

# Long Term Care Covid-19 Commission Mtg.

Ontario Long Term Care Clinicians (OLTCC)  
on Wednesday, September 30, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 30th day of September, 2020,  
4:00 p.m. to 5:20 p.m.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9 Dr. Fred Mather, President of OLTCC;

10 Dr. Evelyn Williams, Past President of OLTCC;

11 Dr. Benoit Robert, Vice President of OLTCC;

12 Dr. Rhonda Collins, OLTCC Director.

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14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat;

19 John Callaghan, Counsel, Long-Term Care Commission

20 Secretariat;

21 Derek Lett, Policy Director, Long-Term Care

22 Commission Secretariat;

23 Lynn Mahoney, Counsel to the Ministry of Health and

24 Long-Term Care;

25 Ida Bianchi, Counsel, Long-Term Care Commission

1 Secretariat;  
2 Kate McGrann, Counsel, Long-Term Care Commission  
3 Secretariat.

4  
5 ALSO PRESENT:

6  
7 McKaya McDonald, Stenographer/Transcriptionist.  
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1 -- Upon commencing at 4:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, good afternoon, everybody.

5 DR. RHONDA COLLINS: Good afternoon.

6 DR. EVELYN WILLIAMS: Hi.

7 DR. FRED MATHER: Good afternoon.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 I'm Frank Marrocco. This is Commissioner Kitts and  
10 Commissioner Coke, and together we make up the --  
11 our Commission of Inquiry.

12 And, Dr. Mather, you're leading the  
13 clinicians?

14 DR. FRED MATHER: Yes. I will speak,  
15 and I am joined by three of my colleagues here, and  
16 I hope we all have a chance to introduce ourselves.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 We'll certainly do that. I saw a great deal of  
19 your son during the Collingwood inquiry, and  
20 there's a strong resemblance.

21 DR. FRED MATHER: Okay. Well, I hope  
22 you consider that favourable.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 It is. It is. He's doing a great job.

25 DR. FRED MATHER: Good. Thank you.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2   So well, go ahead, doctor. Why don't you introduce  
3   your side of the staff.

4                   DR. FRED MATHER: Okay. Thank you very  
5   much for this invitation to present to the Ontario  
6   long-term care COVID-19 commissioners. We are the  
7   Ontario Long-Term Care Clinicians.

8                   I think I will first open it up and  
9   tell you a little bit about ourselves. I'm the  
10   current president of the Ontario Long-Term Care  
11   Clinicians completing a second term as president  
12   next month.

13                  My background is in long-term care.  
14   I've worked in long-term care now for 39 years  
15   since I completed my postgraduate training. I did  
16   a family practice as well until I retired from my  
17   office three years ago.

18                  I'm currently the Medical Director of  
19   Sunnyside Home in Kitchener. It is the municipal  
20   home operated by the Region of Waterloo. I also  
21   work in two other facilities, Forest Heights  
22   Long-Term Care in Kitchener and Columbia Forest  
23   Long-Term Heights in Kitchener.

24                  I was the chairman of the Healthcare  
25   and the Elderly Committee at the College of Family

1 Physicians from about 2005 to 2011. I'm also a  
2 peer assessor for the College of Physicians and  
3 Surgeons of Ontario, and a member of the American  
4 Medical Directors Association.

5 So I will then have our past president  
6 Dr. Evelyn Williams introduce herself.

7 DR. EVELYN WILLIAMS: Good afternoon,  
8 and thank you for having us. I'm a family  
9 physician with about 30 years' experience as an  
10 attending clinician at the Sunnybrook Veterans'  
11 Centre where I was also head of the Division of  
12 Long-Term Care for 20 years.

13 I have a Masters in Health Admin from  
14 U of T, and I'm also an associate professor in the  
15 Department of Family and Community Medicine at  
16 U of T.

17 I also spent ten years as a long-term  
18 care peer assessor for the college, so I had the  
19 opportunity to go into about 50 different  
20 facilities across the province to assess the  
21 quality of medical care.

22 I'm the co-founder of our Medical  
23 Director course and current chair of the curriculum  
24 committee. Also current medical coordinator for  
25 the City of Toronto ten long-term care homes.

1 Thank you.

2 DR. FRED MATHER: And our vice  
3 president is Dr. Benoit Robert.

4 Ben, you're on mute.

5 DR. BENOIT ROBERT: Thank you for your  
6 time. I'm Ben Robert. Having practiced since 1988  
7 in the Ottawa area, I started doing long-term care  
8 in the early '90s because I felt it was the right  
9 thing to do.

10 I continue to have my family care  
11 practice which includes home palliative visits.  
12 I'm an assistant professor at the University of  
13 Ottawa and continue to be an attending a physician  
14 at the Ottawa Hospital since 1988.

15 I'm the Medical Director of the Perley  
16 and Rideau Veterans' Health Centre Co-Medical  
17 Director at the Glebe Centre. And the Perley and  
18 Rideau is a 450-bed, long-term care facility that  
19 experienced a COVID outbreak in April.

20 I chair the regional medical directors  
21 forum and have founded a community practice for  
22 long-term care locally. I'm on the board for the  
23 Ontario Long-Term Care Clinicians. I have  
24 additional certification in care of the elderly and  
25 palliative care.

1 I've presented at local, regional,  
2 provincial, and national conferences with matters  
3 relating to long-term care. And I contributed to  
4 the LEAP Long-Term Care course which is a  
5 palliative care course that's been designed by  
6 Pallium Canada.

7 DR. FRED MATHER: And Dr. Rhonda  
8 Collins who is on our Board of Directors.

9 DR. RHONDA COLLINS: Good afternoon,  
10 and thank you very much. This is going to be  
11 repetitive.

12 I am also a family physician with an  
13 advanced set of certification in care of the  
14 elderly. I have been doing long-term care for  
15 approximately ten years as both medical director  
16 and attending physician.

17 I also did palliative care and hospital  
18 medicine prior to long-term care and actually in  
19 conjunction with long-term care. I also am on the  
20 Board of Directors for OLTCC.

21 I am an assessor for the college on the  
22 Investigation of Complaints and Review Committee.  
23 I have sat on numerous tables throughout the  
24 pandemic. I'm on the Toronto Region Implementation  
25 and Planning Table as a co-lead. I am the

1 Long-Term Care and Congregate Care Table Sector  
2 Lead and Co-Chair, and I'm on the COVID Provincial  
3 Action Table. And I have -- I'm also a member of  
4 American Medical Directors Association. I think  
5 that's all.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Okay. Well, if that completes the team,  
8 Dr. Mather, let me just tell you in a couple words  
9 kind of what we're about.

10 We're in an unusual situation  
11 ourselves. Normally a Commission of Inquiry is  
12 called after something has happened, and it looks  
13 back, studies what has happened, and it reports to  
14 the public on what occurred.

15 Our situation is different because we  
16 are all in the middle of something, and it's not  
17 something that has a great deal of precedent behind  
18 it, at least not in our lifetimes.

19 Typically, the Inquiry investigates,  
20 holds public hearings, and reports. And that can  
21 take two to two and a half years, and, you know,  
22 our collective view is that that's not really  
23 particularly helpful in this situation.

24 And so we're very probably  
25 investigating, going to make some preliminary or

1 interim recommendations, and then continue looking  
2 at the problem and try to respond much more  
3 promptly to the environment that we find ourselves  
4 in. So that's what we're doing is investigating but  
5 with that kind of a focus at this particular time.

6 We're transcribing the interview, I  
7 believe, Ms. McDonald, and so we will have a  
8 transcript of it. And we have been publishing  
9 those -- not publishing but putting those  
10 transcripts on our website.

11 And if you have a website, then I would  
12 ask you if it would be okay for us to put a link on  
13 your website to our website so that anybody  
14 visiting your website that wants to find us could  
15 easily do so.

16 U/T DR. FRED MATHER: We'd be pleased to do  
17 so.

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 Well, thank you very much. And that's basically  
20 all I wanted to say.

