder to get a placement or it is harder to prioritize placements in long-term care or retirement home settings, for example, so people aren't necessarily getting exposed as early to those opportunities.

The pay isn't as attractive, so why would you choose that first when there is a job at a hospital.

And I think the other challenge that we have when we think about recruiting and retaining staff in these environments are that we often

create barriers, for example, for people to come into these fields. For example, a personal support worker, someone who wants to be a personal support worker would have to undergo a few months of training, and that training can be quite extensive and that unto itself can be a barrier for them to actually come into training.

So Quebec, for example, that is trying to recruit 10,000 personal support workers into its long-term care system has offered to actually pay people full-time and I think even cover the costs of their training, so that we don't actually create that barrier, especially for personal support workers.

But we should also make sure that the training that personal support workers and nurses get for these settings actually include training on how to care for people who have dementia, how to care for people who have behavioural issues, how to actually have geriatric skills and even infection prevention and control and other basic things that we would think are happening but often are not necessarily happening to the standards that we actually want.

So I don't want to just harp on pay. I

think pay is part of it, but I think pay alone, without addressing how do we actually better support people entering into the profession; how do we support making sure that not only do they enter but they feel quipped to do the jobs well and properly so that they will feel successful in their work; and then number three, that we are paying them well enough or we are giving them work schedules and supports that actually make the work attractive.

So not only adequate pay, if you will, or wage parity, if you will, but also the notion that they don't feel they are working in understaffed homes and they actually feel that they are equipped to do the job. I think that is important.

Because the last point is, to you as Commissioners, you will be aware that recently through the Wettlaufer Inquiry there was a request to actually do a staffing review in Ontario, and those results only came out I think about a month or so ago and that is where the panel was recommending that even with the workers that we have, we recommend 4 hours a day minimum care standards for residents right now, where on average

we have about 2 and a half hours of direct hands-on care that people will be receiving.

I don't honestly know what that magic number is, whether it really should be 4 or it is 3.5, but I think the point is there that if you imagine yourself as a worker who has come into this space, has not been adequately trained and doesn't feel that they have the adequate skills and then feels that they are working in a short-staffed environment as well, and then there is a job at a hospital where you are more likely to get more full-time employment as opposed to more part-time employment, for example, it just creates a -- it doesn't create a tenable situation, for example, to have people not only want to be recruited in but then they'll also stay there and work for a long period of time.

And so I think it is not only the challenge of recruiting people in, but it is also the retention issues that we have had. And I think if we think about a long-term care staffing strategy, which I think is really important, and perhaps this is our opportunity to start getting that right, I think we have to look at all those elements together and not necessarily in isolation.

I think just paying people more and not addressing the other issues is not going to solve these issues that have been well-known for years but I think have been looked at in a piecemeal way and not necessarily in a holistic way as well.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, thank you, Doctor. I don't want to monopolize the questioning.

Ms. Coke, were there any questions you wanted to ask?

COMMISSIONER ANGELA COKE: Just two quick things.

One, just following up on the HR issues, your thoughts on the right mix of staff, the right mix of professionals? From what I understand, you know, there is a large percentage of the folks are the PSWs, but in terms of the complexity of the needs of the residents, do we have the right sort of number or balance of types of staff from your perspective?

DR. SAMIR SINHA: No, it is an excellent question.

I think part of the challenge is we have minimums. We don't actually have kind of, you know, say a recommended -- you know, we say that

there needs to be one RN, for example, in a home at any given time, for example, but we haven't necessarily come out and said that for every ten residents, there needs to be 'x', 'y' and 'z', for example.

I think there have been a number of staffing studies that have been done, and there actually is good evidence out there. I can't quote it to you directly right now. I am happy to follow up and forward you some examples, for example, where this work has been done to talk about kind of what ideal staffing levels have been done, because this has been studied in the United States but it has also been studied here.

You are absolutely right, Ms. Coke, that I think one of the big challenges that we have had in the long-term care system, in particular over the last 10 or 15 years, is we have seen the complexity of the resident population significantly increase over time. We have a lot more people living with dementia in these settings. We have a lot more people living with behavioural issues. We have a lot more people living with more complex and unstable health care needs.

But when we start looking at kind of

what is the right staffing mix, for example, if you talk - and I am going to say this respectfully - if you talk to the RN group, for example, they'll say we need more RNs. If you talk to the personal support worker group, they'll say we need more PSWs. We need more RPNs. There is a lot of territorial and I have worked very closely with all these different associations and I hear their arguments.

I think there is some very good evidence out there that actually speaks to, for example, what would be a better mix, you know, in terms of staff, based on kind of the complexities that we are actually seeing.

So I don't think it is a matter of just, you know, more -- like I agree that we probably need more hours of care in a home, number one. We probably need a more enhanced staffing mix. I can't tell you on the spot right now, you know, what does that mean in terms of two RNs versus that.

It also depends on skill mix, for example, and scope of practice. What are we actually expecting certain people to do, because I think if you are certainly saying that only RNs can

do 'x' and RPNs can only do 'x' and PSWs can only do 'x', then I think you are pigeonholing yourself into a certain staffing formula that actually makes sense.

So there has been, I believe -- I have not read the recent report that was done by the Staffing Commission, but I know that there certainly have been pieces published out there speaking to what could more idealized staffing ratios look like, so it is not just a matter of more staff but I think a better improved skill mix.

But I think on top of that it is also making sure that those folks working in these environments have the right training and skills.

I'll give you one example recently that happened was that a few years ago when I was -- I was always advising the Ontario Government, but they had come out with this plan to hire more Nurse Practitioners to work in long-term care settings, for example, which I thought was great because certainly I think that is a great opportunity to bring a more advanced practice role into these settings.

The lead of the Nurse Practitioner Association came to see me because they said, here

is our problem is that we have all these NPs that are going to be working in long-term care but they haven't been properly trained on how to work in a long-term care setting or been given training in geriatrics and those sorts of skills. Could you help us out.

So I worked actually with U of T to try and create a bit of a boot camp, for example, for nurses working and doing telemedicine and tele-home care in the home care community to learn a little bit about CHF, but that was a one-time funding thing from the Ministry. It wasn't an ongoing way that we could train.

And for the NPs, for example, there was never an appetite -- for example, there was an appetite to create the roles and let people hire these folks, but they have been having a huge trouble retaining these folks as well because they are going in unprepared.

So just staffing and more people without the right training to understand what to do is not going to be helpful in that way, and I think, again, it really speaks to having a really coordinated human resources approach where we can say what is the right mix that we want to have, and

you know, what would that scope of practice be, and how do you adjust it based on specific needs of certain populations of residents as well from that perspective.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kitts?

COMMISSIONER JACK KITTS: Yes, thank you very much. That was a very comprehensive review of what needs to be done.

You introduced this, Dr. Sinha, by saying that we need to apply evidence-based solutions for resolution, and you listed four -- you listed staffing, which you just explained the staffing.

You also mentioned data, coordination of efforts and visitation policies. My question is are you going to expand on each of those? Because if you are, then I will hold my questions until later.

DR. SAMIR SINHA: No, I am happy to move from staffing and briefly just talk about the other three things, if that would be helpful at this point.

COMMISSIONER JACK KITTS: If that is what you think is appropriate.

DR. SAMIR SINHA: Okay. I am just going to leave the staffing piece by also talking about another staffing piece that needs to be resolved and figured out, if you will, and that is medical direction in homes as well.

So a colleague of mine who has been coordinating work for the Ottawa Hospital Group, for example, has been on the phone to me many a time, and I have been working with Revera, for example, where they have been doing a review of medical direction because lot of the issues I talk about that are involved in Ontario are not Ontario-exclusive issues. They are actually uniform issues across the country, and that is the role of medical direction, because we just talked about nurses and personal support workers, those frontline workers, but we haven't really focussed on ultimately, at the end of the day, the care in the home is, if you will, under doctor's orders, for example.

