Long Term Care Covid-19 Commission Mtg.

Nurse Practitioners' Association of Ontario and Partners
on Friday, November 13, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 13th day of November, 2020, 1:00 p.m. to 2:46 p.m.

BEFORE:

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

PRESENTERS:
Carrie Heer, RN(EC), BScN, MN, NP-PHC} Nurse Practitioner Coordinator/Clinical Lead, Nurse Led Outreach Team;
Dana Cooper, Executive Director, NPAO;
Claudia Mariano, Manager of Practice and Policy, NPAO;
Kathy McGilton, Senior Scientist, Toronto Rehabilitation Institute - University Health Network; Professor, Lawrence S. Bloomberg Faculty of Nursing, Rehabilitation Sciences Institute, University of Toronto.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term

Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Policy Unit, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Sanjay Bahal, Team Lead, Operations, Long-Term Care;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat.

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good afternoon.

CARRIE HEER: Good afternoon.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, I think the commissioners are here, Commissioner Jack Kitts and Commissioner Angela Coke, and I'm Frank Marrocco.

So, Ms. Mariano, are you waiting for anybody, or are you ready to go?

CLAUDIA MARIANO: We are. Our team is all here.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, we're ready. We are in the habit of asking questions as we go along, if that's okay.

And there is a transcript which we will publish on the website at some point. Beyond that, I think we're ready to go when you are.

COMMISSIONER JACK KITTS: Justice Marrocco, I think this is Nurse Practitioner's Week, and I think we're going to have a screenshot.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, right.

COMMISSIONER JACK KITTS: So Happy Nurse Practitioner's Week.

COMMISSIONER FRANK MARROCCO (CHAIR): I am so sorry about that.

CLAUDIA MARIANO: No, thank you so much for agreeing to have a quick shot taken. I am going to do my best to do this without getting my phone in it, but I don't know how I can do that, but...

Okay. There we go.

COMMISSIONER FRANK MARROCCO (CHAIR): Make me look as good as you can.

CLAUDIA MARIANO: I'm going to try to edit out my wrinkles.

Wonderful. Thank you all so much. I really appreciate that.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you, Commissioner Kitts. I had completely forgotten about that. As usual, I didn't make a note.

COMMISSIONER JACK KITTS: I have so many friends that were nurses that they would never forgive me if I didn't --

Dana Cooper: Well, we appreciate that recognition, for sure. And thank you so much for having us and allowing us your valuable time to talk a bit about nurse practitioners.

Just a bit of a caveat before I start: I have an unwell dog that is at my feet and won't leave my feet without making a big fuss, and she snores.

So I will mute when I'm finished, but you may hear her while I'm unmuted, the snoring in the background, which is a little Yorkshire Terrier but sounds like a German Shepherd.

COMMISSIONER FRANK MARROCCO (CHAIR): And, Mr. Cooper, don't be unduly concerned about it.

DANA COOPER: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): All of our hearings have been played by the duck people who keep phoning me every day. So I'd much rather be looking after your dog than looking after the duck people.

Dana Cooper: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): So don't worry about it.

Dana Cooper: So again, good afternoon. My name is Dana Cooper. I'm the executive director for the Nurse Practitioners' Association of Ontario or NPAO, as we call it. And we're the only organization exclusively dedicated to representing

the nurse practitioner profession here in Ontario.

We're the largest nurse practitioner organization in Canada. And while half the nurse practitioners in this province are actual members, of course, we work on behalf of all nurse practitioners.

And I thank the commission for, again, having us here today so we can present the incredible work that is being done by nurse practitioners in long-term care during this pandemic and most importantly the potential for vast improvements in the long-term care that can be realized by leveraging this very unique profession.

With me here today to share information with you are Claudia Mariano. She's NPAO's manager of practice and policy and has been a nurse practitioner for over 2020 years.

Carrie Heer is there. She's also a nurse practitioner, and she's the coordinator and clinical lead for the Waterloo Wellington nurse-led outreach team and the current chair of the provincial NLOT, as we like to call the nurse-led outreach teams; chair of the provincial NLOT collaborative committee, and you'll want to definitely hear about what they're doing.

And Dr. Katherine McGilton, she is a senior scientist with the Toronto Rehabilitation Institute - University Health Network and professor with the Lawrence S. Bloomberg Faculty of Nursing in Rehabilitation Sciences Institute at the University of Toronto.

It is these three that you really do want to hear from today, not me, as they have very relevant information and perspectives to share with you.

We each have our individual parts. And as you said, you'll ask questions as you go. But you might find some of the answers that you're seeking might be in one of these sections.

Now, I am not a nurse practitioner, but I can certainly attest to the incredible potential and the incredible value that nurse practitioners have for healthcare here in Ontario, you know, not only for the quality of care in long-term care homes but across healthcare in general.

I have seen and experienced quite the enlightenment these past five months I have been with the organization about the skills, competencies, and scope of practice of nurse practitioners.

Their versatility and potential they represent for improving healthcare in Ontario and unmatched by any other healthcare profession, and I recognize that's a lofty statement. But you would share this perspective if you were as exposed as I have been to the plethora of roles nurse practitioners are not only involved with but are leading in this province.

And Claudia's going to provide you a bit more information about the specifics about nurse practitioners in a moment, but I just want to capture a few things here before I turn it over to Claudia.

So, I mean, of course what we know today is during the COVID pandemic, long-term care residents are experiencing the highest rates of morbidity and mortality in the country.

According to the National Institute of Ageing, 82 percent of all COVID deaths occurred in long-term care and residential nursing home settings here in Canada with Quebec and Ontario most negatively impacted. Homes are unprepared for the pandemic and remain to this day in a state of crisis and unable to plan for the second wave of the pandemic.

Over and above the current pandemic crisis, long-term care residents are becoming increasingly complex, unstable, and unpredictable. Many are extremely frail; living with multiple complex, chronic health and mental health conditions; and once this pandemic is over, long-term care must prepare for even more frail residents as our population continues to age. And, of course, the time for leveraging our best nursing resources and building a better long-term care system is now.

And just by the fact that this commission exists suggests that it is a critical time for the future of long-term care in this province. NPAO has suggested to the Ministry of Long-Term Care that bold decisions and actions are needed now to write the long-term care shift.

Unfortunately as COVID pandemic has accentuated and what Justice Gillese said: Public inquiry has shown, as well as Ontario Government's own staffing study, there are a number of barriers to overcome in the current long-term care system. Being able to achieve the vision for long-term care which includes the enjoyment of residents, the respect, the comfort, safety, and the quality of

care that they deserve.

And I think it's critically important that the focus of resident care is paramount in our work going forward. We can implement all the structural changes in the world, but if they do not improve the effectiveness and quality of care for residents in long-term care homes, we have certainly failed.

Now, to avoid that, the NPAO submitted a response to the government, a long-term care staffing study, that represents our perspective on what is needed to address the long-term care gaps identified in the staffing study.

As Justice Gillese pointed in her Public Inquiry Report:

> "In 2019, Ontario's 626 long-term care homes provided just over 78,000 beds for residents. The long-term care home resident population is undeniably one of high needs. The vast majority of residents have some form of cognitive impairment and physical frailty along with chronic health conditions that have compromised

their well-being.

In 2017-2018, 90 percent of the residents in long-term care homes had some form of cognitive impairment, and 86 percent needed extensive help with activities such as eating and using the washroom.

A number of residents with cognitive impairments and those who require extensive or complete support with everyday activities are steadily increasing."

She goes on to state:

"Ontario population redistribution and the increasing acuity of older Ontarians are facts modern life. We cannot dismiss the challenges that these matters pose for the long-term care system on the basis that they will disappear over time."

So as Justice Gillese pointed out in her report, long-term care homes are the most regulated area of healthcare in this province.

She also stated, and I quote:

"Ontario has no need to jettison the existing regulatory system and start over. Instead, we need to identify and acknowledge the strengths of the existing system and build on those."

And that is our perspective today and our position that nurse practitioners are an important opportunity to build on the competencies of these professionals which are ideally suited to the long-term care sector. We need more nurse practitioners in long-term care.

Now, it should be obvious that to achieve the vision for long-term care of increasing the quality of care for residents, appropriate and adequate staffing for long-term care homes will be a critical success factor.

We need the healthcare providers and support workers to be an efficient and effective team that sets the tone for this vision. Recognizing the need for commonsense regulations, staff must be provided the flexibility to render the most appropriate care and support the residents require.

NPAO is long known and stated that:

"Nurse practitioners are an important component to increasing the quality of care in long-term care homes."

NPAO has taken initiatives and put in place mechanisms to ensure nurse practitioners have the knowledge, skills, and best practices required to increase quality of care in long-term care.

We offer a one-day conference for nurse practitioners in long-term care. As well, we have established communities of practice to develop best practices and resources to support nurse practitioners in long-term care and are actively supporting research in long-term care, as Dr. McGilton will highlight one study currently underway.

We are pleased that the staffing study recommend the expanding and the use of nurse practitioners. However, one of the biggest barriers nurse practitioners face is the lack of awareness and understanding of nurse practitioner competency by policy-makers, other health professions, support personnel, and patients.

This lack of understanding and awareness about nurse practitioners is compounded

by changes to the nurse practitioner scope of practice which is rapidly expanding.