21 And, Dr. Mather, we're ready when you  
22 are.

23 DR. FRED MATHER: Okay. We do have  
24 some slides to share that will guide us in what we  
25 want to share with you. They're taken from the

1 written submission that I provided the secretariat  
2 with yesterday. So I'll pull up my screen share  
3 here.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Or, Ms. McDonald, can you do that?

6 DR. EVELYN WILLIAMS: Oh, here we are.

7 DR. FRED MATHER: Yeah, I've got it  
8 there.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Dr. Mather, we're viewing your screen?

11 DR. FRED MATHER: Yes, yeah. So what  
12 we're going to share with you today -- and I  
13 understand that you will be asking questions  
14 throughout our presentation -- is we will tell you  
15 who the Ontario Long-Term Care Clinicians are; what  
16 our experiences and observations have been during  
17 the COVID-19 pandemic; what we see happening in  
18 long-term care now, as you referred to, as we get  
19 into a second wave -- I think, within the last  
20 24 hours, it's felt that we are in a second wave  
21 and beyond; and finally, we'll share with you our  
22 vision of long-term care for Ontario.

23 So the Ontario Long-Term Care  
24 Clinicians is a not-for-profit organization  
25 representing physicians who practice in long-term

1 care. Our members include physicians, nurse  
2 practitioners, pharmacists, and other healthcare  
3 professionals.

4 The vision of the OLTCC is that all  
5 Ontarians in long-term care receive excellent care.  
6 Our mission is carried out through education and  
7 advocacy, and we will talk to you much more about  
8 education and long-term care.

9 The OLTCC's value statement is:

10 "We believe a dedicated,  
11 collaborative, interprofessional  
12 team with physician leadership  
13 provides the highest quality,  
14 comprehensive, evidence-based  
15 medical care for long-term care  
16 residents."

17 Our history goes back over 40 years  
18 with the creation of the Ontario Long-Term Care  
19 Physicians. It was created as a charitable  
20 organization over 40 years ago by committed  
21 colleagues in primary and long-term care at that  
22 time.

23 In 2016, the Board of Directors of the  
24 Ontario Long-Term Care Physicians created OLTCC, a  
25 not-for-profit in order to provide greater advocacy

1 and education.

2 The OLTCCP continued until this year  
3 providing educational grants for our conference,  
4 Practical Pearls in Long-Term Care, and the Medical  
5 Director course.

6 Now, the Long-Term Care Acts requires  
7 that each home has a medical director who is a  
8 physician. The medical director shall advise on  
9 matters of medical care and consult with the  
10 Director of Care, the administrator -- be it an  
11 executive director or an administrator -- and other  
12 health professionals.

13 We created the Medical Director course  
14 in 2014 in order to improve the quality of care  
15 provided by medical directors. It is an accredited  
16 Mainpro+ program that is offered annually.

17 The course involves a day in quality  
18 management, a three-day interactive course, and an  
19 online component.

20 The picture here is from the last  
21 course, and this was taken on February 2nd. The  
22 interactive course went from January 31st to  
23 February 2nd -- February 1st to February 2nd.

24 The curriculum includes many things,  
25 and I'll have Dr. Williams explain that further.

1 DR. EVELYN WILLIAMS: Okay. So we  
2 actually have a couple of courses, and one is  
3 called fundamentals primer. This is the  
4 preparation for attending physicians and nurse  
5 practitioners to really understand their  
6 environment so their clinical practice can improve.

7 So that includes topics like the  
8 regulatory environment, resident rights, admission  
9 and discharge, abuse and neglect, restraints,  
10 complaints and critical incidents, documentation,  
11 the resident assessment instrument, and infection  
12 control, and PPE. So that's a one-day workshop for  
13 all attendings.

14 Next slide. So let me just introduce  
15 the Medical Director course by saying that it is  
16 fundamentally about quality. We think that if you  
17 want to improve healthcare, then you have to have  
18 positive involvement of physicians in changes to --  
19 and improvements to medical services.

20 So our purpose with this course is to  
21 give them the knowledge and skills to effectively  
22 engage in improvement. So we've got the  
23 fundamentals covered in more depth, and then these  
24 components -- Medical Director contact, staff  
25 management, safety and risk, program management,

1 performance indicators, leadership, working in  
2 teams, and resident and family-centered care -- are  
3 all modules in the Medical Director course.

4 And the next slide.

5 And the third component, we partnered  
6 with HQO for Resident Firsts and now Ideas  
7 curriculum to offer that. That's the skill set  
8 that we say medical directors and anyone else in  
9 the sector needs to lead or even be involved in  
10 change and improvement.

11 And I would like just to add that we  
12 have evaluated the course. We've been able to show  
13 that there's increased knowledge and confidence on  
14 the part of medical director participants, and  
15 we've also been able to demonstrate using a medical  
16 engagement scale that our participants had  
17 increased participation in decisionmaking and  
18 change and increase in purpose and direction.

19 So we're doing this in order that our  
20 medical directors and physicians and nurse  
21 practitioners have the skills and the knowledge to  
22 improve care for the long-term care residents.

23 Thank you.

24 DR. FRED MATHER: Thank you,  
25 Dr. Williams. I will point ahead also that Ontario

1 Long-Term Care Physicians was a participant in the  
2 Long-Term Care Inquiry.

3 Commissioner Eileen Gillese, who  
4 addressed our conference last year, released the  
5 final report of the inquiry on July 31st last year.

6 Recommendation for the inquiry states  
7 that:

8 "Licensees should amend their  
9 contracts with medical directors to  
10 require them to complete the  
11 training required under  
12 Section 76(7) of the Long-Term Care  
13 Homes Act and that they take the  
14 OLTCC Medical Director course within  
15 two years of assuming the role of  
16 Medical Director."

17 The other major educational offering we  
18 have -- and this is an annual affair -- is our  
19 annual conference which is now called Practical  
20 Pearls in Long-Term Care.

21 The feedback we get from our  
22 300-and-some attendees each year is that they want  
23 practical, current, clinical knowledge in long-term  
24 care, and we develop a program each year according  
25 to what the evaluations are from the year before.

1                   This year we have to give the  
2 conference virtually, and it will be offered over  
3 four half days in October. This is just the  
4 program of the opening afternoon on Friday,  
5 October 16th.

6                   And it has been a tradition in the past  
7 to be a great opportunity for networking and peer  
8 presentations by our colleagues. And we hope with  
9 the evolving virtual platforms that we can  
10 replicate this in a virtual conference this year.

11                   I'll pass on Dr. Robert to comment on  
12 what we see the long term reality is.

13                   THE REPORTER: Doctor, you're muted.

14                   DR. BENOIT ROBERT: Thank you. So  
15 long-term is often a person's last home. So upon  
16 admission, most receive a chronic palliative care  
17 approach.

18                   And most residents are in the final  
19 chapter of their lives on admission, and the depth  
20 of frailty is often first brought up by the  
21 attending physician in the home at the initial care  
22 conference with the resident and families.

23                   But all who work in long-term care  
24 actually already know this. The stark reality is  
25 that 40 percent of people will die within a year of

1 admission, and this reflects really how frail they  
2 are.

3           The average length of stay is  
4 approximately two years, and that can be rephrased  
5 to the time to death is roughly two years. It's a  
6 heavily regulated sector but made to match as  
7 closely as possible a home-like environment rather  
8 than an institution. And the care focus is on  
9 socializing, congregate dining, congregate  
10 activities.

11           There's a highly efficient staffing  
12 model that allows for the greatest number of  
13 interactions with the greatest number of staff. At  
14 the same time, the staff are a stable population  
15 with little or no surge capacity.

16           So the residents of long-term care, in  
17 general, 70 percent of them have dementia. Over  
18 three-quarters have multiorgan and/or multidisease  
19 complications. And so the aim is to prevent  
20 progression of complications and also prevent  
21 progression of medical interventions that could  
22 cause the frailty to worsen. Most residents have  
23 an advanced care plan in place.