And right now, if you actually look at what our standards are, for example, or our expectations are within long-term care homes, I think our policies around medical direction need to be clarified and need to be more firmly in place as

well.

I know my colleague, Dr. Rhonda Collins, she and I sit on -- she is the Chief Medical Officer of Revera, but she is also the Co-Chair of our Long-Term Care, congregate care table through the Ontario Health, Toronto Region, and I sit on that table. I am the senior clinician lead or senior physician lead for the Ontario Health, Toronto Region, and so one of my roles is to sit on the long-term care table and provide advice to our local region.

She and her team have actually submitted document guidelines and recommendations on medical direction to Ontario Health, and I believe via to the Ministry of Long-Term Care as well, to really talk about the importance of making sure that we know what the roles or the expectations are around medical direction in homes, because what we did find or what we did observe is that in many cases, for example, we don't have clear guidelines on how often a medical director should be visiting or, as the primary care provider to a population in a long-term care home, how often should they be expected to be checking in on individuals. If they are unable to provide care,

who is the backup person to provide care? How is that care or that coverage regionally coordinated?

Because I think one thing that you will hear is that throughout the pandemic, for example, and I know certainly some of the homes that my team at Sinai and UHN supported, we had situations where the doctors, you know, who might have been older physicians themselves, didn't feel comfortable going into the home and providing care. They would only feel comfortable providing, you know, virtual supports via the telephone, for example, and sometimes relying on external physicians, for example, from hospitals or other settings going in and trying to provide that care.

So the question becomes what is that mechanism that we have in place to make sure that these clinicians, A, have the right training they need in providing care, you know, geriatric care, care for these types of individuals, but where does it fall in terms of other certain standards that need to be in place, including what their role would be in terms of providing routine care in a non-outbreak situation but then also care in an outbreak situation there.

Moving on from the staffing issues,

just to focus on data, data was one of these clear issues - and I know this was one of the questions that I was specifically asked, any issues you have observed in getting the information you needed and what you think, you know, needs to be done.

From a data standpoint, this has been a real difficult situation, for example, and I think it is still something that the government I think is still trying to resolve in different ways. For example, early on in the pandemic, for example, and I think as many folks will be well aware of, the question was how are we actually collecting data so that we can actually facilitate a realtime response.

My desire was to make sure that to support, you know, hospitals that might be involved locally, to support residents and their families who want to have information on what is actually happening in their local home, other homes to know what is happening in their own regional homes as well, Public Health Units, just in the interests of transparency how do we actually make sure that people know, you know, what is happening and then how do we better coordinate our responses.

And I think our challenge that we

realized early on is that our Public Health Units, certainly in their Public Health responses, whenever there is an outbreak, for example, they don't treat it or they are not in the business or it hasn't been their traditional response or work to actually do realtime reporting. So they are not necessarily or they haven't traditionally worked in a way that they are actually going to, you know, put their reporting together so that by the end of every day or in a realtime method you know exactly what is happening around an outbreak in every home in their region.

As I was educated early on, a Public Health Unit, for example, you know, will do the work that needs to be done, but generally, at the end of an outbreak, they'll tally everything up, they'll post it and they'll report it.

And that has worked really well in the past, if you will, when there are the usual outbreaks that occur in long-term care homes. But I think during a pandemic there was a greater thirst to say what is actually happening, what is going on, what is the size of the outbreak and what does our local response need to be.

And so in this method, I think a lot of

Public Health Units started, with time, trying to kind of improve their kind of way of starting to put their information into place.

The challenge is it was not clear to me how every Public Health Unit was determining how they would report information, and so there didn't seem to be a standardized or agreed upon approach. And I will give you an example.

For example, if there is an outbreak at a home say in Kingston versus a home in Toronto, for example, the Toronto region might report on its dashboard the total number of cases, the total number of deaths, for example, but a different region, a different Public Health Unit might not talk about total cases. They might talk about active cases, for example, so what does the outbreak actually look like today versus what does the outbreak look like overall.

And so in that way it becomes hard to understand the size, you know, and the actual situation, and it makes it hard, for example, to compare, if you will, apples to apples that way to kind of get a better handle on what is actually happening, and hard to certainly at some times understand when did that outbreak start and when

did that outbreak finish, for example, so just common data elements that would actually be helpful.

And the other challenge that we had was certainly the Public Health reporting system itself just became so challenging to use that the Ministry then halfway through reverted to a new system where they decided to have inspectors calling the homes individually, trying to get their information from them in a way that they then said we are no longer going to use the Public Health kind of reporting mechanism. We are now going to start using our own system to try and just call homes and find out what we can from them and then use that in our way to do that.

So I think it has been really challenging because we have seen this is the situation that has been happening in long-term care.

Retirement homes have been a completely different kettle of fish as well where, again, we haven't actually been -- we have had a lot of challenges collecting data in similar ways as well.

And then my ultimate challenge was when the government itself was reporting information,

for example, they would often only be talking about long-term care homes. They wouldn't be talking about retirement homes. That may, you know, be inconsequential to you, but my view is at the end of the day, a home is a home is a home. These are congregate settings. They have older people. Yes, 70 percent of the people in a nursing home have dementia, but 50 percent of the people in a retirement home do. Yes, most of the people in a retirement home are in a single-bed setting, but you know, the majority of people in a long-term care are too.

But many of these homes are adjacent to each other. Many of these homes actually share staff or were sharing staff, for example. So there are homes, for example, that have retirement on one wing and long-term care on the other, and so almost talking about data of one without the other and not having a unified approach to actually share that data and report that data becomes problematic.

And part of the problem was, as I was learning along the process, is that at the very beginning of the pandemic it was clear that long-term care homes are required to report an outbreak to the Ministry of Long-Term Care. You

know, it is a reportable thing to the Ministry.

But retirement homes, which are regulated by the Retirement Home Regulatory Authority and governed by the Ministry of Seniors' Affairs and Accessibility, they didn't have that requirement for retirement homes. So there was a lot of work that then had to be done to try and encourage retirement homes to tell the government what actually was happening, and you can imagine that all of this together made it a real challenge to try and get reliable and clear data.

So our NIA then as a result, where we were seeing this issue in many jurisdictions, we actually created a national tracker. We created a tracker where we have actually outlined all 5,801 homes in Canada, long-term care and retirement. We have actually created a map which is publicly accessible. It is a Google map. It shows the map of Canada. It goes to your province. We actually have shown the data by Public Health Unit, Ontario Health Region, and we have actually made it really simple for people to understand. You go on a pin of a home. You actually see, for example, if the home is in red, it is in outbreak; if it is green, it means the home is recovered; if it is black, it

means the home isn't in outbreak. You have the information for the home; you have their web address; you have their phone number, for example; you know how many beds in total they have; you understand how many total cases there are; you understand how many deaths have occurred, and you know that information by staff and you know that information by that.

And the goal of this was that families, for example, could actually get clear, accurate information. They could actually get the information that they were looking for. A local home, for example, if Dr. Kits, for example, had a home just down the way and I saw, Oh, my goodness, you know, his home is in outbreak, I might be able to actually have a better locally coordinated response because at the very beginning homes reporting shortages of PPE or my home and Dr. Kitts' home, for example, might be sharing staff, immediately at a ground level you could start facilitating home-to-home responses.

But when we were starting to get involved with hospitals, Public Health Units, other people involved, it is sometimes helpful to kind of see what you are actually dealing with in your

local geographical region and what is happening.

