

Long Term Care Covid-19 Commission Mtg.

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



77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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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.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9 Carrie Heer, RN(EC), BScN, MN, NP-PHC} Nurse
10 Practitioner Coordinator/Clinical Lead, Nurse
11 Led Outreach Team;

12 Dana Cooper, Executive Director, NPAO;

13 Claudia Mariano, Manager of Practice and Policy,
14 NPAO;

15 Kathy McGilton, Senior Scientist, Toronto
16 Rehabilitation Institute - University Health
17 Network; Professor, Lawrence S. Bloomberg Faculty
18 of Nursing, Rehabilitation Sciences Institute,
19 University of Toronto.

20

21 PARTICIPANTS:

22

23 Alison Drummond, Assistant Deputy Minister,
24 Long-Term Care Commission Secretariat;

25 Dawn Palin Rokosh, Director, Operations, Long-Term

1 Care Commission Secretariat;

2 Ida Bianchi, Counsel, Long-Term Care Commission
3 Secretariat;

4 Jessica Franklin, Policy Lead, Policy Unit,
5 Long-Term Care Commission Secretariat;

6 Derek Lett, Policy Director, Long-Term Care
7 Commission Secretariat;

8 Lynn Mahoney, Counsel to the Ministry of Health and
9 Long-Term Care;

10 Sanjay Bahal, Team Lead, Operations, Long-Term
11 Care;

12 John Callaghan, Counsel, Long-Term Care Commission
13 Secretariat;

14 Kate McGrann, Counsel, Long-Term Care Commission
15 Secretariat.

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Good afternoon.

4 CARRIE HEER: Good afternoon.

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

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

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

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Oh, right.

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

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

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

8 Okay. There we go.

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

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

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

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

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

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

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

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

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

12 DANA COOPER: Okay.

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

18 Dana Cooper: Thank you.

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

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

1 the nurse practitioner profession here in Ontario.

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

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

14 With me here today to share information
15 with you are Claudia Mariano. She's NPAO's manager
16 of practice and policy and has been a nurse
17 practitioner for over 20 years.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 care that they deserve.

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

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

14 As Justice Gillese pointed in her
15 Public Inquiry Report:

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

1 their well-being.

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

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

13 She goes on to state:

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

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

25 She also stated, and I quote:

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

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

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

18 We need the healthcare providers and
19 support workers to be an efficient and effective
20 team that sets the tone for this vision.

21 Recognizing the need for commonsense regulations,
22 staff must be provided the flexibility to render
23 the most appropriate care and support the residents
24 require.

25 NPAO is long known and stated that:

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

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

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

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

24 This lack of understanding and
25 awareness about nurse practitioners is compounded

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

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

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

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

17 The Nurse Practitioner Attending
18 Program that was implemented by the government in
19 2014 with the promise to employ 75 nurse
20 practitioners in publicly-funded long-term care
21 homes over three years, only 60 of those positions
22 have been hired to date. And the staffing study
23 just recently completed suggested that Phase 3 of
24 that initiative be completed, meaning another 15
25 nurse practitioners in publicly-funded long-term

1 care homes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So, for example, in a typical day, a

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

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

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

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

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

1 around that long-term care.

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

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

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

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

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

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

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

20 DANA COOPER: You just cut out,
21 Claudia.

22 CLAUDIA MARIANO: Oh.

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

25 CLAUDIA MARIANO: Oh, my apologies.

1 Okay. Are we back?

2 DANA COOPER: Yes.

3 CLAUDIA MARIANO: Sorry about that.

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

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

8 You're on -- are you on mute?

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

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

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

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

19 They monitor all those acute and
20 episodic conditions. And because of
21 the expertise of the --"
22 And that's where you left off.

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

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

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

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

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

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

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

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

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

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

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

25 So of the 60 that we currently have in

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

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

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

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

1 around that in a moment.

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

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

21 So with that --

22 COMMISSIONER JACK KITTS: Can I
23 just ask a question?

24 CLAUDIA MARIANO: Yes, m-hm, please.

25 COMMISSIONER JACK KITTS: So there's

1 626 long-term care homes. There's 60 attending
2 nurse practitioners. Most of them are attending in
3 a home, somehow maybe two?

4 CLAUDIA MARIANO: Yes.

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

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

17 I think it's important to understand
18 that the 60 positions we have currently were
19 actually funded several governments ago. I mean, I
20 remember this has to be at least 10 or 15 years ago
21 that the current government announced funding for
22 75 NP positions in long-term care. That's what we
23 have in the long-term care program now.

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

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

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

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

12 CLAUDIA MARIANO: So to --

13 COMMISSIONER JACK KITTS: Is that --

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

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

25 CLAUDIA MARIANO: Yeah. It's a very

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

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

12 COMMISSIONER JACK KITTS: Okay. Thank
13 you.

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

17 Are those nurse practitioners available
18 to the municipal homes?

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

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Okay.

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

1 understanding is that, yes, they would be
2 available.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

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

12 CARRIE HEER: Okay. Thank you,
13 Claudia.

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

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

25 So this program was funded back in 2008

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

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

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

25 So in terms of our roles in the

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

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

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

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

1 central setting.

2 In terms of this pandemic --

3 Sorry, go ahead.

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

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

11 CARRIE HEER: Correct.

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

14 CARRIE HEER: That's correct.

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

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

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

1 administration, wound care, et cetera.

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

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

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

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

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

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

25 And then the teams that we work

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

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

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

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

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

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

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

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

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

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

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

25 But I think the role of the nurse

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

6 COMMISSIONER JACK KITTS: Okay. Thank
7 you.

8 CLAUDIA MARIANO: Just --

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

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

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay.

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

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

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

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

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

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

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

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

15 DANA COOPER: 75 over three years.

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

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 So 780 --

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Okay.