24           As mentioned, the staffing model is  
25 efficient. It's designed and regulated for

1 socializing and activities. All activities are  
2 encouraged. It's estimated that the number of  
3 interactions per resident is roughly 20  
4 interactions with staff for a resident who requires  
5 in-person care.

6 Some homes are heavily reliant on  
7 volunteers and family members as well. The  
8 physicians working in long-term care serve many  
9 different populations including having a full time  
10 practice, and as a result, their time is quite  
11 scheduled.

12 So the implication overall is that, as  
13 mentioned, there is all surge capacity. The  
14 staffing levels are designed to maximize  
15 interactions, and the ability of cohort is quite  
16 limited. Staffing numbers may not permit cohorting  
17 staff. It's very difficult to cohort residents  
18 with dementia when they're wandering, and many of  
19 the physicians work in multiple healthcare sites.  
20 Infection prevention and control is often a  
21 part-time position.

22 So at the Pearls Conference, the annual  
23 conference, we provide, as part of our vision,  
24 expertise and new approaches to palliative care.  
25 And so the workshops provided rely on palliative

1 care and will include advanced care planning, goals  
2 of care, critical illness conversation, pain and  
3 symptom management. Then the attendees will then  
4 return back to their homes and share the expertise  
5 with the rest of the staff.

6 Thank you.

7 DR. FRED MATHER: Thank you,  
8 Dr. Robert. And, Dr. Collins, can you lead off now  
9 with sharing with the commissioners what we, as  
10 clinicians, experienced during the pandemic?

11 DR. RHONDA COLLINS: So --

12 COMMISSIONER KITTS: Can I just ask a  
13 question before we go on?

14 DR. FRED MATHER: Yes, Dr. Kitts, yeah.

15 COMMISSIONER KITTS: So, Dr. Robert, I  
16 think what you said was that I think all physicians  
17 who are medical directors in long-term care homes  
18 often -- I don't know if all or most have a  
19 full-time practice outside of the long-term care  
20 home?

21 DR. BENOIT ROBERT: No, not the medical  
22 directors, but many physicians have a family  
23 practice as well, and they do long-term care in  
24 addition to their practice. A full-time practice  
25 in Ontario has a wide range of patient roster size.

1                   So as an example, my full-time practice  
2 is much smaller than people who would not be doing  
3 long-term care because they need to allocate time  
4 for my long-term care visits.

5                   COMMISSIONER KITTS: So the medical  
6 directors are not necessarily the physician  
7 responsible for the residents in the home; is that  
8 correct?

9                   DR. BENOIT ROBERT: I can't comment on  
10 other homes, but the homes that I work with and the  
11 homes that I know people work at, the medical  
12 director is the attending physician at that same  
13 home.

14                   COMMISSIONER KITTS: They are.

15                   DR. BENOIT ROBERT: Yeah.

16                   COMMISSIONER KITTS: But they also have  
17 a family practice, and they also may work in  
18 multiple homes?

19                   DR. BENOIT ROBERT: Or they may work in  
20 the hospital or provide home palliative care  
21 visits, but they work in multiple sites.

22                   COMMISSIONER KITTS: Okay. So it's --

23                   DR. EVELYN WILLIAMS: Just to answer  
24 your question, Dr. Kitts, there's quite a number of  
25 physicians who dedicate themselves to long-term

1 care practice and don't have a community practice,  
2 so there's quite a mix. But the ones who just do  
3 long-term care practices are usually in more than  
4 one home.

5 COMMISSIONER KITTS: Okay. Okay.  
6 Thank you.

7 DR. FRED MATHER: And if I could just  
8 add to that answer, from visiting different  
9 long-term care homes throughout the province, there  
10 are some long-term care homes where the medical  
11 director may be the attending physician for the  
12 majority of residents if not most of the residents  
13 in a smaller home.

14 And there are instances where the  
15 medical director may oversee more than one home  
16 that's operated by a municipality or a corporation  
17 in order to provide stronger leadership in the  
18 medical director role, and that medical director  
19 may not be an attending physician in all those  
20 homes.

21 COMMISSIONER KITTS: Okay. Thank you.

22 DR. FRED MATHER: Okay. Dr. Collins?

23 DR. RHONDA COLLINS: Thank you. So I  
24 apologize. I'm having a little bit of an unstable  
25 internet connection. If I'm cutting out, Fred,

1 could you please let me know, and I'll go onto my  
2 phone.

3 DR. FRED MATHER: Okay.

4 DR. RHONDA COLLINS: I'm back on my  
5 computer now.

6 So we've identified systemic problems  
7 early in the pandemic, and some of them preexisted  
8 the pandemic. Staffing shortages that existed  
9 pre-COVID were exacerbated when homes went into  
10 outbreak, and positive staff were either directed  
11 to stay home for 14 days while some staff opted not  
12 to come in for fear of contracting the virus.

13 We have older homes with three- and  
14 four-bed rooms and shared bathroom space that  
15 created challenges when it came to cohorting and  
16 isolating residents.

17 As Dr. Robert also mentioned, we have  
18 residents with dementia who often wander throughout  
19 units and do not understand physical distancing or  
20 isolation or hand hygiene practices.

21 To increase capacity in the acute care  
22 sector to prepare for a surge, many homes were  
23 directed to keep residents out of hospital to the  
24 best of their abilities, so engaging in end-of-life  
25 conversations and goals-of-care conversations with

1 residents and their families to prevent transfers  
2 to the acute care sector.

3 As well, resources like PPE were  
4 redirected toward hospitals, and long-term care was  
5 encouraged to focus on conservation strategies.

6 We were unaware at the beginning of  
7 this pandemic about asymptomatic spread until after  
8 universal masking was recommended in our sector,  
9 and it was only recommended after. It had already  
10 been implemented in the acute care sector.

11 Staff, as well, were only tested if  
12 they were symptomatic. Well, many of them were  
13 asymptomatic, had not been tested, and were not  
14 privy to universal masking strategies.

15 As well, we weren't aware of the  
16 atypical presentation particularly in older adults.  
17 So following WHO's recommendations, we were looking  
18 for fever, cough, shortness of breath.

19 What we came to discover is that,  
20 especially in our population, atypical symptoms  
21 consist of things like delirium, fatigue, anorexia  
22 and, in our staff, headaches, muscle aches,  
23 fatigue, and things like loss of taste and smell,  
24 things that we weren't expecting for and certainly  
25 weren't looking for.

1                   Early on in the process, governing  
2 bodies like the College of Physicians and Surgeons  
3 of Ontario and Ontario Medical Association gave  
4 recommendations that family physicians and primary  
5 care practitioners should be providing virtual care  
6 primarily.

7                   But what we didn't have was any  
8 direction as to long-term care physicians, as  
9 discussed, the majority of whom are family  
10 physicians, so taking guidance for a group of  
11 physicians but not sector-specific.

12                   And a lot of times homes were excluding  
13 physician for fear of spread as well as for lack of  
14 PPE. As already mentioned, many long-term care  
15 doctors practiced in multiple settings -- either  
16 academic, hospital, or family practices.

17                   And as Dr. Mather pointed out, in some  
18 smaller homes in urban settings, a single physician  
19 is responsible for care of all the residents and  
20 may not have access to other physicians to provide  
21 coverage.

22                   We also identified some physicians who  
23 did not go into homes and practice exclusively  
24 virtual medicine for fear of contracting the virus  
25 themselves or spreading it from site to site if

1 they worked in more than one location.

2 OLTCC advocated for necessary visits  
3 utilizing a combination of virtual care for  
4 nonurgent visits and in-person assessments for  
5 urgent situations, particularly a change in  
6 condition.

7 All right. Could you move the slide  
8 forward, please? Oh --

9 DR. FRED MATHER: Yeah. I think I  
10 would just mention the last point on this slide  
11 which was something that I oversaw during the  
12 pandemic.

13 Before the first 50 days of the  
14 pandemic, our organization provided a daily report  
15 to our members reporting on the data trends and  
16 science of managing the pandemic. These reports  
17 promoted a lot of ongoing dialogue with our  
18 neighbours and questions that they asked.