So this is why we independently created a tracker. We actually were invited and I talked to the Ministries of Long-Term Care, the Ministries of Health and the Ministries of Seniors' Affairs and Accessibility right off the beginning about our intention to create this back towards the end of March. There was a lot of interest from them in even supporting this and even funding this.

But what we really saw very quickly through this process was there wasn't a huge interest in transparency. We were working with the local associations, AdvantAge Ontario, the Ontario Retirement Communities Association, with the Ontario Long-Term Care Association. We shared with everybody our interest in creating this instrument.

We have created it for the grand total of $15,000. That is how much we spent creating this. I have a team of volunteers who are collecting this data by looking at media scans and looking at that information.

This didn't cost a lot of money, but immediately we started seeing that people did not want to share data. We found that the associations were very reluctant to cooperate and collaborate in

this approach because this data could maybe make their homes look bad. You know, outbreaks are not good for business, for example. We started seeing an increasing reluctance through the Ministries of Health and Long-Term Care and Seniors' Affairs and Accessibility to share the data that they were having.

As we were developing this and we were showing them what we were doing, for example -- and again, everything we have is publicly accessible. There is no shock factor here. It is just accurate reporting. We found that other ministries like BC and Alberta have been terrific. We will let them -- we send them our spreadsheets, and they actually update them for us and they actually help correct it so that we have clearly accurate information.

But I have made several requests to the Ontario Government and I have all this documented in emails asking how do we actually get information and better access to streams to actually make our work more efficient and ensure it is accurate, and those responses still have not -- we still haven't been met with an adequate response.

We have had many phone calls with folks

like Matt Anderson from Ontario Health who says we are absolutely interested in being transparent, but this data would come from the Ministry of Long-Term Care, the Ministry of Health, the Ministries of Seniors' Affairs and Accessibility and the Retirement Home Regulatory Authority. And I think as you can imagine, any time you make a request, your emails kind of get responded to saying that we'll look into this, we'll get back to you, but I have learned over time in a career in working with government that, you know, not responding is a perfectly reasonable response. And it hasn't been clear why there is a reluctance to participate in a more transparent method of reporting information and data.

And my point is that this sort of data and this information, for example, can help with a local grounded response, because one thing that we heard routinely through this period is when the IMS table was created, and I certainly talked with Rachel Kampus, she was my original ADM, interim ADM when I started working with the government in 2012, I sent her our proposal about the tracker and I let her know what we were doing and how it is a resource. She told me she thought it was a great

idea and that it could be very helpful as the government created its IMS table to try and help better coordinate.

But one of the things that she shared with me and that we readily know is we had this red/yellow/green system that the Ministry of Health had created to try and identify homes that were in crisis, homes that were stabilized, and homes that were, you know, a rising risk or in danger.

What was troublesome for me to hear from local homes in the Toronto region and others around was they weren't aware that they were actually being colour-coded. They weren't aware that actually those questionnaires that the Long-Term Care Inspectors were asking them on a daily basis were actually determining their risk. And even when they found out that they were being rated as a red, yellow or green home, they weren't actually having their own status disclosed to them to help them out.

And so I think really there is a common theme here that, yes, there has been an interest. Everybody has been interested in collecting their own data, analyzing their own data, for example, looking at it to determine their own things, but

there hasn't really been a more public open data response that can help frontline providers and that can actually help everybody look at this data together in a collective way and that can actually better respond, and I think other provinces accomplished this in a more robust way and in a way that worked better that way.

I am going to pause there on the data, just in case there is a question before I talk about coordination and visitation.

COMMISSIONER FRANK MARROCCO (CHAIR):

Dr. Kitts.

COMMISSIONER JACK KITTS: That is excellent. And it is my experience as well that there is a lot of data, and I think what you don't hear clearly is who is leading, who is accountable for the data.

You spoke to the notion that Public Health Units are accountable for outbreaks, but there is government that is accountable and has data, Public Health, and IPAC, which I think is mostly housed in hospitals.

And then there is the leadership, the governance and management of the long-term care home itself, and I may be missing it, but it seems

that that's where the ownership should be in terms of the performance of the home and the data, similar I think to hospitals.

But did you come across any clear lines of accountability and alignment that really defines where is the most responsible organization? Is it government? Is it long-term care homes? Is it Public Health?

DR. SAMIR SINHA: Great question, and so I think part of the issue is kind of I think at a home level, for example, a home absolutely has to report kind, if you will, if they are in an outbreak, for example, they have to report to the Ministry of Long-Term Care. So that is that piece.

When it comes to the other types of data that a home would have in terms of their governance, you know, their structures, their staffing ratios, their PPE supply, for example, or even their performance, you know, that is all things that are happening at a home level.

One thing that was very interesting when I was working with the associations back in February, for example, to try and help homes kind of work, you know, and get them ready, saying that this is a pandemic and this has now been declared,

and I remember doing a webinar for all long-term care and retirement homes in Ontario in partnership with the three associations and some of the key messaging we had at that time and some of the early conversations we had was that one of the big challenges that they had at the time was that homes were very reluctant - and I think this is on the long-term care side, if you will, but also the retirement home side - actually being honest about their PPE supplies.

So to your question, Dr. Kitts, about like at whose level do we need to be understanding what that issue is? That would be a home level thing.

But homes, for example, I didn't want to tell you, to any of you, that actually the cupboards are bare. We don't actually have PPE. Some homes actually were well-stocked with PPE, but I heard often that many homes were reluctant to honestly disclose their situation principally out of fear that they would be penalized, that they would actually be told by the government, for example, that you are not in compliance with 'x' or 'y', even though I think the government genuinely was trying to say this is a no-blame situation. We

just really will do well if we know what your situation is. But I understood and I could see routinely through the bulletins I get from the associations that they were begging homes, saying that you have not filled out your PPE reports and you haven't told us what your situations is. We need that information. The Ministry needs that information to be able to tell you.

I think when it comes to a higher level about, okay, there is an outbreak and who should be in charge of that data, I think this is where there was a lot of confusion and I think, you know, to a certain extent I think a comedy of errors.

I think when I spoke to Matt Anderson early on, and I have a good relationship with him, you know, and asking him about data and what is his take on it, he said to me that at the command table level, one of their biggest challenges during the first month or so of the pandemic, if you will, was just trying to get good quality data, you know, because the command table obviously is dealing with data from a number of different sources.

But as I just shared with you, the retirement home situation, well, there wasn't even a requirement for retirement homes to tell the

Retirement Home Regulatory Authority. And so there was some work being done behind the scenes to try and change their regulations to require retirement homes to start reporting data into a stream, if you will.

And Public Health Units already had a mechanism, but quickly it was being found that that mechanism wasn't timely, it wasn't accurate, and it wasn't that -- or I won't say it wasn't accurate, but I'll say that because it wasn't timely and it wasn't consistent, I think that the Ministry was having trouble trying to rely on that.

So I think when you think of the command table itself that was trying to bring together three different Ministries that have a stake in long-term care, the Ministry of Health from a Public Health response standpoint, the Ministry of Long-Term Care from a nursing home standpoint, and Ministry of Seniors' Affairs and Accessibility from a retirement home standpoint, I think you have three different Ministries, and then you have Public Health, you all of a sudden have three different -- there is a real focus as opposed to a definitive we need to have one system and this is how we are going to report.

And I think partly, you know, I don't know -- I don't have enough of the inside knowledge to know, for example, that was there kind of a decision at one point saying we need all Public Health Units to report things in a consistent way to try and salvage that, because at some point, for example, there became competing efforts on long-term care reporting and then basically let's just forget the Public Health reporting. Let's do our own long-term care report with a reporting standard in that way, a similar way the retirement home piece, and then only a month or two later or a month or two ago that they started trying to compile that data in a bit of a similar way or demonstrate in a similar way.