To fully capitalize on this educated and competent healthcare professional, there must be an understanding and appreciation of what nurse practitioners can bring to the table. And as I mentioned, Claudia will be giving you this insight momentarily.

Another barrier faced by nurse practitioners is the funding models that are employed that they have access to. Nurse practitioners are primarily salaried employees.

Given the lack of options for employed nurse practitioners, the cost to do so represents an expense to privately funded long-term care homes.

The Nurse Practitioner Attending Program that was implemented by the government in 2014 with the promise to employ 75 nurse practitioners in publicly-funded long-term care homes over three years, only 60 of those positions have been hired to date. And the staffing study just recently completed suggested that Phase 3 of that initiative be completed, meaning another 15 nurse practitioners in publicly-funded long-term

care homes.

From our perspective, that is woefully inadequate to address what is required in long-term care homes in this province, and nurse practitioners do not currently have the capability to build a public healthcare system from the care that they provide.

Physicians can't build the public healthcare system for the care provided by nurse practitioners in the facility that they worked.

So not only do nurse practitioners represent an expense to hire in privately-funded long-term care homes if government funding is not available, it can also be viewed as taking away from a physician's compensation if they perform activities that would be normally provided by a physician and could be billed for.

So we know that nurse practitioners have a positive impact on the quality of care. You're going to hear about that in a minute. You will hear, you know, the Ministry of Long-Term Care as well as other provinces have seen the impact of nurse practitioners through pilot programs and the first two phases of the Attending Nurse Practitioner Program.

The capabilities of nurse practitioners are on full display throughout the 25 nurse practitioner-led clinics that exist in Ontario that provide care to over 100,000 Ontarians, most of them in rural and underserved communities.

You'll also see -- you'll hear from Carrie in a minute how they're employed through the nurse-led outreach clinics.

But the inherent comprehensive relational and patient-centred model of care employed by nurse practitioners is exactly the type of care perfectly suited for the needs of long-term care home residents.

And I'm going to now turn it over to Claudia Mariano to talk a bit more about nurse practitioners, who they are, and what they are.

CLAUDIA MARIANO: Thank you. Thanks so much, Dana. We weren't quite sure what the familiarity would be among the commissioners and commission staff around the role of the nurse practitioners.

So we thought before Carrie and Kathy got into specifics, I would just give you, perhaps, a bit of background in terms of what exactly is a nurse practitioner.

So a nurse practitioner is a registered nurse with a minimum of two years of clinical experience who then goes on to complete master's-level education at a recognized university. There are ten universities in Ontario that offer a Nurse Practitioner Program.

And we then complete those additional exams, write an additional licensing exam that allows us to be registered as extended-class nurses with the College of Nurses of Ontario.

And so we have an expanded scope that allows us to diagnose illness, communicate a diagnosis, order treatments and medications, prescribe all medications. We perform comprehensive health assessments, make referrals to the specialists, and really having a very comprehensive scope of practice with a nursing lens.

So we continue to work on our nursing model or nursing foundation to provide support for patients in a very broad biopsychosocial context.

So what exactly does that mean in terms of what a nurse practitioner does on a daily basis? What to we do with patients?

So, for example, in a typical day, a

nurse practitioner might do physical examinations or specific-focus assessments for patients. Might make a diagnosis for a patient; provide that diagnosis; and then, perhaps, prescribe a medication, if appropriate, for that condition.

We might manage the treatment plan. We might make a referral, for example, to the local CCAC if a patient required support in home. We would assist a patient to manage their chronic conditions. So, for example, managing diabetes, hypertension, and so on.

We also, then, can provide medical assistance in dying. That's an area that Nurse Practitioner Ontario have been quite involved in now that NPs have the authority to do so. And we also can admit, treat, and discharge patients from hospital for those NPs who work in hospital settings.

So for our purposes here and the commission, we're looking at particularly wanting to share with you what the role is of nurse practitioners in long-term care.

So I'll, again, sort of go over a little bit of that generally, and then Kathy and Carrie will provide you with more of the specifics

around that long-term care.

So nurse practitioners, as a regulated health profession, we are responsible for our own practice. We are carry our own professional liability protection, and we work under that legislated and regulated authority. We do not require supervision, but we do work very collaboratively in teams, and most nurse practitioners do work in team settings. And I think you will hear that quite clearly from Carrie and Kathy in a minute.

And so we communicate very well with other team members and also with families. Nurse practitioners are among the most studied of profession. So we have the most amount of evidence-based literature and studies to show that outcomes with nurse practitioners, satisfaction of nurse practitioner care are incredibly high, and Kathy will share some more of that specifically with a study that we've been involved in over the last number of months as the pandemic started.

So in terms of the long-term care role, essentially the role of a nurse practitioner in long-term care is to help long-term care residents avoid transfers to emergency departments. We want

to assist the long-term care home residents to remain in their familiar surroundings, getting care from the staff that they are familiar with.

So we want to divert care away from those costly hospitals and hospital emergency rooms and continue to maintain that circle of care in the long-term care home which is that patient's residents, after all, as much as possible.

So in long-term care, the nurse practitioners, as you'll hear from Kathy and Carrie, will do that by providing individualized, specific resident care; performing assessments; managing their acute and chronic conditions; prescribing or deprescribing medications for patients to help them stay as healthy and well as possible.

They monitor all those acute and episodic conditions. And because of the expertise of the --

DANA COOPER: You just cut out, Claudia.

CLAUDIA MARIANO: Oh.

DANA COOPER: Oh, there you are. You just cut out, Claudia.

CLAUDIA MARIANO: Oh, my apologies.

Okay. Are we back?

DANA COOPER: Yes.

CLAUDIA MARIANO: Sorry about that.

COMMISSIONER FRANK MARROCCO (CHAIR): Just a second, Ms. Mariano.

Carrie, can you tell Ms. Mariano where she cut out?

You're on -- are you on mute?

THE REPORTER: If you'd like, I can as well. I have the transcript.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, okay. Fine. Sorry, I got mixed up there for a second.

THE REPORTER: That's okay. So you were talking about:

"...deprescribing medications for patients to help them stay as healthy as possible.

They monitor all those acute and episodic conditions. And because of the expertise of the --"

And that's where you left off.

CLAUDIA MARIANO: Okay. So yeah, because of the expertise of the NPs in those long-term care homes, I think you'll find that

particularly Carrie and Kathy will draw your attention to the ways that nurse practitioners are successfully impacting those residents who have cognitive and behavioural issues which can be so tremendously challenging for staff and for families in long-term care homes.

One of the other roles that nurse practitioners provide in long-term care homes is teaching and education and mentoring of staff to increase the capacity of the staff to provide care to those very complex residents.

As Dana commented, one of the recommendations and items that came out of Justice Gillese's report was the culture of the team in long-term care homes. The culture among the staff was critical to the quality of care that was provided to those residents.

And I think you'll see shortly that a nurse practitioner can play a very critical role in managing and maintaining that culture to be as open and inclusive and collaborative as possible.

So there are currently two specific funding models for nurse practitioners in long-term care that you're going to be hearing about in a few minutes. One model that Carrie will speak to is

the nurse-led outreach team model which is a concept that's spread geographically across the province although not equally distributed.

And Carrie will speak specifically about the composition of those teams and how they provide there. But essentially, you have a team of registered nurses, nurse practitioners, who will support care to, at a minimum, five nursing homes in a geographic region and really work with the medical director, who is a physician, in each of those homes to ensure service to those patients.

And you'll hear from Carrie how those NLOT teams have stepped up and stepped in to provide care to the patients in those long-term care homes during the pandemic.

The other model of funding is, as Dana alluded to, the -- what we call the "attending NP in long-term care" role which is currently 60 physicians that are funded by the Ministry of Health.

That funding flows through the LHINs, the Local Health Integration Networks, who then pass on the funding for that NP physician to individual long-term care homes.

So of the 60 that we currently have in

place, we -- as Dana mentioned, the recent announcement is that those additional 15 will hopefully be funded. Each attending NP position generally supports one home, but there may be sharing between two long-term care homes.

So those are currently the two models that we have funded. There is an additional model where the NP can be hired by the long-term care home operator individually and hired as an independent contractor to provide service.

It's a bit more difficult to know how many of those physicians there may be across the province because there isn't a simple registry, and the long-term care homes employ those NPs the way they might for any other independent contractor who provides a service.

But the funding for those positions would then come out of the operating budget for that long-term care home, and that long-term care home has generally made that decision because they recognize that the cost to them for the NP salary, tremendously, you know, is a small price to pay for the tremendous impact that that NP is going to have on the care for those residents in the long-term care home. And you're going to hear more details

around that in a moment.

Now, we certainly have really good evidence that the long-term care homes that have an NP have significantly reduced rates of transfers to emergency departments. And we also have some good evidence that, during the pandemic, the NPs in the long-term care homes are -- or the long-term care homes that already had an NP were able to manage the pandemic significantly better. They had fewer outbreaks of COVID-19, and where they did have outbreaks, they tended to be smaller and more easily contained than in those long-term care homes that did not have a nurse practitioner.

Now, I don't think we're certainly at the place where we can say that that difference is specifically because of the nurse practitioner. It's likely due to a number of broader things, but I think it really speaks to the context of the nurse practitioner role and the significant impact that we can have.