19 I want to emphasize here that we are a  
20 voluntary organization, and we could only share  
21 ideas without giving clear directions on what  
22 physicians should be doing. It did give us an  
23 opportunity to share resources with our larger  
24 membership -- for example, recommendations on how  
25 to provide the best virtual care; recommendations

1 on PPE; and appropriate ways of doing rounds where,  
2 if you needed to go in and do rounds, you would do  
3 a lot of your routine stuff first and leave anyone  
4 who was sick or had respiratory symptoms until the  
5 end of your rounds so you could examine that person  
6 in full personal protective equipment.

7 Resources also included managing cases  
8 of COVID, providing conversations on advanced care  
9 planning and goals of care and end-of-life care as  
10 well. For example, we provided a couple of order  
11 sets -- one from Fraser Health in BC and one from  
12 Baycrest, which our members found very useful.

13 There were also algorithms on how to  
14 manage possible transfers so we could encourage  
15 appropriate transfers and avoid inappropriate  
16 transfers to the emergency departments in the  
17 hospitals.

18 Okay. Rhonda?

19 DR. RHONDA COLLINS: Thanks. So --

20 COMMISSIONER KITTS: Dr. Collins, could  
21 I -- just a point of clarification. Did you say  
22 that many homes were excluding doctors from coming  
23 in because, A, they were concerned about possible  
24 spread, they worked in multiple sites, concerned  
25 about PPE shortage; is that correct?

1 DR. RHONDA COLLINS: Yeah. There were  
2 some homes where the leadership at the homes  
3 actually did not want the physicians, and we heard  
4 this actually at OLTCC at our town halls where  
5 executive directors and directors of care were  
6 asking physicians not to come on site for the  
7 reasons of, you know, fear of spread particularly  
8 if you worked at other sites.

9 COMMISSIONER KITTS: And in those  
10 cases, was virtual care used, or there was no  
11 medical care for that time?

12 DR. RHONDA COLLINS: I can't speak for  
13 all homes. There are different virtual care  
14 platforms, so I cannot speak for all homes. I can  
15 speak for my homes which was we had one dedicated  
16 platform as well as iPads at all of our homes to  
17 allow physicians to do virtual care, and I'm not  
18 certain about all operators having access.

19 COMMISSIONER KITTS: Thank you.

20 DR. RHONDA COLLINS: So despite the  
21 fact that I say some physicians did not go in, many  
22 physicians did do in-person visits with some making  
23 arrangements with colleagues to cover one another's  
24 residents so they could focus on single homes and  
25 to reduce traffic between the clinical settings.

1           The presence of physicians allowed for  
2 ( indiscernible ) of cases for mild symptoms that  
3 might not be identified by staff and also  
4 supporting and cohorting and isolating residents.  
5 There is -- anecdotally I heard from a --

6           DR. EVELYN WILLIAMS: Oh, we lost  
7 Rhonda.

8           DR. FRED MATHER: We lost you, Rhonda.

9           DR. EVELYN WILLIAMS: Oh...

10          DR. FRED MATHER: Okay. I think  
11 Rhonda's had further problems with her connection.

12          Rhonda, if you want to join us by  
13 phone, that would be good. I can just carry on  
14 with this slide here which goes on about how we  
15 participated during the pandemic.

16          With the Ontario Medical Association,  
17 we sponsored two virtual town halls --

18          DR. RHONDA COLLINS: I --

19          DR. FRED MATHER: -- that were very  
20 well attended. The first one had our own experts  
21 in ( indiscernible ), infection prevention and  
22 control, and experienced long-term care.

23          Directors on the town hall -- the  
24 second one was made up mostly of physicians who had  
25 first-hand experience with outbreaks in their homes

1 including some of the more severe outbreaks sharing  
2 what they learned and what they advised others and  
3 what we could do differently.

4 We also had another webinar back in  
5 July with Dr. Allison McGeer and Christopher  
6 Kendall (ph) from Mount Sinai. We called that one  
7 in the wake of the first wave in anticipation that  
8 there would be a second wave, which is where we're  
9 at now.

10 The topic that Dr. McGeer covered --  
11 what we had learned so far at that point from the  
12 first wave of the COVID-19 pandemic and how we can  
13 prepare for the second wave including the use of  
14 chemo-prophylaxis in the long-term care case.

15 Chemo-prophylaxis is using the evidence  
16 that shows that prescribing an antiviral drug when  
17 there is an outbreak may reduce the number of  
18 people who are affected by the virus.

19 So moving on to what some of the  
20 general observations were. They included the fact  
21 that timely medical oversight that is specific and  
22 knowledgeable to long-term care was needed to  
23 support and guide the leadership during the  
24 pandemic.

25 But we felt --

1 DR. RHONDA COLLINS: Fred, I'm back. I  
2 can take over if you'd like.

3 DR. FRED MATHER: Okay. Thank you,  
4 Rhonda. I tried to do as good a job as you, so  
5 we're on the slide with the observations document  
6 of medical oversight.

7 DR. RHONDA COLLINS: Thank you. I'm  
8 sorry. I'm going to stay on my phone because my  
9 internet connection is just entirely too unstable.

10 So the timely medical oversight is  
11 specific to meeting the needs of the residents.  
12 Long-term care doctors have a relationship with  
13 residents and families that includes understanding  
14 their goals of care.

15 We know that not all residents want a  
16 medical intervention if their condition changes.  
17 Having a conversation about what is available and  
18 what meets their goals of care is important for  
19 reducing unnecessary transfers as well as putting  
20 residents at the end of their life through testing  
21 and treatment with little efficacy.

22 If they choose to transfer to acute  
23 care, there must be a collaborative and respectful  
24 relationship between long-term care and acute care.  
25 The same is true for Public Health. There needs to

1 be not only consistent messaging but an  
2 understanding of the sector.

3 We saw, within the Public Health units,  
4 that the messaging we were receiving with regard to  
5 IPAC practices, cohorting, isolating, testing was  
6 variable across the 34 different health units, and  
7 there is still a little bit of a lack of  
8 understanding of what transpires in long-term care  
9 within some of our stakeholder partners that  
10 include hospitals and Public Health.

11 I see this as a great opportunity to  
12 breakdown some silos that have existed and develop  
13 a really effective and coordinated system that  
14 recognizes the needs and challenges of each of the  
15 stakeholders.

16 COMMISSIONER KITTS: Do you think that  
17 Wave 1 demonstrated that, what brought really  
18 long-term care hospitals and Public Health together  
19 and made a significant positive difference?

20 DR. RHONDA COLLINS: I think there --  
21 yeah. There were definitely some improvements in  
22 understanding. In those conversations with Public  
23 Health and with the hospitals that I engaged in,  
24 there was, expressed by some of those stakeholders,  
25 a lack of understanding of what we even have access

1 to in long-term care and what we can do with regard  
2 to services.

3 So I think that drew some attention,  
4 and I have seen more collaboration between each of  
5 the stakeholders. That's my personal experience.  
6 Again, I can't speak for the others.

7 COMMISSIONER KITTS: Thank you.

8 DR. RHONDA COLLINS: So a chief medical  
9 officer for the long-term care is a novel concept  
10 in Canada. And something that I failed to mention  
11 in my bio, I'm a Chief Medical Officer of Long-Term  
12 Care. I'm the first one in the sector in Canada.

13 In the US, they've existed for a long  
14 time generally within different long-term care  
15 organizations. We think that a chief medical  
16 officer in each of the Ontario Health regions could  
17 be a valuable investment.

18 But we think that the chief medical  
19 officer must be an experienced long-term care  
20 physician who is knowledgeable about the sector and  
21 is aware of the responsibilities of medical  
22 directors and attending physicians, and they should  
23 have completed the Medical Director curriculum.

24 A chief medical officer could be  
25 instrumental in ensuring best practices,

1 coordinating efforts between acute and long-term  
2 care sectors, liaising with Public Health and other  
3 stakeholders, and providing a bidirectional flow of  
4 information between long-term care physicians and  
5 Ontario Health.