So to be honest, I think, you know, at an outbreak level and beyond, I don't think it has been very clear, for example, how that data needed to be reported. But then second to that, all of those other aspects from IPAC and that, I know the long-term care, the Ministry itself, they have a Data Analytics Branch, you know, that has been taking a look at their own internal long-term care tracker that they have created and it does have a lot of information there. But to be honest, I

don't know at what level that information really gets shared at the regional level, reasonably gets shared, for example, with local hospital resource partners, for example, that are being involved.

And I think, again, some really clear clarity about these are the ways that we need to collect data and this is the information that we need to collect would be helpful.

I'll give you another just quick example on the data front. Right now I was talking to Michael Hillmer, the Executive Director of the Data Analytics Branch of the Ministry yesterday, because he is very interested in this issue of visitors, you know, visitors coming to long-term care homes.

The government is about to announce this week or started announcing on Friday that they will now allow absences, and of course, as many of you will be aware of, we actually closed long-term care homes suddenly to visitors, if you will, a few months ago. When we started re-opening these homes now, I was quite surprised to find out that we haven't actually been -- at the home level we might have been asking homes to log how many visits are you having a day, you know, or how many absences

potentially, you know, what types of visits are you having and what is actually happening. Because I think there was a lot of reluctance to re-open homes originally, some homes were saying that we'll be overwhelmed with visitors and we can't handle it; other homes were saying that we don't anticipate it being a problem.

But it is interesting that, you know, Michael Hillmer was sharing with me that their current long-term care tracker doesn't capture anything about visitation right now, and we both identified that that's a problem, because right now, as we are worried about a second wave, for example, and the real reason to restrict visitors at the very beginning was we were reluctant to have visitors come into a home that potentially, like staff, could bring COVID into the home, then you might want to be monitoring the volumes and you might want to be monitoring, you know, what types of visits are occurring because, again, a data-driven approach could be really helpful to understand how is visitation impacting potential outbreaks or spread. It could help give us clearer data to understand do visits actually increase the risk of COVID-19. Because great data that we have

from the Netherlands say that their homes that re-opened to visitors months ago, for example, during their pandemic, they didn't show that outbreaks were being driven by visitors, for example. And even Quebec made the deliberate decision, because they were so short-staffed of workers, to allow visitors to come into the home and provide care to their loved ones because otherwise they just wouldn't get care at all. And we didn't hear any reported outbreaks.

But a good colleague of mine said, But are we even collecting data to actually link whether visitors are linked to outbreaks as well?

So there is an interest to say that, again, how are we actually having an open data approach to make sure that we are capturing data on things that matter and that we can actually really evaluate it properly, because I think with data in different silos, data that is being shared in different ways, for example, I think that we are really still having a fragmented approach in Ontario to really say that we are secure with what we have and that we can make the most of what we have should a second wave occur and we are building a local coordination response with local hospitals

or Public Health Units in a meaningful way.

COMMISSIONER FRANK MARROCCO (CHAIR):

Doctor, I did want to follow up a bit. Was there a province that had a standardized realtime data collection and publication process that you thought was worth imitating or copying?

DR. SAMIR SINHA: Yeah, to be honest, like I think certain provinces were just -- I always point to BC in terms of BC didn't do what we saw as a geographical, you know, kind of a visualization approach.

I mean, BC, what they would do when it comes to long-term care or retirement homes and hospitals, they basically lumped facilities in one batch, for example, and they were clearly updating their data, you know, on a daily and a regular basis in that way.

We certainly worked in collaboration with the Office of the Seniors Advocate of BC, you know, to actually make sure that we have the correct information for our tracker moving forward.

I don't see any province, for example, that has done a particularly robust way of, you know, showing, for example, geographically.

What we were actually quite impressed

with was awhile after we had started our own Canadian tracker, if you will, our visualized method of understanding outbreaks in a much more clear and transparent way, for example, the CDC in Atlanta actually came out with something that I am incredibly jealous about, and this is where they actually have an exquisite tracker. It looks very similar to ours. It shows a map of the United States. It shows every single home that has actually had an outbreak and where it is located and very detailed data to actually get that response.

I don't know if more recently where the U.S. government has actually decided that people don't have to report their data to the CDC but now towards the U.S. government instead of as opposed to the CDC, I don't know if that has hampered the CDC system.

But the CDC system, I thought, which came online after ours - and I am not trying to say that our work was in any way as exquisite as the CDC's work - but I was just really impressed. If you want to have an example of an incredible example of a clear dashboard that could actually give you geographical information to say what was

happening in your community, what was actually happening at a home level, I thought that they did an exquisite job with what they had actually created, if you will.

COMMISSIONER FRANK MARROCCO (CHAIR): And I had a second question and it related to staffing, and I don't want to get back into that in a serious way because I know there is other aspects of this that you want to comment on.

But was there some place that had found a way to achieve the kind of integrated staffing model that you were talking about?

DR. SAMIR SINHA: Yeah, so I think a few examples that I think are helpful, quickly, is that, again, I think, you know, BC, for example, they did a really good job. You know, first of all they -- you know, and I would encourage you to talk to the folks in BC like Isobel Mackenzie, who is the lead of their Office of the Seniors Advocate. She has a very good handle on what happened in BC and what was unique to their response, so I don't want to speak on behalf of them.

But what I can tell you is that in British Columbia what worked particularly well is because they actually knew who all of their

registered personal support workers were and staff and long-term care workers were, for example, they just took over the employment of everybody. And because they actually had a health authority model, for example, where basically, you know, they actually said, look, you know, our health authority is in charge of staffing the hospitals, the local home care pieces, et cetera, by doing that they were able to redeploy even health authority staff, for example, quickly into local homes that may have needed extra support, but they were able to get their whole staffing situation under control a lot earlier by actually delegating who would work where and to stabilize that approach in a better way.

In Kingston, for example, they did a really good job, for example, because again there was a better local coordination of approach where at least between Public Health and the local long-term care homes -- you know, Kieran Moore, who is their Chief Medical Officer of Health for Kingston was able to kind of quickly redeploy their restaurant food inspectors, for example, to actually IPAC coordinators in local homes.

And so I don't actually even think that they had to really -- because they had so few

outbreaks in the Kingston area, I don't even think they had to compel local hospitals like Kingston General to get involved in that way in a significant way, unlike other regions where you had significant outbreaks, like Ottawa, like Toronto, in that way to redeploy staff.

I think that the other great example was say the City of Toronto, for example. So I am the Co-Chair of the City of Toronto Senior Strategy and Accountability table, it is a mouthful, but I work very closely with the newly created division which is called Senior Services and Long-Term Care. And when I was helping to advise on the City of Toronto's local response, for example, we had a lot of great things at our disposal.

One is we had the City of Toronto long-term care workers across ten homes and 2,500 beds, for example, those are City of Toronto employees. So immediately the City of Toronto could say, right, we need extra staffing, so all of these staff that right now don't have active things to do, guess what, you are all going to work in local long-term care homes that are owned by the City of Toronto. And they could better coordinate PPE purchases. They could better coordinate

staffing and response because, again, these are examples where the staffing of a long-term care home could quickly be accommodated by other staffing that were within the remit of that organization, like the City, or in the case of a group like, you know, Kingston, for example, you had a more coordinated approach.

And I think when you look across the country, where you have a health authority model, for example, where, if you will, all the staff are kind of employees of the health authority, there was a much easier way to deploy things.

I think the challenge that we had in Ontario where long-term care homes really are independently governed organizations like a hospital, even like a Public Health Unit, for example, where you saw readily deployed staffing work was where there was a good relationship, where there was a pre-existing or a very quickly developed relationship.