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

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

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

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

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

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

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

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

1 being overwhelmed with individuals with COVID.

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

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

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

20 In terms of --

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Can I just interrupt for a sec? When you say
23 "multiple health sectors," this is kind of sort of
24 in my mind, and I'm trying to understand it.

25 For example, you're providing IPAC

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

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

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 That starts when?

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

21 So the --

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

25 CARRIE HEER: And so there would have

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

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

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

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

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

24 CARRIE HEER: That's correct.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 And is that person an employee of the home?

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Right.

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

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

15 So do they have an IPAC person as well?
16 Are they providing that kind of support
17 as well as what's in the home? I'm asking you
18 because of your -- if it's based on your
19 experience. That's why I'm asking the question.

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

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

4 And let me come back to the districts.

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

8 CARRIE HEER: 14.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 14 regions.

11 CARRIE HEER: 14 LHINS, yes.

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

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

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

25 CARRIE HEER: And so the Public Health

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 That was going to be my next question.

5 CARRIE HEER: Sorry.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Sorry.

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Because they're not delivering that support?

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

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

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 That's what I'm having some trouble with because
9 there are at least three different groups that are
10 purporting to provide IPAC expertise into a
11 province that they divided in different ways.

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

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

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

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

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

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

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

19 So the staffing recommendation of 1 to
20 100, we did acknowledge that that would be a very
21 large number of individuals. However, we see this
22 as an opportunity and a solution to supporting
23 these complex residents within the long-term care
24 homes.

25 And again -- so during COVID, all of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And especially with the mobile teams

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

5 COMMISSIONER JACK KITTS: Okay.

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

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

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

22 CARRIE HEER: Right.

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

1 being transferred out of the home to a hospital.

2 CARRIE HEER: Right.

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

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

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

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

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

25 COMMISSIONER JACK KITTS: Okay. Thank

1 you.

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

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

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

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

25 In terms of research, my colleague

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

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

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

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

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

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

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

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

25 And the last piece I just want to end

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

5 And so her statement to us was:

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

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

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 And just one last question. The military went
18 into, I guess, seven homes altogether. Were your
19 teams in those seven homes as well?

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Okay. Thank you.

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

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

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

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

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

1 evidence-based care that those residents deserve.

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

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

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

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

17 15-20 years ago, there were quite a
18 few, and it's actually dwindled, and now we have a
19 lot of RPNs. So why is that? We have to look at
20 that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 So we had, first of all, cases between
14 1 to 170 residents were sometimes identified with
15 COVID-19. So there was quite a distribution.

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

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

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

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

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

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

23 Mask? What kind of mask?

24 Gloves? What gloves?

25 So every other day, there would be new

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

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

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

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

25 We've got this great evidence, but how

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

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

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

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

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

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

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

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

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

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

12 "I often wondered 'could I
13 manage without the most responsible
14 physician in the building?' It was
15 kind of always in the back of my
16 mind as an experiment."

17 She said:

18 "The experiment happened, and I
19 actually phoned him five times
20 during those six months.

21 Three times was because the
22 family said 'you have to speak to
23 the doctor before I kind of agree
24 with your recommendations.' And two
25 times was because we needed CT

1 scans."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 Carrie, what are your thoughts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 before we talk about some of our recommendations?

2 Yes?

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

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

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

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

25 But it isn't exactly like your home

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

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

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

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Sure.

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

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

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

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

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

11 KATHY MCGILTON: Oh.

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

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

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

1 person's wishes when we've been told that
2 70 percent of the people are suffering from some
3 form of dementia. Your wishes can be a little odd
4 when that's -- anybody who has had experience with
5 that would agree with that.

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

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

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

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

25 DANA COOPER: Yeah. And with any

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

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

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

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

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

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

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

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

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

25 And that's the beauty of the broad

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

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

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

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

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

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

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

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

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

1 nursing leadership, staff education.

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

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

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

12 KATHY MCGILTON: Yeah.

13 COMMISSIONER JACK KITTS: When will
14 that paper be published?

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

20 COMMISSIONER JACK KITTS: Okay.

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

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

25 KATHY MCGILTON: Yeah.

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

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

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

17 It represents, right now, about
18 .6 percent of the registered nursing staff in
19 long-term care homes in Ontario. We're suggesting
20 taking that up to 3.6 percent. But currently,
21 there's about -- and correct me if I'm wrong,
22 Claudia -- ten nurse practitioner programs in
23 Ontario, about 20 students per program, on average.

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

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

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

15 DANA COOPER: And certainly --

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

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

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

5 DANA COOPER: Yeah.

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

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

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

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

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

4 COMMISSIONER ANGELA COKE: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So there's barriers that need to be

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

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

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

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

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

25 You know, we certainly asked all the

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

4 So I just want to say thank you.

5 Oh, yes.

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

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

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

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

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

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

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

17 CLAUDIA MARIANO: Thank you.

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

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

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

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

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

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

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

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 All right.

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

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Well, and thank you for the offer to share the
20 study. That will be very helpful from our
21 perspective. We'll look forward to receiving it.

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

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

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

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Okay.

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

9 COMMISSIONER ANGELA COKE: Thank you.

10 DANA COOPER: All the best in your
11 work.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Thank you.

14 CLAUDIA MARIANO: Thank you, everyone.
15 Stay safe.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Bye.

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

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25

1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, Chartered
4 Shorthand Reporter, certify;

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth, at which time the witness was put under oath
9 by me;

10
11 That the testimony of the witness
12 and all objections made at the time of the
13 examination were recorded stenographically by me
14 and were thereafter transcribed;

15
16 That the foregoing is a true and
17 correct transcript of my shorthand notes so taken.

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19 Dated this 14th day of November, 2020.

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