6 The chief medical officer should ensure  
7 that medical directors have the appropriate skill  
8 and training to provide leadership to the homes and  
9 provide support and guidance as well as  
10 coordinating efforts to ensure adequate coverage  
11 for homes with a single physician.

12 COMMISSIONER KITTS: Quick question.  
13 Who do the medical directors report to today? Each  
14 Medical Director of each home, who do they report  
15 to?

16 DR. EVELYN WILLIAMS: The facility.

17 DR. RHONDA COLLINS: Yeah, they report  
18 basically to the executive director. There's a --  
19 what we called "a triad" of medical director,  
20 executive director, and director of care to ensure  
21 best practice within long-term care.

22 But the idea of having a chief medical  
23 officer is then those medical directors -- right  
24 now, they can liaise with other members of OLTCC  
25 with other medical directors in their environment.

1 I did a survey last month of medical  
2 director relationships with other medical directors  
3 within their communities, and about 60 percent of  
4 the time, they didn't have that. That was  
5 national, but it very much depends on where they  
6 work and who they have access to as far as  
7 facilitating conversations.

8 COMMISSIONER KITTS: Are medical  
9 directors employees of the long-term care home?

10 DR. RHONDA COLLINS: They're  
11 contracted. They're not employees.

12 COMMISSIONER KITTS: So they're --

13 DR. RHONDA COLLINS: Yeah. They sign a  
14 Position Services Agreement.

15 DR. EVELYN WILLIAMS: The contract --  
16 yeah. The contract is between the facility and the  
17 Medical Director as an independent contractor.

18 COMMISSIONER KITTS: Thank you.

19 DR. RHONDA COLLINS: We also feel that  
20 a consistent outbreak plan needs to be developed  
21 that can allow for quick cohorting and isolation  
22 and, if necessary, decanting of residents to acute  
23 care during outbreak to prevent rapid spread and  
24 worsened morbidity and mortality. And they're --

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Ms. Collins, if I can interrupt for a second. Is  
2 there a reason why this could not be done by the  
3 local medical officer in the health unit -- in the  
4 local health unit?

5 DR. RHONDA COLLINS: For an outbreak  
6 plan?

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 The role that you have assigned to the chief  
9 medical officer of long-term care who will exist in  
10 each region, is there some reason why the local  
11 medical officer of health couldn't do those things  
12 or -- couldn't do those things?

13 DR. RHONDA COLLINS: I think because of  
14 lack of understanding of the sector and the  
15 responsibilities and roles of the attending  
16 physicians and the medical directors. We're  
17 looking at somebody who has that experience, that  
18 knowledge of long-term care. It's a very  
19 specialized sector.

20 Again, back to Dr. Robert's point in  
21 the beginning, these are people who are living in  
22 their homes. It is not meant to be an  
23 institution-like environment. It's not meant to be  
24 a hospital.

25 It's meant to be a home where they are

1 provided with the additional care that they  
2 require, and sometimes that requires some medical  
3 oversight. I think that if a chief medical officer  
4 position were to be created, it would provide some  
5 support and guidance to the long-term care medical  
6 directors and physicians.

7 And I don't think the medical officer  
8 of health, whose focus is predominantly infection  
9 prevention and control and epidemiology, would have  
10 an understanding of the specialized of this  
11 particular sector when it comes to things like  
12 palliative care.

13 Definitely IPAC needs to be a part of  
14 it. And again, that's an idea where a CMO of  
15 long-term care could absolutely liaison with the  
16 CMOH to get great feedback and guidance on  
17 infection prevention and control strategies.

18 DR. FRED MATHER: Further to Justice  
19 Marrocco's question, over four decades of my  
20 longitudinal experience in a couple of regions, I  
21 would say that the medical officer of health often  
22 doesn't have a lot of understanding about long-term  
23 care.

24 She or he is perhaps more likely to  
25 consult the long-term care physician on what the

1 best approach is to managing an outbreak or other  
2 public health concerns in long-term care.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Thank you.

5 DR. RHONDA COLLINS: And then finally,  
6 I wanted to just mention that staffing shortages  
7 have continued to haunt us in long-term care. We  
8 need well-trained health professionals in the areas  
9 of nursing and PSW support.

10 Particularly it's necessary to ensure  
11 optimal care of residents. They need to have  
12 sufficient time to provide exceptional  
13 emotional-based and resident-centered care to our  
14 residents instead of being task-oriented and  
15 focussing on documentation. I think that's going  
16 to be key in providing the best care for our  
17 residents.

18 DR. FRED MATHER: And I'll carry on  
19 with the recommendations on this slide. We do feel  
20 that further training in infection prevention and  
21 control is required. This includes certification  
22 for all staff, and it should be part of ongoing  
23 professional development. It also includes ongoing  
24 palliative care and care of the elderly for  
25 long-term care clinicians.

1 I make the comparison here to the  
2 training we should have in basic life support which  
3 is our CPR training. It's something that, when we  
4 have the certification, we're required to renew it  
5 on an annual basis. And it's the same way  
6 infection prevention and control should have that  
7 same sort of recertification.

8 Another possibility is one when we get  
9 recredentialled at the hospitals. Every couple  
10 years we have to update our knowledge of the  
11 privacy and confidentiality legislation and take an  
12 online course. This also could be a method of  
13 making sure that our clinicians maintain their  
14 certification in IPAC.

15 As Rhonda has already mentioned, we  
16 feel that there needs to be emphasis on the  
17 collaboration between the leadership triad in  
18 long-term care -- the collaboration among medical  
19 directors, directors of care, and the  
20 administration of the long-term care home. That  
21 person may be an administrator or an executive  
22 director.

23 We know from our experiences in the  
24 Medical Director course and post-course surveys  
25 that we have done that both directors of care and

1 medical directors should report back that there is  
2 a much better relationship after they take the  
3 course.

4 My observation throughout the pandemic  
5 was that the homes that did well had this  
6 interdisciplinary leadership team working and could  
7 foresee issues, manage things such as clinicians  
8 working between multiple settings, or providing the  
9 best virtual care.

10 And as we already discussed, we  
11 recommend that need for communication collaboration  
12 and coordination of care with hospitals and Public  
13 Health needs to be improved. And I think that this  
14 has been promoted on so many things throughout the  
15 pandemic.

16 An example I can give in my area is  
17 that from the onset of the pandemic, we had regular  
18 meetings with the chiefs of the four emergency  
19 departments including the Public Health and people  
20 at the leadership table during the pandemic.

21 And there's probably many examples of  
22 how this coordination between the homes, the  
23 hospitals, and Public Health worked that can be  
24 applied as we prepare for the second wave, future  
25 pandemics, or a similar crisis. And again, we feel

1 that a chief medical officer for long-term care can  
2 help in providing coordination and leadership for  
3 this.

4 I think what I've seen in other  
5 provinces, too, when you have that higher level of  
6 oversight in long-term care for the medical  
7 directors, it helps with issues such as assuring  
8 your staff are trained, that they have performance  
9 appraisals, that they go through a regular  
10 credential process the same as in hospitals, and  
11 also that they help out with the recruitment and  
12 retainment of good clinicians into long-term care.

13 COMMISSIONER KITTS: Dr. Mather?

14 DR. FRED MATHER: Yes.

15 COMMISSIONER KITTS: So one of the  
16 positive effects that came out of the COVID-19  
17 crisis was the advent of virtual care.

18 Obviously it needs to be studied to  
19 where it's going to be most effective, but that's  
20 something.

21 Would you akin your relationship with  
22 the four emergency departments -- so the  
23 relationship between long-term care, hospital care,  
24 and Public Health -- as one of those things that  
25 you would see might be built upon and continued

1 even without a crisis?

2 DR. FRED MATHER: I hear there's two  
3 parts to the question here. I think one is the  
4 part about the virtual care, and I think we've  
5 developed good virtual care.