So with that --

COMMISSIONER JACK KITTS: Can I just ask a question?

CLAUDIA MARIANO: Yes, m-hm, please.

COMMISSIONER JACK KITTS: So there's

626 long-term care homes. There's 60 attending nurse practitioners. Most of them are attending in a home, somehow maybe two?

CLAUDIA MARIANO: Yes.

COMMISSIONER JACK KITTS: And the goal is 75? Can you tell me a bit about how long have nurse practitioners been in the homes, and how did you choose the lucky 75?

CLAUDIA MARIANO: Thank you for that question. The lucky 60 right now and, perhaps, the potentially lucky next 15, those would be selected by the Local Health Integration Networks when they assess where the need is, perhaps, greatest in their communities. And my understanding is they make applications to the Ministry for a funded NP position.

I think it's important to understand that the 60 positions we have currently were actually funded several governments ago. I mean, I remember this has to be at least 10 or 15 years ago that the current government announced funding for 75 NP positions in long-term care. That's what we have in the long-term care program now.

The first 60 were funded over the course of a couple of years, 25 or 15 at a time,

until we got to 60, and then there had been no further funding. So this current government recently announced -- or the recommendations from the long-term care study are that the final 15 from those initial promised 75 will now be funded.

That, as you mentioned, will supply an extra 15 nurse practitioners who would then support between 15 -- potentially 30 long-term care homes.

COMMISSIONER JACK KITTS: And did I hear you say that they're in the not-for-profit homes and not the for-profit or municipal homes?

CLAUDIA MARIANO: So to --

COMMISSIONER JACK KITTS: Is that --

CLAUDIA MARIANO: Yeah. To my knowledge, the funding for those 60 positions is for the not-for-profit homes. And as I said, the funding flows through the Local Health Integration Network. So if the LHIN has the authority and the accountability for the long-term care homes in that region, then they may choose a particular long-term care home or one of those funded positions.

COMMISSIONER JACK KITTS: And are all these homes different sizes, or are they generally the large homes, or do you know?

CLAUDIA MARIANO: Yeah. It's a very

good question. I'm not sure I have that information right now. The LHINs would likely be choosing the homes based on greatest need, and that may be larger homes who haven't had the adequate staffing, but it may also be smaller homes who also have had challenges retaining staff.

So I think there's a variation, and I don't think that the number of residents in the long-term care home would be a significant factor in whether they would receive a funded attending NP position.

COMMISSIONER JACK KITTS: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And I just want to follow up because I didn't quite understand part of the answer.

Are those nurse practitioners available to the municipal homes?

CLAUDIA MARIANO: My understanding is that, yes, they are.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CLAUDIA MARIANO: They would be available for funding. How many there are in those homes, I don't have that answer for you. But my

understanding is that, yes, they would be available.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CLAUDIA MARIANO: M-hm. Okay. And so I think with that, hopefully with some of that background about what nurse practitioners do and the current models of nurse practitioners in long-term care, I think I will turn it over now to Carrie to provide you with some background information on the nurse-led outreach team program.

CARRIE HEER: Okay. Thank you, Claudia.

So the nurse-led outreach team is another model that supports long-term care. We're currently comprised of -- we're mobile teams. We're mobile outreach teams that support long-term care homes.

There's a nurse-led outreach team in each of the 14 LHINs to support long-term care homes. Our models are comprised of blended models. So some teams have RNs. Some teams have RNs and NPs, and then many of the teams are exclusively NP teams.

So this program was funded back in 2008

with the plan to reduce ED wait times. And now we can see that we are now 12 years later, and we still have an issue with ED wait times and an issue with ER overcrowding; hallway healthcare; as well as significant, alternative levels of care and individuals remaining in hospital for long periods of time.

So with these teams, our mandate really is around quality resident-centred care within the long-term care study. But our goals are also around ED diversion so preventing those unnecessary emergency department transfers which then reducing hospital admissions and also assisting with reducing length of stay of those hospital admissions by supporting repatriation back to the long-term care homes.

So as Claudia and Dana have both alluded to, we have an ever-increasing, complex population in long-term care. People with multiple complex needs, multiple comorbidities, and many of these individuals in the past would have been managed in a complex continuing care hospital setting, and now they are being managed in long-term care.

So in terms of our roles in the

long-term care homes, we not only focussed on direct care provision but also on building capacity within the nursing staff so through education, coaching, mentoring, and supporting families and substitute decision-makers along the care journey as well.

And so that direct-care provision works collaboratively in supporting those residents in the home setting; working collaboratively with physicians; as well as other healthcare professionals such as pharmacist, physiotherapists, nurses, et cetera.

And so throughout the 14 LHINs, all of our teams support a number of long-term care homes. But it should be noted that not all long-term care homes in the province have access to the nurse-led outreach team. So there is a geographical disparity, and there is definitely an inequity in the number of homes that are supported versus those that are not supported.

We do have teams that support rural and urban areas. Some of the larger LHINs, the nurse-led outreach team is only supporting those urban areas. So there definitely is a need for additional support to many of the homes beyond that

central setting.

In terms of this pandemic --

Sorry, go ahead.

COMMISSIONER JACK KITTS: Just before you go on to the pandemic, can you describe who is in the nurse-led outreach team?

And let's say I'm -- we're picturing a rural area with a nurse practitioner travelling to various -- and it's all long-term care homes, I assume?

CARRIE HEER: Correct.

COMMISSIONER JACK KITTS: It's not home visits, but it's --

CARRIE HEER: That's correct.

COMMISSIONER JACK KITTS: Okay. Who is part of that team, and are they physically there? Are they virtually there? How does the team work?

CARRIE HEER: Yeah. Great question. So we are physically there. We are physically in the homes supporting residents with direct care.

And so with some of the teams that are comprised of registered nurses, they will go in and support the nursing staff -- education, coaching, mentoring -- as well as support them with clinical skills so whether it be intravenous or medication

administration, wound care, et cetera.

And then of the nurse practitioners -- so a similar role but then the expanded role where they will actually see residents very similar to a physician in terms of assessing, diagnosing, prescribing or deprescribing, having conversations with the resident and family around goals of care wishes.

So care from the full spectrum: acute, episodic, emergent care, chronic disease management, as well as palliative and end-of-life care.

COMMISSIONER JACK KITTS: And who is on that team, though? Is that all led by the nurse practitioner?

And the team members are the people at the home, the healthcare professionals at the home?

CARRIE HEER: Correct. So the teams are nurses, the "nurse-led." Again, some are registered nurses and nurse practitioners, and some are just nurse practitioners.

And so those teams that are comprised were small, small numbers for those teams, and support multiple long-term care homes.

And then the teams that we work

collaboratively with can also be other external consultants such as pharmacists or physiotherapists, et cetera. And then we work directly in the home working with the staff alongside the staff supporting the residents.

COMMISSIONER JACK KITTS: I think that's what I was getting at is does the team exclude -- or sorry, does the team include, you know, contact with emergency departments or contact with specialists or contact with pharmacists?

Is that part of it, or is that sort of anticipated in the future?

CARRIE HEER: No, that's a great question. Thank you for clarifying the question.

We do work directly with other healthcare partners as well. So whether it be an individual that we're seeing that needs to be transferred to hospital, we would have a conversation with that emergency department. Or is it a specialist that we can follow up with or work directly with?

So the one advantage of this team approach is we are actually supporting multiple long-term care homes, and we're supporting it at system level. So working around if it's a resident

that needs to be transferred to hospital, or is it a resident that's in hospital that we need to support with repatriation and support the staff and the hospital with that discharge so that resident can get the best evidence-based care in the care setting?

COMMISSIONER JACK KITTS: This may not be a fair question because you've got 60 nurse practitioners for 626 homes, and you're hoping to get 75.

But could you answer the question: Would it be most beneficial to have an attending nurse practitioner in each home physically present during the hours of work as opposed to dropping in from time to time?

CARRIE HEER: Right. So that's a great question. I think there's a role and an opportunity for both roles. So not only -- as an attending nurse practitioner, they are in the home.

And as I speak about what happened during the pandemic, many of the nurse-led outreach team nurse practitioners actually were embedded in those homes to provide direct care to the homes in crisis.

But I think the role of the nurse

practitioner period is an exceptional opportunity and support to those homes to ensure that the residents are getting that quality-centred care, timely access to care, and also support with any transitions whether it be to or from hospital.

COMMISSIONER JACK KITTS: Okay. Thank you.

CLAUDIA MARIANO: Just --

COMMISSIONER FRANK MARROCCO (CHAIR): You're going to describe how the teams worked during Wave 1?

CARRIE HEER: That's correct. That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER ANGELA COKE: Can I just ask a follow-up question before you get to that?

You had spoken about the sort of unevenness of the support of the teams, and so I just want to clarify. Is the barrier to implementing the model in a more sort of consistent comprehensive way strictly a funding issue or anything else or something else?

CARRIE HEER: Yeah. I think it's a funding and a resource issue. It's not due to lack

of willingness to support beyond our current homes that we support.

DANA COOPER: I just want to add one other point, too, in regards to the 75 attending nurse practitioners.

That is not our goal. That was a government determination as to the number of positions to fund for that program.