But in other situations where there weren't those deeply formed relationships or those naturally existing relationships, I remember being on calls with the Minister of Long-Term Care where I was begging her at one point to compel the

hospitals to get involved. I was constantly getting calls from local long-term care homes that were in crisis. I was calling up CEOs of local community agencies and organizations.

You know, we had a Chinese nursing home in Toronto that is very close to my hospital that was having cases and it was a disaster there, and what I was doing was I was calling the -- I am the Honorary Medical Advisor for the Chinese Community Organization here. I called up the CEO and said, Could you get staff in? She did and they got sick. That actually compromised the supportive housing site they had. I then asked the CEO of a private home care company if they could send in people, because if the home had money they could pay for it, and they could only staff up with one or two people. The home was desperate and I was hoping that my hospital, for example, would be able to step in and see where we could deploy ourselves and help out, but there was a reluctance. I think a lot of hospitals were reluctant because they were worried what happens if we have an outbreak here as well.

And so this is where I had to, at that point where we didn't have natural relationships

and networks -- and in my role working through the Toronto LHIN, for example, you know, I was asking, you know, our LHIN CEO, our OH Toronto CEO to say, you know, we need to start compelling the hospitals to get involved.

And so I remember being on a call with the Minister the weekend before or a week or two before Premier Ford announced that hospitals were going to get involved and was basically saying, you know, Look, homes are in crisis. They need staff. People don't want to just necessarily go volunteer and work in these homes.

And so I gave her two options at that point. I said either at this point you compel local hospitals to get involved or you get the army involved. And I remember the conversation was like we can't get the army involved, that looks like a failure. And I said, right, you know, so then you've got to compel the hospitals.

A few days later, you know, here is Premier Ford saying that we are getting hospitals involved. Of course, hospitals had no clue what that meant. I don't think many hospitals appreciated what does that mean that we are involved as a SWAT team. I know at the LHIN level,

the regional level, you know, then it was left to the regions to kind of figure out what a SWAT team means. And you will see that across the province, SWAT teams have evolved organically in different ways and whatever those relationships were. But there wasn't a clear that these are the expectations and these are the roles and responsibilities, because these are all independent authorities.

And then obviously the army gets called in. We are now redeploying school board employees, because I think by this point, all of those delays in getting a coordinated effort in place or even thinking about understanding all of these issues I have just talked about as potential liabilities, I don't think they were well appreciated. And I think by the time they were appreciated, I don't think we were acting quickly enough, especially when we didn't have some of those baseline relationships and baseline kind of practices or things in place that could allow us to be nimble.

I think we now have an opportunity with all the lessons we have learned through wave one to try and say, okay, you know, it didn't go so great but we are through this, through a bit of luck and

through a lot of effort, but now knowing what we do, we need to actually quickly make sure that we have got these pieces in place. But I personally don't have the confidence that we do have that, that we do have those clear issues that I have been talking about - data, coordination and coordination of efforts in place at this point to actually be ready to respond should we have a significant second wave on our hands.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right, I don't know if there were any other questions? Yes, Dr. Kitts.

COMMISSIONER JACK KITTS: Just quickly, Dr. Sinha, I don't know whether you know enough about Ontario Health Teams, but do you think that that's a solution to the coordination and bringing all affected parties together for a second wave?

DR. SAMIR SINHA: Yes and no.

I'll say it this way. So right now we have about I think the latest number is about 30 Ontario Health Teams. We have others that are in development at the moment.

You know, what I can tell you is that back in February, for example, I was asked by the Ministry of Health to provide some further advice.

As Health Teams were being formulated, the Deputy Minister had asked my advice and support, you know, to help provide a geriatric lens and advice towards Health Team development.

So you have to remember that, first of all, we have a few dozen Health Teams that have been approved, if you will. I think there was a recent announcement that we had I think five or six more that had now been green-lit, if you will, to be Health Teams.

But you have to remember that let's say there is 30 Health Teams, I don't know the exact number to date, for example, but that doesn't cover a significant part of the province, and number two is that only I would say about maybe 20 or so have actually chosen the frail elderly, if you will, or older adults as a key focus of their Health Team, of their Health Team work.

But the challenge with many of the Health Teams are -- I think one of the benefits of the Health Teams that are in development, for example, or have been allowed to move forward is it has at least brought people together to have conversations about what they want to do.

And a great example is in East Toronto,

there is the East Toronto Ontario Health Team, if you will, that right now being a team doesn't mean that you actually literally have any control over your resources. It is not that you actually control what happens in the local long-term care home or what happens in the hospital and that. You just have a bunch of partners who come together and said we are going to work together, and probably through that process of working together, they have had conversations. They actually know -- you know, Dr. Kitts is a former CEO of the Ottawa Hospital and probably knows who the CEO of the local long-term care homes are now and the local community agencies.

So in that way, frankly, you have some of that baseline relationships and buildings that can actually allow more friendly interactions and more coordinated approaches.

So what was a really good example, if you want a good Ontario Health Team example, was because there has been years and years of work in East Toronto building that relationship with an interest in the frail elderly as one of their focus, at the beginning of the pandemic we saw that the Michael Garron Hospital, which is the anchor

hospital, they were able to kind of coordinate a local long-term care home response. So I think the eight or ten homes or so in their region, they were more proactive than, before all these other SWAT teams were being created, to be able to work there.

But I think that wasn't because of the Health Team. You know, well, I think it was facilitated by their desire to become a Health Team, but it wasn't that this was a funded effort. It wasn't that this was a required effort.

So this is where I think that Ontario Health teams can be enablers because they are building local networks. But again, we have to remember that most of the province isn't covered with a Health Team. Even if you are covered with a Health Team, it is not guaranteed that the frail elderly are a focus, and therefore, local long-term care and retirement homes are actively participating in a meaningful way.

But I think where there are Health Teams, we should leverage that if that can be a mechanism, for example.

But I think, you know, moving forward, I think what is important is to understand how did every Ontario Health region or LHIN respond. You

know, what were the things that we learned overall, so what happened in the Champlain or the East Region, for example, versus in Toronto. I think they figured out, because they were given a lot of leeway by the government to how they actually wanted to create their own local response, I think at this point it is better to figure out what worked well and what didn't and what are the lessons we can share, and then what are the things we need to facilitate that future local response.

Because right now, for example, I know that my hospital, you know, Sinai Health System and UHN, I think we have been partnered with about 15 or 20 or so care homes. You know, most of them were never in outbreak, but we have established a relationship where we were forced, in a good way, in my view, to actually have a relationship with homes, meaning that we actually have made contact. We have determined if they need IPAC support. We have given IPAC training. We have said that we can help supply PPE if you need that. We have done those sorts of things. But to more involved homes, we actually created a much more integrated response to help them get through.

The problem is in our local situation

in Toronto, for example, I don't think there was necessarily a need for us to create a more in-depth relationship, and I don't know, for example, for a home that we worked with that really didn't have many needs at all and said that we are doing fine, we are good with IPAC and we are good with everything, I don't know if the strength of that relationship is good enough now that if that home entered outbreak tomorrow that we would be expected and ready to response or if we would kind of look to the LHIN first and say, are we expected to now be their resource partner for life or in a coming wave or, you know, what is the expectation of these groups and partners.

So I don't think that that has been clearly outlined, and I think that that in the more immediate future could be helpful to really actually help ensure like what are the expectations. And where there might be a local Health Team, an Ontario Health Team, we might say, right, the Ontario Health Team has created their own local effort. I just think the problem is right now we don't have enough of clear standardized infrastructure in Ontario where we can dictate what a common response needs to be.