6 I know I've had good reports about OTN  
7 improving their platforms during the pandemic. OTN  
8 is the Ontario Telemedicine Network, and it  
9 provides two specific platforms that have been used  
10 and improved in the last six months.

11 One is videoconferencing where there  
12 can be virtual consultations, and this would  
13 include, between the emergency physician and the  
14 clinician in the long-term care home position or  
15 the nurse practitioner, to discuss a case and the  
16 appropriate sub-transfer. That has been used.

17 The other platform that is secure and  
18 confidential is going to be developed by Think  
19 Research in connection with PointClickCare who  
20 provides software to 92 percent of our long-term  
21 care homes, and that's providing a confidential  
22 virtual platform that's used as well.

23 The second part of your question is do  
24 I see this sort of relationship, this dialogue,  
25 between the long-term care clinicians and emergency

1 departments and hospitals carrying on? Yes, I do.

2 One of the quality measures of  
3 long-term care is to avoid inappropriate transfers  
4 to the emergency department. In some ways, this  
5 may have been problematic for some of our  
6 clinicians during the pandemic deciding what's  
7 appropriate and what's not.

8 But I think that there has been a fresh  
9 look at the transfer of care and the assuming of  
10 responsibility and virtual consultation acquired  
11 throughout the pandemic.

12 COMMISSIONER KITTS: Thank you.

13 DR. RHONDA COLLINS: Can I add to that?

14 DR. FRED MATHER: Yes, please.

15 DR. RHONDA COLLINS: Just besides  
16 emergency physicians, one of the things that has  
17 come out of this is an understanding from acute  
18 care that in long-term care we do not have access  
19 to the same resources, so we cannot get emergency  
20 laboratory results or tests. We can't get  
21 emergency diagnostic testing.

22 So some places don't even have access  
23 to ultrasound. They can get x-rays, but they're  
24 often not same-day -- generally not same-day.

25 And so being able to communicate with

1 the emergency department and explain why we are  
2 sending somebody in or why we are thinking about  
3 sending somebody in allows for that conversation to  
4 occur and sometimes allows for collaboration with  
5 other specialties, so orthopedics or geriatrics or  
6 internal medicine that might not take place  
7 otherwise.

8 So that liaising between the long-term  
9 care and acute care can involve more than just the  
10 emergency physician and can help them to determine  
11 whether somebody should be transferred to a  
12 hospital or whether we can get them quick access,  
13 quicker access, to a fracture clinic, for instance.

14 DR. FRED MATHER: There's been a real  
15 benefit to our residents going forward, I feel,  
16 with the advent of virtual care.

17 For example, in a home where a medical  
18 director is looking after a convalescing care unit  
19 where many of the individuals who are there,  
20 they're there for a short-term rehab and functional  
21 restoration before returning, hopefully, home, they  
22 often have fractures which requires follow-up  
23 visits to the orthopedic surgeon.

24 I see that through remote imaging and  
25 virtual care. Those transfers to hospital, which

1 are a nuisance for the resident and expensive to  
2 the system, can now be done more readily through  
3 the virtual care platforms.

4 I'll carry on with some the  
5 recommendations and our submission that are  
6 specific to the pandemic following the  
7 recommendation of the Gillese inquiry.

8 And we feel that Medical Director  
9 training is -- should be an ongoing requirement and  
10 recommend a mandate of the OLTCC's Medical Director  
11 course to ensure qualities in the home.

12 I know you've heard the next point from  
13 other groups but the need to change the  
14 infrastructure in order to prevent the spread of  
15 COVID-19 and related pathogens in the home.

16 Going into the second wave, I hope that  
17 long-term care homes are relatively safe places  
18 because we're carrying on with screening, staff  
19 testing, and assiduous use of PPE. But, of course,  
20 we want to see faster testing in long-term care  
21 homes and that staff and residents continue to be  
22 tested routinely.

23 And as with other groups, we want to  
24 ensure easier access and sufficient supply of  
25 personal protective equipment, and that's all part

1 of our recommendations for guidance and training  
2 and infection prevention and control.

3 So we'll carry on by sharing with you  
4 what we see as our vision for long-term care.

5 And, Dr. Robert, would you like to take  
6 the stand?

7 DR. BENOIT ROBERT: Take the stand,  
8 yes, sure. So the focus on palliative care by all  
9 staff to ensure quality of life, care for  
10 residents, and support for family givers -- I think  
11 it would be very nice if everyone were able to  
12 understand that long-term care is likely to be  
13 their last home, that the level of frailty that  
14 people being admitted to long-term care is  
15 understood prior to admission, and also that  
16 long-term care has a focus for chronic palliative  
17 care.

18 An example of this would be palliative  
19 care training for the personal support workers or  
20 even for family caregivers. This training would  
21 build on the relationships that staff and families  
22 already have and would strengthen and ease the  
23 journey.

24 The funding should be stable, and  
25 quality indicators should focus on quality of care

1 and quality of life rather than the expected  
2 outcomes in the frail elderly.

3 What is meant by that is that the  
4 funding should reflect the care required to help  
5 residents with dementia stay happy and content and  
6 that the quality indicators that we are asked to  
7 look at would match what is being done.

8 The primitive quality indicators  
9 typically have a focus and are a measure more of  
10 the progression of the end-stage disease and the  
11 expected outcomes of an end-stage disease rather  
12 than being a true quality care indicator.

13 As an example, if somebody has  
14 worsening incognizance, frequently that's a sign of  
15 progression of dementia. Or if somebody develops a  
16 pressure injury, we know that the development of a  
17 pressure injury is a poor prognostic sign and is  
18 the equivalent of end-staged sort of skin  
19 condition. Much like congestive heart failure,  
20 people understand the end-stage heart disease.  
21 Often those pressure injuries indicate end-stage  
22 skin issues.

23 The recruitment, development, or  
24 retention of confident and educated healthcare  
25 professionals must be a priority.

1 Long-term care is not glamorous, but  
2 it is quite rewarding. So if the strong pipeline  
3 of healthcare workers emphasize in the joys of the  
4 care and the relationships that occur with this  
5 work, we would be able to mitigate some of the  
6 shortages that have been seen so far.

7 And this stems from healthcare workers,  
8 from PSWs, to registered practical nurses,  
9 registered nurses, pharmacists, physiotherapists,  
10 physicians.

11 Exposure and opportunities in long-term  
12 care in nursing and medical schools, and as well in  
13 family medicine and postgraduate training programs,  
14 should be more readily accessible.

15 At the OLTCC, we would hope that  
16 medical schools and all healthcare schools would  
17 have a stronger emphasis on frailty and end-staged  
18 disease, and that would include in the earlier  
19 exposure to long-term care.

20 With that exposure and the knowledge of  
21 what long-term care has to offer, being seen early  
22 in the training, our hope is that interest would  
23 grow simply due to that exposure and would mitigate  
24 some of the development and retention of healthcare  
25 workers.

1                   Improved coordination of regional  
2 programs, we, at the OLTCC, envision a state of  
3 coordination with real programs throughout the  
4 province.

5                   I'll speak to Ottawa where we have a  
6 psychogeriatric outreach team that offers regular  
7 on-site and currently virtual visits to offer an  
8 expert opinion on the more difficult cases relating  
9 to advanced dementia care.

10                  We imagine a situation where the local  
11 geriatricians would offer a similar service where  
12 dermatologists would offer their services in the  
13 home as well. And if we're thinking big, we would  
14 imagine a situation where dentists and optometrists  
15 could come in the home and help sort of ease and  
16 improve the quality of life of long-term care  
17 residents.

18                  We do believe reliable laboratory and  
19 diagnostic imaging service is possible through  
20 mobile units. I've been talking about the frailty  
21 a fair amount, and the image that comes with that  
22 frailty is an overloaded canoe with very little  
23 freeboard.

24                  And so if this canoe is on a lake and  
25 the water is quite still, it can float for a very

1 long time. But should there be any kind of  
2 headwind or small waves, then changes can occur  
3 very quickly, and that's what happens with frailty.