So, certainly, our goal is much, much higher as far as nurse practitioners in long-term care than what that attending program laid out there, and I'd like to --

COMMISSIONER FRANK MARROCCO (CHAIR): What was the goal?

DANA COOPER: 75 over three years.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no, no. I heard that. But you said your goal was much higher.

DANA COOPER: Oh, yeah. It's coming up in our recommendations, but we recommend one nurse practitioner per every hundred residents. And there's 78,000 residents in the long-term care in Ontario, so...

COMMISSIONER FRANK MARROCCO (CHAIR): So 780 --

DANA COOPER: Yeah. Ten times what the government funded several -- a number of years ago.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CARRIE HEER: Okay. So during the pandemic, all of our teams pivoted and shifted and took on additional roles/responsibilities to support the residents in long-term care.

And so in those roles, we change from what our normal role would be in mobile treating those homes to include providing IPAC support -- so infection prevention and control education -- coaching, mentoring, support with that, working alongside other healthcare system partners, whether that be Public Health or acute care facilities to provide that education and support those homes.

That was certainly one of the needs that was identified very early on, and so the nurse-led outreach teams had the flexibility and ability having those relationships with those homes to support.

They also provided that direct resident care that we have been providing. And as I had previously mentioned, some of the nurse practitioners actually then became embedded in

those long-term care homes that were in crisis and supported those residents directly and so provided the direct clinical management, provided palliative care, end-of-life care, working alongside the staff, supporting the staff, building capacity through education, knowledge translation, and also working very closely with those individuals, families, and substitute decision-makers.

As you recall, visitation was shut down into long-term care, so they weren't -- families were not able to visit their loved ones as they were -- many of them as they were very ill and, many of them, dying.

So not only did the nurse practitioners step up and provide that direct care, building capacity with that education, many teams also pivoted to provide support to the acute care centres such as COVID testing and assessment clinics.

Many of us worked on ED diversion strategies working with our local acute care centres/emergency department as to what strategies we could implement and utilize within the facilities to prevent unnecessary ED transfers especially as we were concerned about the hospitals

being overwhelmed with individuals with COVID.

The other opportunity that came up during COVID was virtual care and being able to implement and support the long-term care homes and their staff with virtual care so those individuals then having timely access to acute, episodic, chronic care, even specialist care.

And again, the goals of providing that care within the long-term care setting and avoiding unnecessary emergency department transfers that could then lead to hospital admissions, et cetera. And so that was yet one of the other strategies.

I think one of the most important pieces that I want to identify here with the role of the nurse-led outreach teams is our responses were at a system level. So we supported multiple homes, but we also supported multiple health sectors in caring for the residents within the long-term care setting.

In terms of --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just interrupt for a sec? When you say "multiple health sectors," this is kind of sort of in my mind, and I'm trying to understand it.

For example, you're providing IPAC

support. Is anybody else providing IPAC support, for example, Ontario Health or Public Health Ontario? Did they have IPAC support people in the district?

CARRIE HEER: So many of the -- since we're now into the second wave of this pandemic, there's been many other systems mobilized to support.

Initially, it was the nurse practitioners in the home, especially the homes in crisis. So, you know, issues identified lack of PPE but lack of PPE training with the staff. So the nurse practitioners that were in the home were able to provide that coaching and mentoring, how to utilize the PPE; how to don and doff, you know, masks, gloves, gowns, et cetera.

COMMISSIONER FRANK MARROCCO (CHAIR): That starts when?

CARRIE HEER: So that started during the first wave right at -- back in March/April.

So the --

COMMISSIONER FRANK MARROCCO (CHAIR): In the period leading up to March, is anybody doing any of this?

CARRIE HEER: And so there would have

been infection control support within the home. Each long-term care home does have an infection control expert that provides education and resources and informations.

If you have somebody in a respiratory outbreak or with pneumonia that's isolated in their room, they would have provided that education throughout.

What we found was with the pandemic, especially with the spread of this disease and this disease just spreading like wildfire within the long-term care home, there needed to be more support and more active engagement supporting multiple staff on three different shifts throughout.

And so not only providing education, but also many of these nurse practitioners provided that direct, in-person role of supporting and mentoring the staff with that.

COMMISSIONER FRANK MARROCCO (CHAIR): Pre-pandemic, there's an IPAC -- in terms of what you know, there's an IPAC person or expert in each home?

CARRIE HEER: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

And is that person an employee of the home?

CARRIE HEER: So there is somebody -- there is -- infection control is one of their requirements or programs, and it is a staff within the home.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

CARRIE HEER: And they may not necessarily be an IPAC expert, but they do have some knowledge, and that would be their role.

COMMISSIONER FRANK MARROCCO (CHAIR): Then also operating in the environment is Health Ontario, for example -- or Ontario Health, I should say.

So do they have an IPAC person as well?

Are they providing that kind of support as well as what's in the home? I'm asking you because of your -- if it's based on your experience. That's why I'm asking the question.

CARRIE HEER: So Public Health does provide education, and they do support the homes with any outbreaks. And that would be each individual Public Health that supports that regional setting for where that long-term care is housed. But --

COMMISSIONER FRANK MARROCCO (CHAIR): So there would be a Public Health person that is knowledgeable in IPAC procedures in each district?

And let me come back to the districts.

You said the 60 registered nurses are in the 15 -- the LHIN is operating out of 15 regions, I think.

CARRIE HEER: 14.

COMMISSIONER FRANK MARROCCO (CHAIR): 14 regions.

CARRIE HEER: 14 LHINs, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And we heard this morning, I think, that Ontario Health is operating in -- there are five. They divided the province up into five regions.

And the local Medical Officers of Health, the health units -- there are 34 health units. So, like, the province is divided into three different groupings by three different organizations, which is odd since it's the same province, but leave that aside for a minute.

Would Public Health Ontario also have IPAC people that are available to the long-term care homes?

CARRIE HEER: And so the Public Health

Ontario is different than the local Public Health units, and so the local Public Health units --

COMMISSIONER FRANK MARROCCO (CHAIR): That was going to be my next question.

CARRIE HEER: Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry.

CARRIE HEER: And I don't want to speak too much in detail because I'll leave that to their expertise around their roles and scope, et cetera. But in terms of outbreaks in long-term care homes, contact tracing, infection control and prevention, there are individuals at each local Public Health area that do support all long-term care homes. They support multiple long-term care homes throughout this.

So there was that support, but in terms of on-the-ground support during the crisis, that was an opportunity that the NLOTs took. That's where the NLOTs actually became involved directly with the homes. And so --

COMMISSIONER FRANK MARROCCO (CHAIR): Because they're not delivering that support?

CARRIE HEER: Because it was identified as a critical need, and we knew that the

transmission of the virus and the rapid spread -- so the need for education around the transmission, how to protect and prevent, how to isolate, how to cohort, and how to use the protective equipment, that was a huge challenge and ensuring that it was utilized appropriately.

COMMISSIONER FRANK MARROCCO (CHAIR): That's what I'm having some trouble with because there are at least three different groups that are purporting to provide IPAC expertise into a province that they divided in different ways.

But nevertheless, it's still good old Ontario, and there's -- sort of you have to step in while there's an emergency, notwithstanding which centres around, in part, lack of training, lack of education.

I'm trying to understand why that -- I'm not asking you to, you know, give me an authoritative answer. But you're familiar with it, and I'm curious if you can help me understand why that happened.

CARRIE HEER: So I think -- I mean, seeing what I'm seeing out there and with talking to my colleagues, you know, I think the fact that we saw -- this is a new virus we didn't know about.

And seeing the rapid spread knowing that you had the staff within the facility was a role they took on.

And so, you know, I can't really speak to -- each home has -- they are regulated. They are legislated in terms of what kind of education they need to provide, and IPAC is something that is a requirement as well. And that's something that is Ministry of Health and Long-Term Care Inspectors would be monitoring ongoing.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I think you actually did help me with the answer. Very tactful. Go ahead.

CARRIE HEER: So in terms of the staffing, that is something that, you know, both Dana and Claudia have spoken to, the opportunity for nurse practitioners to support the long-term care homes and to support ongoing.

So the staffing recommendation of 1 to 100, we did acknowledge that that would be a very large number of individuals. However, we see this as an opportunity and a solution to supporting these complex residents within the long-term care homes.

And again -- so during COVID, all of

our teams shifted into what our regular roles were, to support during a crisis, support what the needs were for the residents and the needs for the staff to support those individuals within the long-term care setting thereby reducing unnecessary ED transfers and burden to our acute care centres.

With taking on these additional roles, it has left these teams very stretched very thin. And so, if anything, what we're seeing at this time -- and I actually just met with a group this morning, seeing that there is an absolute need for more resources and more nurse practitioners to support not only the current work we're doing during this pandemic but moving forward with the complexity and the needs of these individuals.

In terms of end-of-life care, this was another piece that the nurse practitioners provided care around. So we know the morbidity and mortality of these individuals in long-term care is incredibly high. We know that the death rate is the highest in our long-term care setting which is our most vulnerable individuals.

And so these were roles that the nurse practitioners also took on. And again, some of them embedded in the home worked directly with the

palliative care specialist to provide this care and working, again, alongside the staff, resident, their families, substitute decision-makers in providing this care.

This was one of the -- a need that was identified by many of the homes to be something that was required from the nurse practitioners to be able to provide that palliative and end-of-life care, and that is something that the nurse-led outreach teams were able to step up and provide.