What I think we want to make sure that is in place is that we know that in every part of Ontario where there are homes and there are local partners, what does that local response need to look like. And working at my own level for Ontario Health, I can't tell you confidently in Toronto Region, for example, or in any other region, that we now have it clearly baked that if home 'x' goes into outbreak, this is exactly kind of the way that that local response is supposed to occur with their hospital resource partners or with their OHT or whatever the case is. And I think that would be helpful with clear direction in that way, you know, to move that forward.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): I think you may have covered it, but you did mention local coordination with the hospitals, and I think you have sort of talked about that.

And finally, then you were talking about patient visitation policies.

DR. SAMIR SINHA: Yes, so one of the challenges that we have had in terms of kind of from a thinking about it at the end of the day,

this is all about the residents, right. These are about people who are in these settings and how do we actually support these folks.

So you know, as you probably are well aware, the average or the typical person who enters a long-term care home typically is in the last two years of their life. We know that life expectancies are declining. It doesn't mean they are palliative by nature.

I know I was certainly distressed when you have heard, you know, we have had various officials who basically have said, Well, you know, if they go a little bit sooner, you know, is that a big deal because they are towards the end.

I mean, at the end of the day, yes, you could say these folks are in the last years of their life, but they are not all imminently palliative in that way.

COMMISSIONER FRANK MARROCCO (CHAIR):

Oh, I am not sure those officials would feel the same way if they were talking about themselves.

DR. SAMIR SINHA: A hundred percent.

COMMISSIONER FRANK MARROCCO (CHAIR):

They might see the two years as quite

important.

DR. SAMIR SINHA: I a hundred percent agree. But it was interesting to see kind of I think what was a challenge for me personally as a clinician was I was having a lot of calls with other, you know, kind of geriatric leads at other hospitals across the province who were experiencing a lot of moral distress because they felt that certain partners were not valuing their roles with the long-term care homes as important because perhaps the lives of those patients weren't considered as valuable or those residents weren't considered as valuable because potentially they had a shorter life expectancy ahead. So I agree.

I mean, these are deeper issues when it comes to the issues of ageism, and when we think about sectoralism, for example, these are a lower paid, a less respected workforce versus kind of our hospital workforces in that way.

But when we come, for example, to the consideration that when we think about these residents and what is important to them, for example, that often at this point when many are living with dementia, many need kind of very specific care needs and those familiar faces

around, for example, that, you know, visitation from visitors, whether it would just be on a socialization basis or from a family caregiving benefit, is absolutely important.

I think one thing that actually has gone under the radar for a long time, partly because we don't actually measure the number in any meaningful way, is I don't think we have ever actually understood -- we do a good job actually understanding what the residents in these homes look like because I think on an every six months or so or maybe even on a quarterly basis we do something called the interRAI Assessment and this is an assessment that we do to kind of assess what are the care needs of the individuals in these homes, for example, so that we understand what are their limitations, what are their care needs, for example, and that helps the Ministry understand the complexity of the residents in that home. That actually helps inform the funding envelope for that home, the care envelope for that home, but it also helps us appreciate the complexity. And that is when I tell you numbers like 70 percent have dementia, 50 percent are living with behavioural issues, this is where I am getting that data from,

because we do a pretty good job collecting that information.

Where we don't do a really good job is understanding the role of family caregivers in these settings. A lot of people just assume that when you go in, when you go into a home, well, you have the caregivers there, the paid care providers, the nurses, the PSWs, and the doctors who are providing all of the care.

But they forget that a lot of these individuals prior to going into these homes were being cared for by individuals who might have been receiving 24-hour supports from family members in addition to home care workers and other things and that when these individuals go into homes, for example, that they often do have spouses or family members who might be going to visit every day or several times a day, for example, and helping with very essential and personal care tasks, like feeding or dressing or bathing because that person doesn't trust anybody just to come and do that task with them or, frankly, they respond better when it is a familiar face or a loved one doing that care.

Some of the care, like feeding, for example, for an individual might take 45 minutes to

help them get, you know, a good meal into them, for example, but you can imagine if a personal support worker is caring for up to ten or even more people, they only have a certain amount of time, and the military reports really started reflecting on this in a short-staffed environment how, you know, feeding or basic care needs were being neglected or not being met.

I think the challenge we had is at the very beginning of the pandemic, for example, I didn't disagree with the approach of saying that right now, with community spread being what it is, we need to limit the number of visitors' foot traffic going into homes.

So when we said, yes, let's actually ban visitors from going into homes, I was fine with that and I think most people were. I am not going to lie to you and say that I was always against that, because I think at that time we were just trying to do the right thing and do the best thing by limiting visitations.

I think certainly we did say that if someone is palliative and right at the end of life, we will allow people to go in, you know, to try and visit their loved ones and do that, but I think in

many cases we have heard that many families, you know, weren't even facilitated or given that opportunity to go and say good-bye to their loved ones or do that for various reasons.

I think more importantly that months in now, as we start to re-open homes, I think the guidance has not been as evidence-based and evidence-informed as we need it to be, and this is the idea that, you know, while we were saying that we are going to allow outdoor visits, you know, social visits, for example, but we weren't going to allow family caregivers to come back in and it was hard to understand kind of what the reasoning around this was.

I know certainly, for example, there was the view that, well, if we have family caregivers coming in to care for their loved ones, to help feed them or do things with them in their homes, for example, could that introduce COVID, for example.

But again, the evidence was showing from the Netherlands or other countries or other jurisdictions that these family caregivers, they don't want to cause harm to their loved ones. Often, you know, if you tell them and if you treat

them like staff saying if you want to come in, we are going to have you learn IPAC procedures; we are going to have you learn how to don and doff PPE; we are going to treat you like we would staff, that these folks, their interest is to help their loved ones out as well.

But I think that what we saw was a lot of pushback originally and a lot of non-evidence-informed recommendations. I know, for example, that there was this desire to make sure that every visitor has to get a COVID-negative test within 14 days. Well, I sit on the COVID-19 Testing Strategy Panel for the Government of Ontario, and when we heard this requirement, we didn't know where this idea came from. When I talked to the Chief Medical Officer of Health's staff, they didn't know where that recommendation came from. When I talked to -- you know, but what I have surmised is maybe this was more of a political decision to basically say that we want to test people.

But even our Testing Strategy Panel of experts, we said that this doesn't make any sense because a negative test 14 days ago doesn't tell me what happened in the last 13 days, for example, and

you know, it doesn't ensure and it doesn't give us free will. And even at that point at the early stages we said, even if people are six feet apart wearing masks, for example, we wouldn't require them to get a test. And even as a hospital worker right now, I have never required a test to come and work at Mount Sinai Hospital, for example, you know, in that way.

So there was a lot of things that were being decided that weren't really clearly evidence-based in that way and almost things that were overtly restricting visitors, you know, family caregivers from coming into their homes.

So one thing is that by being, you know, frustrated as this was rolling out, for example, and seeing a lot the stress, this is where NIA worked, our National Institute on Aging, and we actually solicited the opinions of 60 folks from across the country, infectious disease experts, you know, caregivers, you know, and the associations themselves to come out with evidence-based guidance, if you will.

And we shared this with the Ontario Government in advance of actually publishing them because we were actually encouraged by people in

the Chief Medical Officer of Health's office to say, please share this. Please help. You know, we could actually use this guidance to try and move things forward.

And we were happy to see that Prince Edward Island fully adopted our guidance, if you will. We saw that the Ontario Government started adapting some of its guidance in its second iteration, and we have been told that a lot of our guidance has now been incorporated in what will be released this week.