4 So having diagnostics in laboratory  
5 facilities more readily available to the home would  
6 assist greatly in a coordinated clinical diagnosis.

7 The current status is such that most of  
8 our decisions are clinical in nature with minimal  
9 laboratory backup. And as it was mentioned earlier  
10 by Dr. Collins, occasionally it results in a  
11 transfer simply for a diagnostic test.

12 When x-rays or laboratory tests are  
13 requested, oftentimes it can take a week, sometimes  
14 more, before the test is performed and then a few  
15 additional days to get the results.

16 So it makes the ability of a situation  
17 where somebody's condition can change very quickly  
18 and being able to anticipate -- makes it much more  
19 difficult to offer the best possible care.

20 Electronic health records are now  
21 needed but electronic health records that speak to  
22 each other so that that collaboration with other  
23 systems results in seamless care. And this is very  
24 important because a lot of concern occurs during  
25 the transitioning of one sector into another.

1                   Also, by having access to the  
2 information that was -- to medical information in  
3 other facilities, this would also increase a  
4 collaboration available between the various  
5 healthcare sectors.

6                   Government and operators should provide  
7 support for and promote continuing education  
8 including the Medical Director course.

9                   Medicine, and particularly in long-term  
10 care, has changed very much in the past 10 to  
11 15 years, and so upgrading is very necessary.

12                   Now, the Medical Director course, as  
13 described, is a good example of leadership training  
14 that physicians can access. The Primer is another  
15 example.

16                   But occasionally -- actually,  
17 frequently, homes do not have a staffing  
18 requirement to backfill change for RNs or RPNs  
19 during the day.

20                   So knowing that there's this support  
21 from government or operators and that this  
22 education, ongoing education, is valued should  
23 improve all aspects of care.

24                   Our vision includes a system that will  
25 allow and ensure timely in-person assessments using

1 the healthcare providers who are available. As  
2 mentioned, our homes are quite heterogeneous and so  
3 may have only one or two physicians in the home.

4 So should changes in condition arise  
5 and physicians or the other healthcare providers  
6 have alternate sites that require the time at that  
7 time, it would be nice to have a system in place  
8 that would allow for an early assessment and a  
9 planned assessment as soon as possible.

10 Provide laboratory services for on-site  
11 point of care testing using the newer handheld  
12 technology.

13 This vision is a further extension of a  
14 timely laboratory diagnostics. With point of care  
15 testing, we would be able, in short order, to have  
16 very accurate clinical decisionmaking that is  
17 supported by this test. And the assessments, at  
18 that point, would be based on more information and  
19 would likely result in more timely, appropriate  
20 care so the right care at the right place.

21 So there should be a reinstatement of  
22 medication reviews for long-term care residents by  
23 clinical pharmacists.

24 In keeping with the long-term care  
25 care's longstanding team approach to care,

1 medication monitoring is very important, and the  
2 clinical pharmacists have been a great aid in  
3 ensuring that approach.

4 So having that reinstatement of  
5 medication used through the clinical pharmacist  
6 would be a very quick win that would sort of  
7 support the vision for better care and long-term  
8 care.

9 So in conclusion, a long-term care home  
10 should be a home, first and foremost, and residents  
11 receive excellent care, and the residents rights  
12 are reserved. We should ensure that the long-term  
13 care is based on people and not on medicalizing the  
14 dying process.

15 DR. FRED MATHER: So thank you. That  
16 is our formal presentation, and we welcome any  
17 questions.

18 COMMISSIONER KITTS: I have a question  
19 for Dr. Robert.

20 You talked about improved coordination  
21 of regional programs like long-term care plus,  
22 like, providing timely geriatric and  
23 psychogeriatric outreach programs.

24 Can you tell me where would you -- I  
25 think you offered that. I think I know that, the

1 psychogeriatric.

2 DR. BENOIT ROBERT: Yeah.

3 COMMISSIONER KITTS: Where do you  
4 begin? If you're going to get -- who are you going  
5 to ask to partner with you to start that ball  
6 rolling, if you will.

7 DR. BENOIT ROBERT: Okay. So that's  
8 the vision, and it's a very good question. There  
9 is, through the Community Geriatric Psychiatry, a  
10 group that's interested in long-term care, and it  
11 is difficult to have people come in to the home and  
12 provide expert opinion on unusual cases.

13 So in the Ottawa area, I would start  
14 with the regional geriatric group that also already  
15 offer outreach assessments to the home, to personal  
16 homes, not to long-term care homes. And that would  
17 be a nice piggyback on their services that are  
18 already being provided, and that would be a start.

19 COMMISSIONER KITTS: Okay. Thank you.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Commissioner Coke?

22 COMMISSIONER COKE: Just a general  
23 question. So based on any lessons learned from the  
24 first wave, are there any things that you think  
25 you'll need to be doing differently to manage the

1 second wave?

2 DR. EVELYN WILLIAMS: I can maybe  
3 answer that. I think in the first wave we didn't  
4 understand that the surge was happening in  
5 long-term care. There were empty beds in the  
6 hospital, and in the long-term care home, which was  
7 full, they couldn't -- they didn't have PPE.

8 They could not actually look after  
9 everyone who was sick well because they didn't have  
10 the staff, and they couldn't move people around.

11 So in long-term care, you can look  
12 after a number of dying patients, but you cannot  
13 look after a whole lot of dying patients at once  
14 with the staffing and the resources they have.

15 So if we get a big outbreak in a home,  
16 I think we have to look at decanting if we're going  
17 to even provide, you know, a -- like, if you have  
18 to do palliative care, somebody -- a nurse has to  
19 go in every two hours, put on all the PPE, see what  
20 the patient needs/the resident needs, come back  
21 out, take off the PPE, get the drugs, go back in.

22 It's incredibly time-consuming to  
23 provide acute care, and we can't provide it to more  
24 than a few people at a time in a long-term care  
25 home.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2 Do you have any ideas on where you would decant  
3 them to? It doesn't appear that there have been  
4 very many --

5                   ( BRIEF INTERRUPTION )  
6 I'll get rid of that phone.

7                   It doesn't appear there have been very  
8 many field hospitals built or --

9                   DR. EVELYN WILLIAMS: Right.

10                  COMMISSIONER FRANK MARROCCO (CHAIR):  
11 -- you know, anything next to the home that would  
12 allow you to do something like that.

13                  How do you see that happening, or do  
14 you?

15                  DR. EVELYN WILLIAMS: So, Fred,  
16 probably, you have an answer. The other is, you  
17 know, there have been cases where the hospital  
18 could send in more staff just to help look after  
19 residents because the home couldn't supply the  
20 staff.

21                  COMMISSIONER FRANK MARROCCO (CHAIR):  
22 Right. And so -- okay. Okay.

23                  DR. FRED MATHER: I was going to give  
24 an example from an incendiary breakout that we had  
25 at one of the facilities here. And we decanted to

1 the hospital because there were a couple weeks in  
2 April when the hospital capacity was 60 percent, so  
3 they had beds.

4 And the one facility where I work, we  
5 decanted about 60 residents to four local  
6 hospitals, and the capacity was there. Some of it,  
7 I think, was a bit too late, but once we  
8 coordinated our efforts, it did work well.

9 And on the other hand of things, it's  
10 worked very well as we've repatriated those  
11 residents back into the facility.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 If the second wave is a little different and the  
14 hospitals have more to do, more to cope with than  
15 they did, then they would not be available,  
16 obviously, as places where you could remove the  
17 patients to.

18 DR. FRED MATHER: And this is where the  
19 Integrated Regional Planning Table really needs to  
20 come in. If beds are needed, I think they may be  
21 found. For example, both Dr. Robert and I work in  
22 short-stay units called "blessed units," and  
23 they've been closed since the onset of the  
24 pandemic.

25 The ones that overlook are being used

1 mainly for isolation of any positive residents and  
2 now new admissions, but there are beds that we  
3 created by suspending the short-stay programs just  
4 for the pandemic itself.