COMMISSIONER JACK KITTS: Can I just ask a question about --

So for, let's say, end-of-life care, do you work with the medical aid in dying, the MAID groups, or do they come into homes, or do you know?

CARRIE HEER: I think that's different based on each regions, and I wouldn't want to speculate on how each region is currently managing that process.

But that is a support that is available to long-term care homes whether it be through a physician or a nurse practitioner.

COMMISSIONER JACK KITTS: So nurse practitioners would be also -- in your nurse-led outreach team, that would be a function of your

nurse-led outreach team would be medical aid in --

CARRIE HEER: Again, I think that would vary on the region. I think it is a role that nurse practitioners can play.

In terms of our mandate around the nurse-led outreach team, it's really around that quality resident-centred care preventing ED transfers and hospital admissions.

COMMISSIONER JACK KITTS: Okay. And you spoke about having palliative care specialists. Is that what you do as well?

And I guess the question that would follow is what role does the medical director of the home play in these things and as a member of your team?

CARRIE HEER: And so we work as a collaborative shared-care model with the medical directors or the attending physicians and so work alongside them to provide this care but independently.

Again, as Claudia had identified, nurse practitioners are autonomous, independent providers. Don't require direct supervision, but we do work collaboratively.

And especially with the mobile teams

where we may not be there every day, we want to work alongside with those other providers who are also going to continue to provide that care with us. So again, a shared-care model of approach.

COMMISSIONER JACK KITTS: Okay.

CARRIE HEER: Okay. And so again, just reflecting back on the nurse-led outreach team -- so we routinely support the long-term care population by strengthening nursing capacity in the homes while providing urgent emergency care to residents that is collaborative, evidence-based, and resident-centred.

The NLOT program has consistently demonstrated a cost effective and consistent ability to reduce unnecessary ED transfers which thereby avoids the hallway healthcare that we're seeing in hospitals.

COMMISSIONER JACK KITTS: Sorry, another question. So we've learned a lot about "these residents are in their home." This is a home and not an institution and --

CARRIE HEER: Right.

COMMISSIONER JACK KITTS: -- certainly not a health facility. My question would be -- the goal is to keep residents as much as possible from

being transferred out of the home to a hospital.

CARRIE HEER: Right.

COMMISSIONER JACK KITTS: So the question is if the homes were equipped with more resources -- let's say some lab and DI -- do you think that that would help you in your goal of keeping residents going to the emergency departments or to hospitals?

And do you think it would be acceptable as turning it more towards an active care centre than a home?

CARRIE HEER: So we actually do have access to diagnostic imaging, x-ray, ultrasound, as well as laboratory services in the long-term care homes. So that does absolutely support us in being able to provide care to individuals within the home.

COMMISSIONER JACK KITTS: So all the long-term care homes have that ability to do those tests?

CARRIE HEER: So I can speak to my region that I support, and there are other regions. I can't speak to what is available in all of the rural areas within the province.

COMMISSIONER JACK KITTS: Okay. Thank

you.

CARRIE HEER: Great. Okay. So I'm just looking at the time and want to make sure I leave enough time for my other colleagues here.

So in terms of the NLOT Nurse Practitioner Program examples, I just want to provide you some examples of roles that we play regularly but also some examples of during the pandemic.

So we talked about our provision of direct clinical care, medical management of these individuals. Optimizing health systems is another role that we play, and so that's in terms of developing, supporting, and implementing region or LHIN-wide initiatives -- so around ED diversion, IPAC education -- in collaboration with other parties which we spoke to at length, such as Public Health and acute care.

In terms of education, the mentoring, coaching, capacity building with staff as well as supporting the staff with complex medical management and education and knowledge translation as well as family education counselling and support.

In terms of research, my colleague

Kathy McGilton will talk in terms of the nurse practitioner and long-term care study that was just completed this past summer.

Leadership -- so in terms of leadership, we play roles around communities of practice, capacity building, and outcome measures -- so quality improvement, data analysis, et cetera.

Consultation and collaboration is a big part of our goal -- and I know we have touched on this during this conversation as well -- whether it be colleagues, nursing colleagues, whether it be physicians, nurse practitioners, specialists, or whether it be other system partners working collaboratively with physicians or nurse practitioners within the acute care setting, within home and community care, and other partners such as physiotherapists, pharmacists, et cetera.

And so in that consultation/collaboration model, that's where we're able to support these individuals throughout multiple sectors and support them within the long-term care setting.

So I know I had talked about many of the nurse-led outreach teams and how we had

expanded our roles during the pandemic. Just wanting to identify again that, in every case, the nurse-led outreach teams did go above and beyond to ensure the right care provided at the right time by the right provider offering in-person care wherever possible, remote care when feasible, educating homes in outbreak, infection prevention and control, developing new models of collaborative care that improves access to specialists and emergency care consultations, supporting and managing COVID-19 testing centres, and even supporting some retirement homes and congregate settings.

We anticipate the impact of the next wave of COVID-19, in addition to the seasonal influenza, in Ontario long-term care homes. It is imperative that we begin to leverage the effectiveness of the nurse-led outreach team program now and the role of nurse practitioners.

There's been a number of media articles in terms of how nurse practitioners supported during the COVID pandemic from being embedded within the home through leading and implementing virtual care as well.

And the last piece I just want to end

my section on is a quote from one of my colleagues who is supporting -- who is the nurse-led outreach team nurse practitioner supporting currently embedded in a COVID home.

And so her statement to us was:

"I have COVID because somebody refused to go. I have COVID due my dedication to this group. I would not change what I have done over the past eight months as I have helped so many vulnerable and suffering.

This is any profession and my passion, but I do want to take this opportunity to make change and fix what is broken in the sector."

COMMISSIONER FRANK MARROCCO (CHAIR): And just one last question. The military went into, I guess, seven homes altogether. Were your teams in those seven homes as well?

CARRIE HEER: So some of the nurse-led outreach teams in the province were in those homes, and some of them were providing direct clinical management during the military's presence.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

CARRIE HEER: Okay. So on that note, I'm going to turn this over to Dr. Kathy McGilton.

CLAUDIA MARIANO: Sorry, Kathy, sorry, I just want to make one point. Carrie, I think you had started to speak to the cost savings that you had experienced, and I just wonder if you could share the quick example with the commissioners just around the cost savings from ED diversion that you've seen just in your one region.

CARRIE HEER: Okay. So just in the region that I support, we estimate the cost of an emergency department transfer to be around $2,000. And an in-patient hospital, just for the bed alone, is around $1,400.

When I looked back at reduction and length of stay, which would have been through support with early repatriation, as well as emergency department diversion, it was savings in an excess of $1.1 million, and that was just comparing one fiscal year to the other.

So if we look at the opportunities that the nurse practitioners have to support residents within the homes and avoid those hospital admissions, it is a significant savings to the system but still provides that quality

evidence-based care that those residents deserve.

Okay. And I will now pass it over to Kathy.

KATHY MCGILTON: Great. Hello. Welcome, and thank you for that opportunity.

A little bit about me: I'm a nurse, and I've been doing research in nursing homes for the last 20 years. And really, my focus has been looking at health human resources, and I've really focussed a lot of my energy on the RN role.

We are RNs. I thought it would be important to look at the registered nurse's role. And what I've done in the last, I guess it was, 15 is I've brought together international researchers because we have realized there are very few RNs in our nursing homes today.

15-20 years ago, there were quite a few, and it's actually dwindled, and now we have a lot of RPNs. So why is that? We have to look at that.

But what's most interesting in this work was the increased complexity of the clients that are showing up, and yet we have less skilled people caring for them in these homes. So that, to me, was a bit of a red flag.

And so we've done work in this area. We've also looked at the important role of the RN as a charge nurse supervising PSWs because -- talk about your team. If you don't have a good leader, charge nurse, supervising personal support workers, we're pretty sure you don't get good care. And we know this number one issue with retention. You don't have a good supervisor.

So as I was sort of mulling around, "what are we going to do next," I met up with Claudia, and I thought "nurse practitioners could be a great solution to also working with some of our RNs to try to provide a better environment for RNs to work in and also then subsequently lead better teams with our personal support workers."

And I thought "what were they doing during COVID-19 that we could kind of emphasize and show case the important role that nurse practitioners had during the COVID-19.

So we sent out information to all of the members of NPAO, and we received -- about 14 of our practitioners said they were interested in being interviewed. And the wonderful part is we pretty much got a nurse practitioner in every geographical region of Ontario. So we're talking

rural, urban, pretty much every district within the LHINs.

And I just want to comment -- we actually had -- half of them were actually attending. So those were the ones that were, perhaps, one NP in a building, versus, like Carrie's model, about seven NLOTs. So these were more -- well, those are more of the team kind of version.

And we said "we'd love to ask you some questions about what your role was before and during, and how did you manage during this?"

And I have to tell you, I, personally, was blown away. Having never done work with nurse practitioners before, I think the results that I will be publishing shortly will actually provide some evidence. They make a huge contribution within nursing homes.

The next thing you need to know is the first thing Claudia said to me is "should we look at which homes had nurse practitioners and which didn't and look at outcomes?"