But I will give you this example. It is great that they are going to -- I emailed the Deputy Minister just the other day saying, I hear that you have actually found our guidance very helpful and that I am glad to hear that it is going to be informing new guidelines coming out. They have never called me. My colleague and I who have written it, we said, should we reach out to them? I said, they know who we are. They could call us if they wanted to. But you know, I asked if we could get an advance copy and I said I'll sign a non-disclosure agreement, right, because I am not here to try and scoop or cause problems, but I said, you know, at least our messaging can be

supportive and helpful and we can understand and we can know how we can respond constructively. But I'll be interested to see when this is announced later this week what it says and does it fully comply with our guidance or not.

But our challenge right now is that this has been an example where I think a lot of family caregivers have been incredibly frustrated because by not being able to get in, back into the homes in a timely way, in a structured way, as other jurisdictions like Quebec, other jurisdictions like, you know, in the Netherlands, for example, who have been doing this for months now and safely, and then finding out this week that the government doesn't have any mechanism through its data collection systems to actually even keep track of visitations or now absences, et cetera, you know, then my big worry now is that it is great that we are finally saying that people can visit their loved ones in homes, that family caregivers can come into homes, but one thing that I have realized is you can have good policy and bad practice.

At the home level, what you are seeing is many homes are saying, great, it's great that

the Ministry is saying that people can come and visit and have absences, but we don't have the staff and we don't have the resources to facilitate this, and so we can't facilitate this.

So we still have many homes that are saying we can only allow you to have one visit a week and 30 minutes, and we can only facilitate an outdoor visit or we might be able to facilitate an indoor visit. And what we are even seeing is that while the policy is permissive in saying that we'll allow more people to come in, many family members are still being shut out because the home is saying that we don't have the resources and they are saying the government won't give us more resources to help out.

So part of our guidance recognizes that, you know, the government should be there. While the government has said no expense will be spared and we'll make sure everybody has PPE and we'll support you in this way, you know, a lot of homes are saying that we don't even have the adequate resources to really support and encourage family visits that are happening.

My final worry is that without a data-driven approach, without the right resources

to support family visiting and this essential thing that is important not only to the residents but to their families and friends in that way, and especially that family caregiving component, we have actually been starting to see the data that is showing that there has been increased rates of malnutrition, increased rates of functional decline, increased rates of behavioural issues, increasing use of anti-psychotics.

So some of the homes, like the Peel Region homes that have been sharing their data publicly in the newspaper, are showing that their residents have been declining, you know, that there have been marked declines.

Some of the literature that is coming out, there was a big paper that was just published recently, just this past week, which was showing that rates of malnutrition or weight loss have been increasing, for example. That wasn't Canadian data but that was I think U.S.-based data.

But we are actually seeing that we are having challenges right now, you know, that are affecting the well-being of these residents as well, and I think that is really challenging to families because they are wondering that right now,

if COVID doesn't get them, you know, will these restrictions be kind of what actually hastens and creates that.

So we reached out to the Government, to the Deputy Minister to say we would love to work with you because partly - and working with the Ministry of Health - to say if we collect this data, if we can get more data to talk about this, not only will this help us to understand how do you shut down homes, for example, or you know, but how do you re-open them. And if we do have another outbreak, for example, how do we actually do it in a way that can actually be systematic, can be transparent, and can be clear so that families don't feel incredibly more frustrated and residents also feel frustrated as well.

COMMISSIONER FRANK MARROCCO (CHAIR):

Let me ask the same question essentially that I asked before. Was there a jurisdiction that you felt had captured visitation policies in a way that is worthwhile for us to either copy or look very closely at?

DR. SAMIR SINHA: Yes, to be honest, I think everywhere in Canada and the U.S., I mean, I am part of an international research network that

basically shares kind of the frustration of visitation policies and these challenges.

I think the earliest jurisdiction to get out there and actually do things, you know, were the Netherlands, for example, where they actually just said that for these family caregivers - again, I differentiate visitors, ones who might come by once a week for a social visit versus a family caregiver.

But in the Netherlands, they certainly introduced family caregivers in place early on. Quebec actually introduced family caregivers I think out of necessity just to have hands-on care being provided.

But I think now, I think, you know, the guidance that our NIA has put out that the Ministry certainly has, I understand that the forthcoming guidance that is supposed to be released this week goes as far as we were saying, that even we believe that family caregivers should be allowed to come into a home during an outbreak, for example, because, again, just as staff can come into a home during an outbreak to provide care, a family member could as well, provided that they are also being taught IPAC procedures, how to don and doff PPE,

and that they are compliant with those roles and responsibilities.

So I think that there is clear guidance here, but I think we need to be capturing the data around visitations.

COMMISSIONER FRANK MARROCCO (CHAIR): I understand.

DR. SAMIR SINHA: And the other thing too is right now, talking to the Ministry of Health folks from the Data Analytics Branch, is that right now, for example, we are not sure, for example, if Public Health, when they are actually investigating an outbreak, so say we have an outbreak in a home and we have three cases, we are not sure -- you know, right now we assume that right now Public Health is trying to determine was it a staff member who brought it in, for example, but we are not sure if they are actually capturing, for example, visitor-related infections or a visitor-induced outbreak, for example, because if we don't have that sort of data, then we are worried that we'll continue to openly villainize, for example, family caregivers as potential risks when they may or may not actually be risks at all.

So one of the things we have been

talking about is should we also be making sure that when Public Health Units are investigating, have they been capturing any data related to was the outbreak due to a visitor versus a staff member bringing it into a home, for example, and then in that way, you know, are we capturing the data to inform our policies and our approaches moving forward to determine how we should re-open or close homes to visitors themselves.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right. Ms. Coke, do you have any questions?

COMMISSIONER ANGELA COKE: No, you have captured what I want. I was trying to figure out who is best practice in these areas, and you have answered my question.

COMMISSIONER FRANK MARROCCO (CHAIR):

Dr. Kitts?

COMMISSIONER JACK KITTS: Yes, let me see if I have heard you correctly.

So there is now a government policy informed by your group, NIA, that allows visitors; is that correct?

DR. SAMIR SINHA: Yes, currently what has been published so far, we are on currently

iteration number two of long-term care retirement home and I think group home guidance, if you will.

What I do understand is that the third iteration will be released publicly this week.

COMMISSIONER JACK KITTS: Okay, and it is based on I think what you said is there is good evidence to suggest that visitor restriction has a negative effect on residents both physically and mentally?

DR. SAMIR SINHA: Absolutely.

COMMISSIONER JACK KITTS: But there is no real evidence to suggest that allowing visitors causes any harm, particularly in increasing the number of outbreaks; is that --

DR. SAMIR SINHA: Right, and we don't have evidence to support that, but being absolutely open and honest, for example, we don't know, for example, how well that sort of information has been collected to say yea or nay to that.

But right now we haven't heard of kind of any significant outbreaks occurring in Canada secondary to visitors after we started or since we have started re-opening homes.

I think you could imagine that in the early days, for example, in Quebec and Ontario and

other jurisdictions, there very well could have been the introduction as community spread was occurring, as we were trying to get a handle, but I think the key I would say since we have started re-opening homes, there hasn't been any clear evidence to suggest that visitors are bringing this into the homes themselves.

COMMISSIONER JACK KITTS: But because of that lack of evidence, I think you have said that different long-term care homes are applying the policy in different ways based on their beliefs, and so the policy isn't really as effective as it could be and you are looking to get the evidence to show that it doesn't cause harm?

DR. SAMIR SINHA: Exactly, and I think the key is that we would like to be able to -- you know, again, better data collection would actually help us to be able to more definitively answer that question in Ontario.

But I think as well, I think what we are seeing again in that line that I have been taught, you know, good policy, bad practice, for example, is that some homes are basically saying that we are protecting our residents, and you know, we are giving them extra protection by really not

allowing visitors to come in or really restricting this.