5 But it needs to be a collective agent  
6 that -- a collective approach which involves the  
7 hospitals and the long-term care homes to, one,  
8 decide where possible beds for decanting or optimal  
9 care can be provided; and, two, how staff can be  
10 deployed if we have another case where there is a  
11 disproportionate number of cases in one setting,  
12 and there's resources that could be transferred  
13 from that setting -- transferred to that setting  
14 from another healthcare setting.

15 COMMISSIONER FRANK MARROCCO (CHAIR):  
16 Okay.

17 DR. RHONDA COLLINS: And if I can add  
18 to that, again, this is another example of where  
19 there needs to be really coordinated and  
20 collaborative efforts between hospital, long-term  
21 care, Public Health, other potential stakeholders  
22 for decanting.

23 But one of the other things that came  
24 out of Wave 1 is that we're not readmitting more  
25 than two residents to a room, and I think that's

1 going to be very, very beneficial. And going  
2 forward and looking at redesign and redevelopment,  
3 there can't be rooms with shared communal spaces or  
4 multiple beds to a room because that makes it very  
5 challenging to cohort and isolate. Whereas when  
6 there are fewer rooms with fewer residents to a  
7 room, it makes it much easier to try and reduce the  
8 spread.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 I'm curious about that. If you had four people in  
11 a room and you reduce it to two people in a room  
12 and there are benefits associated with that, that I  
13 understand. But you do need a place for the other  
14 two people.

15 DR. RHONDA COLLINS: And that's one of  
16 the challenges right now is the impact, potential  
17 impact, on the hospital system when we are reducing  
18 the number of beds in long-term care to prevent  
19 spread of infection that puts additional pressure  
20 on the hospital system.

21 One of the potential strategies that I  
22 can see as hospitals ramp up back to full service  
23 and the need to move ALC patients out of acute care  
24 and into a different environment is potential of  
25 the use of retirement residencies who are not at

1 full capacity, as a potential strategy.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 So in -- and, you know, the reason -- I mean, I  
4 appreciate you could construct something, but  
5 assuming you don't have time to do that, so would  
6 be the retirement residencies where a person might  
7 look to find additional spaces?

8 DR. RHONDA COLLINS: If there's  
9 capacity, yes.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 And you have the -- and I'm not -- I'm asking.

12 Do you have the impression that there  
13 is additional space in the retirement residences,  
14 or are they as full or crowded as the long-term  
15 care homes?

16 DR. RHONDA COLLINS: They're not as  
17 full or as crowded. Once again, speaking of  
18 heterogeneity, retirement residences can range from  
19 independent seniors apartments all the way to  
20 assisted living and memory care units. So they do  
21 vary a great deal.

22 A lot of them who are independent sites  
23 all have suites. They're individual suites.  
24 They're not shared spaces. When you get into  
25 assisted living, there potentially -- I can't speak

1 for all operators. I'm just speaking for Rivera.  
2 The majority of the spaces are single rooms.  
3 Definitely for independent living, they're all  
4 single suites, and so there is some availability.

5 Again, speaking for my organization,  
6 not necessarily all organizations, there is some  
7 capacity right now as many people moved out of  
8 retirement at the beginning of the pandemic and  
9 into homes with families for fear of contracting  
10 the virus.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Okay.

13 DR. FRED MATHER: I'd like to just  
14 follow up on Justice Marrocco's question because I  
15 think it's very relevant. The number that I've  
16 heard from different sources is that there are  
17 going to be 4,500 fewer long-term care beds in  
18 Ontario in the near future because of the number of  
19 four-bed rooms that are now reduced down to private  
20 rooms. So there is quite likely going to be a  
21 capacity issue.

22 We've also heard that there's people in  
23 long-term care who don't really need to be there,  
24 but there's no place else for them to go because  
25 they do have some personal care needs, and they

1 don't have the finances for something like a  
2 retirement home.

3           Based on my experience in convalescent  
4 care being involved in the geriatric assessment  
5 unit in the hospital and some memory clinic work  
6 that I do, I think one of the issues is that there  
7 are plenty of retirement homes, but there's an  
8 insufficient number of subsidized retirement homes  
9 that -- where some of these individuals who are in  
10 long-term care could function in a retirement home  
11 if the subsidies were there. And I'm not an  
12 economist, but I suspect the cost of their care  
13 could be less.

14           DR. RHONDA COLLINS: And to add onto  
15 that, providing additional home care opportunities  
16 for those people who don't necessarily need  
17 long-term care but who can't afford private-pay  
18 retirement and may be able to manage in their home  
19 environment with appropriate supports in place.

20           Again, to Dr. Mather's point, I can  
21 tell you that, in the literature supports, it is  
22 much more economical. That said, that would leave  
23 more space available in long-term care for those  
24 people who absolutely need it because there are  
25 people who need it.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 M-hm. Okay.

3 COMMISSIONER KITTS: Dr. Mather?

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Yeah.

6 COMMISSIONER KITTS: Do you have any  
7 thoughts or idea about what percentage of patients  
8 in long-term care homes could do well at home or  
9 elsewhere?

10 DR. FRED MATHER: I don't have that  
11 information, and I wouldn't hazard a guess. I do  
12 have observations that I make.

13 Individuals with a neurocognitive  
14 impairment -- that is a mild dementia, perhaps  
15 related to past, chronic alcohol use -- if they're  
16 in long-term care, they're well nourished, they are  
17 abstinent, but they still need some supervision and  
18 support in their life to prevent recidivism.

19 Those individuals don't need the  
20 assistance with the basic activities of daily  
21 living such as feeding, dressing, going to the  
22 bathroom, and they will represent a group of  
23 people, I think, that could be accommodated in a  
24 different sort of care setting rather than being in  
25 long-term care.

1                   They're also the ones that are outside  
2 of the group that Dr. Robert mentioned that are in  
3 the long-term care for a short time. They could be  
4 in there for a decade or two.

5                   COMMISSIONER KITTS: Thank you.

6                   COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Yes, Dr. Williams?

8                   DR. EVELYN WILLIAMS: A couple of  
9 points. In terms of dealing with the second wave,  
10 we still need prompt, quick swab tests back. Still  
11 six days to get a test back, so we're waiting six  
12 days to know if we've got an outbreak. This is  
13 just unacceptable.

14                   In terms of decanting, we already have  
15 the example in Toronto of the hospitals getting  
16 ahold of decommissioned hospital buildings and  
17 decanting people who were ALC in a hospital to  
18 these buildings like Humber and Church Site where  
19 they're managed by the acute hospital, but they've  
20 decanted them there.

21                   It may be that there are other  
22 opportunities such as that to look after people  
23 because that is taking people from hospital for  
24 rehab, slow rehab, so they don't go into long-term  
25 care; they go home.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2   Okay. Thank you. Well, thank you very much, all  
3   of you.

4                   Dr. Mather, thank you for bringing  
5   everyone. It's been very informative. It really  
6   has been, and we really do appreciate it.

7                   With your permission, we may come back  
8   to you with further questions as we get along in  
9   our work. And I would say that we will be thinking  
10  very carefully about some of the problems that  
11  you've highlighted, so thank you very much.

12                  DR. FRED MATHER: Well, thank you for  
13  your time, and we are very passionate about the  
14  work that you're doing and the changes that can be  
15  made, and we're more than interested in  
16  contributing if we can in the future.

17                  COMMISSIONER FRANK MARROCCO (CHAIR):  
18  Thank you very much.

19                  DR. FRED MATHER: Thank you.

20                  COMMISSIONER FRANK MARROCCO (CHAIR):  
21  Bye, everybody.

22  -- Adjourned at 5:20 p.m.

23

24

25

1 REPORTER'S CERTIFICATE

2  
3 I, MCKAYA MCDONALD, CSR, Certified  
4 Shorthand Reporter, certify:

5  
6 That the foregoing proceedings were  
7 taken before me at the time and place therein set  
8 forth;

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
12 thereafter transcribed;

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

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