Unfortunately, getting this information sometimes is very difficult to actually get what data we need to look at these questions. There is

very little data collected in Ontario to tell me about staffing which is very crazy because we know good staffing/good retention actually makes a difference to the quality of care, so this is a whole other issue.

When we looked at the 14 nurse practitioners that stepped up and said "I need to be interviewed," they actually said "I have a story to tell."

We actually asked them to tell us how many people had died within their facilities, and that's staff and, actually, residents.

So we had, first of all, cases between 1 to 170 residents were sometimes identified with COVID-19. So there was quite a distribution.

Some residents deaths, anywhere from 1 to 60. So these nurses were in homes where things were not going so well and also were going really well.

And also, COVID-positive staff cases, anywhere from 1 to 89. So there was quite a few staff who were infected. And in terms of deaths, staff deaths, there was one facility where a nurse practitioner spokes about two of their staff having died.

These were emotionally charged, as you can imagine, interviews by nurse practitioners who had gone in to try to make a difference.

I'm going to just start with sort of a summary before I go into some details. I think I was taken aback that there's no role in nursing homes, currently, where one is in charge and is supporting everybody within the building, and this is what kind of blew me away.

The impeccable resident-care focus, they absolutely have been delivering sort of best practices to the resident, and I have some examples of that.

Supporting staff -- I have to tell you. My first interview was -- I was blown away with the nurse practitioner saying during the time when this first started in March, the management team was in their office trying to speak with Public Health agencies to get the latest information on what to do. And as you know, like we all know, everything kept changing because we actually weren't that sure.

Mask? What kind of mask?

Gloves? What gloves?

So every other day, there would be new

information coming. And, pretty much, the staff were left to be on their own. And so when the nurse practitioners came in, they were actually the liaison between management and, actually, the staff. And so they felt that they could support the staff who were, actually, at this point, as you can imagine, very upset and not wanting to come in.

So the ability to take care of staff was there and also families. Right away, nurse practitioners realized they had to be the conduit to making sure that families were aware of what was happening.

And then supporting, actually, the management and directors of care was also their job because they also had to provide -- start developing policies and practices to support directors of care.

And most importantly, they prevented the spread of COVID-19. Once they started understanding what was happening, they started taking the Public Health agency's recommendations and putting them into practice which was absolutely the essential role of the nurse practitioner, is the facilitator.

We've got this great evidence, but how

do we get it into practice? And this was often some of the issues in nursing homes.

I also asked the innocent question: Tell me about the physician coverage during this time.

So you need to know that I thought this was important to see what was happening in their homes because there is usually a most responsible physician.

Of the 14 interviewed, four of them reported that the physicians continued to be present in their facility for very limited times. Most of them went to virtual care.

Now, we have to remember that OMA, of course, told them that limited, in-person availability was really what had to happen. And they recommended to move to virtual care, so they absolutely did so.

So at that time, what happened is we found that the nurse practitioners could talk to them virtually if they needed some help and also by telephone for consultations.

They actually used, often, more so, the specialist. And this is where this virtual care came in that they absolutely loved. The nurse

practitioners were able to get in touch with palliative care physicians, oncologists, hematologists.

By the way, they have never been able to before for some of these specialists, so they were very thrilled about this, and they don't want that, ever, to go away.

So being able to access the people you needed was actually quite wonderful. And I'm actually going to give you a quote. One of the nurse practitioners said:

> "I often wondered 'could I manage without the most responsible physician in the building?' It was kind of always in the back of my mind as an experiment."
>
> She said:
>
> "The experiment happened, and I actually phoned him five times during those six months.
>
> Three times was because the family said 'you have to speak to the doctor before I kind of agree with your recommendations.' And two times was because we needed CT

scans."

So it was fascinating that they were actually able to manage pretty independently doing some of their work. So I'll just let you know that.

And the clinical role -- and I don't want to emphasize or go over what Carrie spoke about, but there was a lot of new clinical practices.

And I'll tell you, I've done some work in knowledge translation. And if you don't have somebody that actually can facilitate bringing that new knowledge to bear, it doesn't happen.

So what we ended up seeing is we had to start inserting IVs. We had to start doing end-of-life care like never before. You know, there were new situations where people are taking care of someone after they had passed.

Our staff and nurses had never had to do this before. We needed somebody to show them how to do it, and nurse practitioners came through big time to facilitate that, bringing the best evidence to bear into practice.

Social isolation was the number one issue for many clients with dementia. They were

very agitated. We heard scenarios where nurses were trying to get Haldol ordered for their patients, and they would come in and say "this is not best practices. Let me teach you how it's done."

So the other thing you have to understand, having studied the RN role for many years, is we upscaled everybody but the RN.

PSWs have more knowledge and skills now. So do RPNs, registered practical nurses.

We kind of forgot and remembered that RNs also need these skills taking care of these very complex clients.

And so now we have nurse practitioners in there facilitating teaching so that nurses could, again, do good assessments so that they were able to make some determinations before they called the nurse practitioner. So there was a lot of teaching happening at this point.

So I think -- and the biggest thing I also did in terms of the clinical role was also speaking to family members. They spent a lot of time providing emotional support, comforting them, providing updates on the COVID situation. So again, nurse practitioners spent a lot of time on

the phone trying to ease, I guess, the pain and suffering of the families.

One of the major roles, clinically, also, was prevention and spread of COVID-19. They developed modules, and they also, which is very important, watched people don and talking off their PPE equipment because we know, in many of our acute care facilities, people are able to watch and mentor, and we didn't have the same thing happening within the nursing homes.

So again, a lot of focus on maintaining relationships with families, and I think they did a good job.

COMMISSIONER ANGELA COKE: If I can just ask a question.

KATHY MCGILTON: Oh, of course. Stop me any time.

COMMISSIONER ANGELA COKE: I'm just trying to get your opinion on whether you think the accountabilities between the nurse practitioner, the director of care, the medical director -- if this is very clear in your view.

You were talking, and some of the things sound like there should be some overlap in terms of the leadership. You know, the nurses

of -- directors of care, rather, you think, would be doing some of the things you're saying that the nurse practitioners did.

So I'm just wondering if there's clarity or if this is an issue that still needs refining and what the experience has been.

KATHY MCGILTON: What an excellent question. I'm going to actually ask Carrie to respond to that because I think, as a practicing nurse practitioner, she probably has a better answer because I did not ask those questions within the research context.

Carrie, what are your thoughts?

CARRIE HEER: So I think it all comes down to communication, that ongoing communication, and collaboration amongst the teams as to, you know, what is my role, and what can I support?

And I think it would vary amongst the facility and depending on the relationship of the NP that works within that facility.

So in terms of, you know, the nurse-led outreach team, we are external consultants. We're not employees of the home where many of the attending nurse practitioners would be employees of the home.

So I think it would vary based on home to home. I know I'm not giving you an exact, direct answer, but it varies.

And again, one of the biggest things that I find in my practice is it comes down to good, open communication. And that, then, helps really identify roles, responsibilities, accountabilities.

KATHY MCGILTON: Yeah. Okay. In terms of when we talk about relationship roles, though, I think we really did find that some of the actual nurse practitioners were actually -- they became the MRPs.

There was an emergency act where, actually, nurse practitioners could become the most responsible physician. And so they did step into that role and, again, I think, for the most part, provided the kind of guidance that was required to do it well.

And in terms of some leadership, really what was -- I think Carrie mentioned some of them were NLOTs which means they were responsible for probably ten nursing homes.

But through a decision, their own acute care director plus the director of care at the

nursing homes -- some of these nurse practitioners actually went into the facilities to work full time, and they thought there was such a need and then decided they better go in there, and they did. And they worked many long hours to take care of the facility, the residents, et cetera. So they were really stepping up to the plate.

In terms of educating, I think this was a huge part of the nurse practitioner role, again, in terms of IPAC education and role modelling and, again, addressing the staff's concerns. Because, again, they were dealing with staff that didn't want to come to work.

So they were really trying to convince them that, again, along with the director of care, if we provide good PPE/resources, perhaps you can stay. And it actually worked out well. And again, these new practices -- for instance, hypo dimer collectisis (ph) -- they actually had to do education.

They were doing IVs for staff, and it actually seemed to really work well. They were upscaling some of the RNs, and it actually -- for clinical care, I think they felt that they were really providing better care.

In terms of administrative responsibilities, they were really doing a good job interpreting Ministry directives, developing and implementing any policy within long-term care homes that was coming. And they really took a big role in swabbing of long-term care personnel and signing off on results. And planning for future outbreaks became a big part of their jobs as well.

I just want to -- I think that was sort of a summary, and I wanted to -- because I think we have some time to talk about recommendations.

But what they also talked about in their roles was sometimes there's some factors that influenced the success of being a nurse practitioner, and this probably speaks a little bit to your question that you asked.

Number 1, the scope of the practice is sometimes limited. For instance, they cannot order CT scans, hearing aids, Form 1s. So there's actually some -- for reasons behind this -- and again, maybe Claudia has more information on this.

But nurse practitioners spoke about that. Also, some of these long-term care homes have to pay directly from their budgets to actually hire a nurse practitioner.

We talked about the Ministry of Health supporting, now, 75. And so this is hard for nursing homes to find a budget to hire a nurse practitioner.

The other thing you need to know is that nurse practitioners don't get paid as much in these environments as the acute care. And so, again, that's sometimes seen as a barrier.