Other homes are using I would say an excuse to say we just have insufficient staffing to support this. We would like to do this, and frankly, it is the government's responsibility to give us more funding or supports. And I might be sympathetic to that argument to say if we are saying we want to make sure you have ample supplies for PPE and we are saying to you that this is the way that we recognize and see these family caregivers as essential care partners, we need to facilitate their entry and their support and their training and we should put resources towards that, I think absolutely.

But I think right now, what we are seeing ultimately are residents and family members being caught kind of in this situation where, you know, I would say an absence of evidence but also kind of an absence of resources or support are allowing us to facilitate their participation.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): All right, anything further, Dr. Kitts?

COMMISSIONER JACK KITTS: No, that is

good.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Coke?

COMMISSIONER ANGELA COKE: Sorry, this was just wanting to clarify something that you had mentioned when you were talking about integration and coordination.

And you know, what I understood is that informally people have relationships and people may have connected, but was the point that there isn't a formalized partner integration strategy and, you know, if there was a more formal understanding of this, you know, that this is who kicks in and who helps who during a pandemic, something that is defined, who do you see as the coordinator of that effort? Is this a LHIN thing or who?

DR. SAMIR SINHA: Absolutely, so I think, you know, so it is a good point and I will just expand on this a little bit.

So actually, in a few weeks, our NIA in partnership with the Canadian Red Cross are actually releasing guidance on emergency preparedness or emergency preparedness that actually has been endorsed by all the long-term care associations in Canada, including the Society

For Long-Term Care Medicine, for example.

And originally, this is work that I started -- I sit on the American Red Cross Scientific Advisory Council as their only geriatrician member, and three years ago I started working with the American Academy of Nurses on developing guidance, disaster preparedness guidance in the United States that looks at a number of domains, including health care facilities as well.

And one thing that we did focus on was that when you look at the U.S., which has varying levels of policies and guidance, for example, we did focus on legislation in Florida, for example, where a local home has to create a disaster preparedness plan. So they say that if there is, you know, a fire, if there is a flood, if there is a hurricane - I don't know if it extends to pandemics or an outbreak, for example - that they need to have an emergency plan and that plan needs to be actually developed in coordination with their local EMS responder, for example, so their local office of emergency services, if you will, in that way. It has to be signed.

So for example, we might say if we have to evacuate the home, we are going to send our

people over to this hospital. We are going to do 'x', 'y' and 'z'. It is all laid out. And then you have to have approval from your local, you know, emergency response kind of unit, if you will, that way.

I know that in Ontario, for example, that all homes are supposed to have a pandemic plan, for example, and I remember, you know, back in February we were asking homes to review your pandemic policies, review your kind of outbreak plans.

But to be perfectly honest, I don't know, for example, you know, what needs to be in your pandemic plan, for example. Do our current pandemic plans actually incorporate kind of what we have experienced under COVID-19? Because I think certainly while homes have a lot of experience dealing with various outbreaks, for example, and even with SARS and H1N1, I don't think it necessarily -- like we didn't really have a lot of transmission in long-term care settings with SARS, if at all.

We didn't really have -- I think with H1N1 I don't recall how much -- I still was out of the country at that time, so I don't know, for

example, how much that was a long-term care issue, if you will, at that time.

The point is that right now I think if we look at those local pandemic plans, for example, is this now an opportunity to say -- and what we have done is in this guidance, for example, we have actually reviewed over 5,000 articles related to disasters, like natural disasters, everything from tornados to winter storms to whatever, like heat waves, for example, to also looking at infectious disease, epidemics and pandemics, for example. We have come up with 29 evidence-informed recommendations.

I am happy to send that because the draft is pretty much done. We are just getting endorsements at the moment. We are going to release this in October, but I am happy to share it with the Commission ahead of time.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, that would be very helpful, and we would appreciate that.

DR. SAMIR SINHA: Okay, because what we basically do focus on is these notions about these are sort of -- we have recommendations at a facility level to think about, you know,

aspirationally what should we do. And this goes back to that notion and some of the themes we talked about, that making sure folks in these homes, for example, have training in geriatrics, right, and know how to care for older people, have training in IPAC and these sorts of things, because even more recently there are some reports coming out where long-term inspectors are going to homes right now, including I was just reading the other day in the newspaper about Orchard Villa, for example, and finding out that some recently hired staff have not had their IPAC training done in the timely way that has been recommended and other things.

So clearly, you know, the goal should be that if these are the standards that we recommend at a level of staffing, at the level of the facility, if you will, in that way, you know, do our pandemic plans actually have that in mind.

And back to Ms. Coke's point, you know, the key is now we could say that this hospital around the corner in Toronto, for example, or wherever it is, for example, if they were to evolve into an outbreak, who is their hospital resource partner? You know, what is their plan to get PPE,

for example? Have they made sure that their staff are already equipped and trained in IPAC training?

You know, what are those key things that they need to make sure that they have done so they are well prepared? Do we make surely that our medical directors, for example - and I think this speaks to that advice and guidance that Dr. Collins and team have provided to Ontario Health around medical direction and their recommendations around that - have we made sure that there is a backup system in place for the medical director and those sorts of things?

Because I think right now, by having that clear plan that has to be made by the home, presumably now with these new relationships those plans that are home-initiated can be done in partnership with their partners. So for example, you know, I know as a hospital, for example, what I am being implicated and what my role is, or if I say I don't think that is my role, I think that should be the role of so and so, either way those issues can be worked out and then perhaps that gets signed off at a regional level, for example, in that way or with the local emergency supports or services group.

And again, you know, there might be a common recommendation that that needs to be done in place, because I think in Ontario, again, our challenge where we don't have things organized through our local health authorities where everything is owned by one entity so that it is really the CEO of the health authority that can just say that this is how we are redeploying staff and this is what we are doing and we ultimately have that responsibility. For independently governed homes, for example, I think probably the onus is on them to create this. Probably there is the onus of the government, if you will, you know, the Ministry of Long-Term Care or the Retirement Home Regulatory Authority saying that you need to make sure that you do this, but that home has to create that. It has to be set timelines.

And perhaps it is kind of figuring out at a local level is this a plan that is developed in collaboration with a local hospital resource partner, the local Public Health Unit, the local Office of Emergency Management, if you will, and also signed off by the LHIN, for example, to make sure that occurs.

And I don't know, for example, if

something like that exists for hospitals, for example, or other kind of care settings in Ontario. But it is not clear to me that those pandemic plans that homes were creating really worked well for many homes when 480 out of the 1400 that we have in Ontario, retirement and nursing, ended up in outbreak, 34 percent, and it is not clear kind of to what extent did those plans have in place what we have currently experienced and what we have currently witnessed in that way.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

Anything further?

Well, Doctor, this has been enormously helpful and a great first step for us, and on behalf of all of us, I want to thank you for a very thorough and very informed presentation.

In case you are wondering how we were going to keep track of everything you said, we do have a transcript which we will use for our purposes, and if there is a thought of putting it on the website, we'll talk to you first and give you an opportunity to read it and see if there is anything you want to clarify.

But from our point of view, we have captured everything that you have said and it has been great, and we really do appreciate the time and how much you know about this area and thank you for sharing that with us.

DR. SAMIR SINHA: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): I think what we'll do, what I would like to do is for us to convene in about 10 minutes or so very quickly to just reflect on what we want to do here.

And, Doctor, I'll leave you out of that. I am sure you have got other things to do.

So, Alison, can you set that up?

MR. DRUMMOND: Yes, certainly I will do that.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay, thank you, and good morning.

DR. SAMIR SINHA: Okay, thank you very much, everyone, thank you for your time.

-- Adjourned at 9:45 a.m.

REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 2nd day of September, 2020.

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WORD INDEX