Often, in some of these homes, there are some leaders that don't actually really recognize the important role of RNs, and I'm talking now even administrators.

And when you asked who were the lucky ones to scoop up those initial 50, I think those were the administrators that probably are more innovative, you know, really understood this important role for our nurse practitioners.

But there are some that aren't so sure about this. So I think there are important roles leaders have to play, and these roles are the administrators and directors. And sometimes we wonder what kind of education and training goes on to be in those spots.

I think the other issue is around registered nurses. They need to have assessment

skills to recognize when nurse practitioners are required. So again, a bit more filling up with some of the staff around so that we can have sort of better outcomes for our residents.

And I also -- this was interesting. We talked about the home environment. I think we have to make sure that we are -- this is a home. Having a nurse practitioner in there, I think, doesn't mean that it's part of a medical model, but we do have to provide complex care because many of these clients are coming in, and they're actually in crisis.

So we do need to make sure that that care is provided, but we also, then, need somebody to make sure that we have social care. We have -- you know, there are issues related to culture, social, mental. We have to make sure all of their needs are met. And because of that, we also need to make sure we have the right people in the home.

So you talk about having specialists available virtually, physios, pharmacists. We need different professionals to help care for the population that are now in nursing homes today.

And I think that's where I'm going to end, and I just wonder are there any questions

before we talk about some of our recommendations?

Yes?

COMMISSIONER JACK KITTS: Well, I think, between all of you, you've fairly accurately described a whole new model of care for long-term care homes that is team-based, collaborative, and includes everybody that the resident may need -- access to specialists, access to emergency departments, and having the ability to do enough testing at the home to reduce those transfers.

I think the $1.1 million saving in your area, Ms. Heer, is great for the system, but the amount of transfers that would be avoided for these frail elders, to me, is priceless.

And so I'm quite impressed with the model and the use of virtual care and the use of team-based approach. So I don't really have any questions except to say I really enjoyed the presentation and learned a lot.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm very interested in what you're saying, but I'm having some difficulty with the idea that this is the person's home. Everybody who appeared here has said that emphatically.

But it isn't exactly like your home

because, you know, for example, people can come and move you to another room to prevent infection. People can decide that your family can't visit you anymore. People can decide that you have to stay in your room. That seems to me to be kind of inconsistent with the idea that it's your home.

And I'm wondering if you think if that analogy really works or not. Because if the analogy is wrong, then a lot of conclusions that flow from that are generally accepted as going with the analogy and won't necessarily be right either.

KATHY MCGILTON: Yeah. I'm thinking about you're not living at home. You're living within a community within a home. And so we're making decisions to protect everybody --

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

KATHY MCGILTON: -- as well as -- and trying to create the best sort of person-centred place for you knowing that you're still within a community, and we have to take care of others. And there's risks depending on the decisions we make.

So I think we try to make it as home-like and -- really, the most important thing is what are the person's wishes and needs, and that

helps inform what our care plans should look like, and how do we make this as home-like as possible?

But with COVID-19 coming, there were decisions made that overrule on, unfortunately, sometimes, the home that you're in for the safety of others and, perhaps, for yourself. We move you out of that room because we were worried about you being infected as well.

COMMISSIONER FRANK MARROCCO (CHAIR): I wasn't quarrelling with the justification --

KATHY MCGILTON: Oh.

COMMISSIONER FRANK MARROCCO (CHAIR): -- for moving somebody, but what I was saying is that it's not something that happens to you in your home. And so it's the analogy that I'm having some difficulty with, and it just seems to me it's almost -- it's an imperfect analogy, but yet it's very firmly held by virtually everybody who has come here. That's what, I guess, I was seeking a comment on.

I wasn't suggesting that infected people should be allowed to walk around the home all over the place or anything like that.

It's difficult, though, you know, just in terms of what you just said, to speak about a

person's wishes when we've been told that 70 percent of the people are suffering from some form of dementia. Your wishes can be a little odd when that's -- anybody who has had experience with that would agree with that.

So it isn't really exactly in accordance with your wishes, necessarily, because of the nature of the condition you're likely in.

KATHY MCGILTON: Right. And I guess, to be honest, people just wish to be dealt with respect. I think there are sort of certain rules we just try to go with when we're caring for you. You're right. And sometimes we can tell by your behaviours and your affect if we are actually following some of the your wishes.

So there are ways of trying to understand that and also understanding from the family's perspective what the individual actually striving for -- what kind of a day do they want?

I think that's also where leadership and the best practices try to focus on, and that's why we're trying to get person-centred approaches. "What do you want to do during the day, and how do we make that happen?"

DANA COOPER: Yeah. And with any

community -- like, as with any community, there's going to be variations within the population in that community and a variation of needs within that population.

So that's the recognition. That's the beautiful thing about leadership is recognizing that variation in needs and being able to cater to them.

I think I'll just wrap up by sort of just outlining some of the recommendations that we have provided. Some of these went forward with our recommendations, our response to the Ontario Government staffing study, and what we saw as ways that we can improve the quality of care in long-term care homes in the province.

So number one is increasing nurse practitioner leadership in long-term care homes, as we were just talking about. And, you know, we've seen a number of different -- both Carrie and Kathy, you know, have pointed to many examples where nurse practitioner leadership was exhibited. And we've recommended that nurse practitioners be able to act in that medical director role.

Now, currently, it is not -- that role is supposed to be filled by a physician as per the

Long-Term Care Health Act. However, during the pandemic, there were emergency orders issued that allowed nurse practitioners to act in that role and were wondering what was going to happen at the end of it when the pandemic is over with regards to that order.

But the bottom line is we failed to see reasons why nurse practitioners cannot fulfill that role within the long-term care homes as -- I think it was Carrie that -- or was it Kathy or Carrie?

Kathy mentioned something about the six calls that one nurse practitioner made to the medical director during that six months. And it's a perfect example as to, you know, support the contention that the nurse practitioner should be able to fill that role of medical directors.

But under the leadership banner, we also include the staff training in there. As both Kathy and Carrie pointed out, the need for the staff training, the capabilities of the nurse practitioners to provide that training, you know, and coach, you know, the RNs, the PSWs, the RPNs, you know, in the various roles that they're performing within that particular facility.

And that's the beauty of the broad

scope of practice of the nurse practitioners. That wide range of knowledge and skills that they possess can be applied across, you know, a broad context within the long-term care home.

So certainly increasing the number of nurse practitioners to address leadership in the long-term care homes is one of our big recommendations.

And it also addresses the culture aspect. I mean, if we're looking at, you know, nurse practitioners, our nursing professionals that are attuned to supporting staff at all levels, as I was just mentioning -- but they bring that nursing care perspective, that compassion, that patient-centred approach that, you know, can help certainly build up the culture within that facility itself and to have that translate to, you know, your staffing turnover, your resident experience, and all that. So certainly increasing nurse practitioner leadership addresses those different aspects.

We've suggested that we need to increase nurse practitioner-to-resident ratio to address that increasing acuity of residents, as we talked about. It is growing. The pandemic is

here, but the pandemic is going to go away at some point, and that acuity issue will still be there.

We believe it's a critical step to improving the quality of care in long-term care homes. You know, we have the complexity ratio, that complexity mix aspect to this that is complicated.

But with the presence of nurse practitioners, it can help to stabilize, you know, that complexity mix by having the capabilities, the competencies within the facility itself to manage the growing acuity amongst the residents.

You know, so we've talked about the attending nurse practitioners and how the staffing study suggests that we complete Phase 3 of that, which is another 15 nurse practitioners. And obviously, from our perspective, that is woefully inadequate to meet the needs that are called for in a long-term care reform.

And again, increasing that nurse practitioner-to-resident ratio, nurse practitioners can fulfill a number of roles within a long-term care home. As I mentioned, medical directors, if they're allowed -- but directors of care, the medication management, complex resident management,

nursing leadership, staff education.

All those different roles can be fulfilled by nurse practitioners, and it makes sense to have them present in the areas in that long-term care facility where they can really make a difference, for sure.

COMMISSIONER JACK KITTS: Can I just ask a question about the --

Did you say that you're doing research and will be publishing a paper on, I guess, the performance or value ahead of a nurse practitioner?

KATHY MCGILTON: Yeah.

COMMISSIONER JACK KITTS: When will that paper be published?

KATHY MCGILTON: Actually, we've got sort of half of it written, and I'm hoping to probably submit it within the -- by the end of this month because the interviews are done, and it's great.

COMMISSIONER JACK KITTS: Okay.

U/T KATHY MCGILTON: Okay. We'll share that with you.

COMMISSIONER JACK KITTS: Yeah, could you share that with us? Thank you.

KATHY MCGILTON: Yeah.

COMMISSIONER ANGELA COKE: And, Dana, just wanted to ask if there was a move to say "yes, we're going to increase to this extent," is there the supply in the system?

DANA COOPER: Yes. I mean, there is a -- there is a capability of scaling the supply, for sure. From what I understand in talking to the Schools of Nursing, you know, we're recommending, like, a 1:100 resident ratio. That represents about 780 nurse practitioners.

Currently, in force, we have the 60. We have -- plus the nurse practitioners working in the NLOTs plus, you know, the handful that are contracted in that -- you know, out -- there's the extent of nurse practitioners working in the long-term care homes.

It represents, right now, about .6 percent of the registered nursing staff in long-term care homes in Ontario. We're suggesting taking that up to 3.6 percent. But currently, there's about -- and correct me if I'm wrong, Claudia -- ten nurse practitioner programs in Ontario, about 20 students per program, on average.

CLAUDIA MARIANO: Yeah. In Ontario, we graduate approximately 250 nurse practitioner

students every year. Plus we also have nurses who take the programs from outside of Ontario, and they are then eligible to still be licensed or registered by the College of Nurses of Ontario. So we might say, maybe, approximately 300 new graduates each year.

So if we were to flip the switch tomorrow and have the, you know, positions available to meet our recommendation of 1:100, no, we wouldn't be able to meet that demand by tomorrow, but we could have a phased-in and scaling approach each year knowing that we should increase the capacity for the Nurse Practitioner Programs to take on new students.

DANA COOPER: And certainly --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, just if I can just follow up, it seems to me that it doesn't really matter whether you could fill the positions today or not. Because if that were the test, you'd never do it.

And if you could -- just because you can't fill them, there's not a reason not to set the goal. That seems to me to be a -- that seems to be a non -- that's somebody who doesn't want to do it and is looking for reasons not to do it.

I didn't mean you, Ms. Mariano. I understand your position. But I'm just saying that that kind of response to me just doesn't make a lot of sense.

DANA COOPER: Yeah.

COMMISSIONER ANGELA COKE: My other question, though, is would you also have to deal with the issue -- somebody mentioned the fact that when you have nurse practitioners, if they're working in the acute care settings, they're getting paid more.

So like the PSWs, would that issue have to be leveled off as well; is that right?

DANA COOPER: Certainly there's a compensation matter/inequity. You know, and it's not just acute care and long-term care. It's in several settings, you know, certainly from a nurse practitioner perspective across the healthcare sector. You know, so there is an inequity.

You know, so -- yeah. Of course nurse practitioners want to see action on that front, you know? And, you know, it's going to -- it's probably -- it's arisen as a function of growth in the scope of practice of nurse practitioners. It's arisen for a number of different reasons as to why

there's inequities, you know, in the different sectors. But, of course, nurse practitioners would like to see, you know, that addressed.

COMMISSIONER ANGELA COKE: Okay.

DANA COOPER: Yeah. So the other recommendations we have -- so we've got increasing the nurse practitioner-to-resident ratio.

We've got, you know, nurse practitioner leadership in long-term care homes and allowing them to access medical directors.

But, you know, as Carrie has mentioned, better leverage to nurse-led outreach teams to support long-term care home residents. There's an opportunity here to support the teams that are in place, the staff that are in place in long-term care homes, with capabilities, you know, that they may not have in house through the NLOTs and also to supplement the capabilities that do have them in house to increase capacities and that -- you know, so it can be a very effective way to go in that team-based approach to resident care to realize, you know, that enhanced experience for long-term care residents.

You know, so currently there's 14 NLOTs in Ontario. We certainly envision, you know, every

long-term care home being able to have access to an NLOT which requires a doubling of that nurse-led outreach teams in the province from 14 to 28 to give every long-term care home access to that additional support that the NLOTs provide.

One thing we've recommended to the Government of Ontario and the Ministry of Long-Term Health is, you know, we share the Ministry of Long-Term Care and the Government of Ontario for recognition of the urgency in addressing the long-term care environment.

And, you know, we suggested to the Ministry that, you know -- and we've heard a lot about the need for staff training and the need for that. And one thing we did hear -- and I think I saw this in Kathy's study or I thought, but correct me if I'm wrong, Kathy.

But the experiences or maybe it was the Government of Ontario staffing study, as a matter of fact, where its respondents suggesting that their experience in the nurse practitioner -- or the schools -- this involved PSWs, RNs, NPs.

Their experience in schools did not match the reality of the long-term care environment. So there is a need for additional

training out there, and NPAO has offered that with Ministry support. We don't take the development of a practical continuing education certificate course credential for all healthcare providers, you know, that can lead to a long-term care/resident care credential, you know? And that could certainly be made up.

Of course, the nice thing about it is it can be tailored to the needs of long-term care at any particular moment. But we envision, like, a collaborative care module or quality care and long-term care homes, medication management, mental health challenges, you know, high-performing cultures and those type of, you know, modules that can make up this credential.

So that was one thing we made an offer to the Government of Ontario to develop with their support.

And as was mentioned by Cathy, Carrie, Claudia, there's barriers remaining for nurse practitioners to be able to practice. I mean, if we're going to add all these nurse practitioners to the long-term care environment and they still have these barriers, we're going to be having a problem.

So there's barriers that need to be

removed, and we call them -- I certainly call them "nonsensical barriers" such as the inability to order CT and MRIs. Now, that, there is action on that front, and so we hopefully will be overcoming that one soon.

The inability to order point-of-care testing, again, there's action on that front, and that one should be overcome hopefully soon.

But the inability of nurse practitioners to order hearing aids and other assistive devices, signing death certificates, Form 1s, mental health services forms, you know, all these different barriers that exist that need to -- that don't make a lot of sense and could certainly hinder effective care in the long-term care home environment, for sure.

That's about all we had to say. I'll open it up to Kathy, Carrie, and Claudia because I could very well have forgotten some recommendations or -- you know, so I just want to make sure that all those points and all the points we wanted to make were addressed.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it sounds like they were.

You know, we certainly asked all the

questions that we wanted to ask as we went along. I don't think the -- I don't see Commissioner Kitts or Commissioner Coke have any further questions.

So I just want to say thank you.

Oh, yes.

CLAUDIA MARIANO: Sorry, I don't mean to interrupt, Justice Marrocco. I just wanted to speak -- I think, Commissioner Kitts, you had asked the question from Kathy around the study that she's currently doing, but I also wanted to point out an addition.

So this, as far as we know, Kathy's study with us, is the first study that we know of that looks at the role of the nurse practitioner in the long-term care home during COVID. Not just in Ontario but anywhere. So I think it will be a really seminal study.

But just also let you know, in terms of research, we have -- there is just volumes of research studies and evidence that support the effectiveness of nurse practitioners in long-term care.

So Kathy's study will be an incredibly valuable additional to that because it focusses specifically on the experience during the pandemic.

But I think the role of the nurse practitioner in long-term care is so well evidenced and well supported that I hope we can all feel comfortable knowing that this isn't something that we have to necessarily inquire but further investigate further.

The role has been around for quite some time. Not well recognized, not well appreciated, but incredibly well supported by evidence of literature in how effective it is for residents and their families.

COMMISSIONER JACK KITTS: Yes. Thank you. I understand that. COVID has introduced a whole lot of new ways to provide a higher quality of care, and it sounds like long-term care homes are no exception, so thank you.

CLAUDIA MARIANO: Thank you.

COMMISSIONER ANGELA COKE: I just have one last question. I was just curious if there are other jurisdictions that have implemented the nurse practitioners in the way that you're envisioning they should be.

Are there any other jurisdictions that are operating a model that is more in line with what you're thinking should be happening?

CLAUDIA MARIANO: I'm not sure if Carrie and Kathy have heard. Not that I am aware of, to be honest, in other provinces. Not that I'm aware of, but Carrie and Kathy may have other experiences.

CARRIE HEER: So I believe there are attending NPs in other jurisdictions and, you know, municipal and for-profit. And just to clarify, in my current region, we do have some of those in attending NPs in for-profit homes as well. I can't speak to the other regions but certainly in this region.

But to my knowledge, we are the only jurisdiction that has the mobile nurse-led outreach teams with the role that we do working at a system-level response to support multiple long-term care homes.

COMMISSIONER JACK KITTS: Is it possible that there might be some northern rural Ontario homes that might have a nurse practitioner filling that role, or is --

KATHY MCGILTON: Oh, absolutely. We did actually probably get a couple from our interviews, but -- so that's actually a good point. I'll keep that in mind when we are looking at that.

But I want to also tell you that the critical work I'm doing is an international search of what's going on with nurse practitioners. So I will have some of that literature to share because we are interested in knowing what is happening in nursing homes globally.

That is an agenda. We want to keep pushing as well. We probably could give a showcase on what others could do one day.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

KATHY MCGILTON: Oh, and by the way, I interviewed six nurse practitioners for-profit -- in-profit and for not-for-profit. So I actually have equal numbers in our studies, so it's kind of nice. So they're definitely in private homes as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, and thank you for the offer to share the study. That will be very helpful from our perspective. We'll look forward to receiving it.

Thank you very much for the thoughtful remarks and thoughtful presentation, and thank you for answering the questions. It's very informative for us and very helpful.

And as I say to almost everybody who is here, we may be back.

CLAUDIA MARIANO: Thank you so much for the opportunity. We really do appreciate it.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DANA COOPER: Yes, we do. Thank you so much.

COMMISSIONER ANGELA COKE: Thank you.

DANA COOPER: All the best in your work.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

CLAUDIA MARIANO: Thank you, everyone. Stay safe.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye.

-- PROCEEDINGS CONCLUDED AT 2:46 P.M. --

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, Chartered Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination 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 14th day of November, 2020.

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PER: MCKAYA MCDONALD, CSR
CHARTERED SHORTHAND REPORTER

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