Long Term Care Covid 19 Commission Mtg.

C.A.R.P. Advocacy Working Group on Long-Term Care
on Thursday, November 26, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 26th day of November, 2020, 11:00 a.m. to 11:41 p.m.

BEFORE:

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

PRESENTERS:

Kathy Wright, Volunteer Board Member at C.A.R.P.
Margaret Eisner, Volunteer Board Member at C.A.R.P.
Barbara Schulman, Volunteer Board Member at C.A.R.P.
Darlene Jamieson, Volunteer Board Member at C.A.R.P.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat.
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst for the Operations Branch, Long-Term Care COVID-19 Commission Secretariat
John Callaghan, Gowling LLP

ALSO PRESENT:
Janet Belma, Stenographer/Transcriptionist

I N D E X

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 22, 32

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

-- Upon commencing at 11:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm Frank Marrocco; Commissioner Angela Coke; and Commissioner Dr. Jack Kitts, we are the Commission. So, Ms. Wright, if you're speaking, is everyone on your side here?

KATHY WRIGHT: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're ready to proceed, then. You know, I think -- I think you know, you know, we're looking back at what happened in Wave 1 and trying to think of recommendations that we can make that are -- that can be implemented that will try to prevent this sort of thing from happening again. Although, Wave 2 is posing a set of difficulties that are reminiscent of Wave 1. But be that as it may, that -- that's -- our job is to try to come up with recommendations, and that's what we're doing.

We'll probably put out a second interim report and maybe -- you know, because we think that may be a better way of going at it than putting out one large report at the end of -- months from now and maybe there's a vaccine and people have -- want to forget about the problem rather than be reminded of it.

KATHY WRIGHT: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): So that's what's -- that's what's going on on our end. You were talking to Janet, who's the court reporter, and we will post a transcript of this so that people can follow along with what we're doing.

So with that having been said, we're in a position to proceed as whenever you're ready.

KATHY WRIGHT: Okay. Okay. First of all, before I start, I would just like to say that we were very pleased and fully supportive of your interim recommendations.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

KATHY WRIGHT: We thought they were excellent, and we were hoping, and we did send a letter to the Minister in the hopes that they would act on those sooner rather than later. So good for you. Congratulations for doing that.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you for doing that. They would probably be wondering when we're going to do it again, so -- and they will find out.

KATHY WRIGHT: Right. Right. Okay. Well, I'll just go ahead, then?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, please do.

KATHY WRIGHT: Okay. So first, I'd -- we'd like to extend our sincere thanks to the Commission for this opportunity to present some very real possibilities that exist to change the way care is delivered in Ontario's long-term care homes. This change would not only improve the lives of residents, family, and staff, but would also help to mitigate the future impact of viral infections.

C.A.R.P. Ottawa, we are from C.A.R.P. Ottawa as you know, also known as the Canadian Association of Retired Persons, is Canada's largest non-partisan advocacy association for older Canadians with more than 320,000 members, most of whom live here in Ontario. C.A.R.P.'s mission is to advocate for better healthcare, financial security, and freedom from agism.

I'd like to introduce now the other members of C.A.R.P., Ottawa's Advocacy Working Group On Long-Term Care who will share the presentation with me today: Barbara Schulman, Marg Eisner, and Darlene Jamieson who will be our resident observer today from our working group.

Collectively, we have had decades of dementia and healthcare experience, and three of us have had parents who lived in a long-term care home.

And as mentioned in the brief, C.A.R.P. is recommending that the Government bring about transformative culture change in Ontario's long-term care homes. We are advocating for every long-term care home in Ontario to adopt one of the existing innovative models of transformative care, the Butterfly Model, the Eden Alternative®, the Green House Project, and Hogewey Villages.

There are successful examples of these models that have existed for years already in the U.S., Europe, the U.K., and more recently, and to a more limited extent, in Canada and even right here in Ontario.

It is interesting to note when we look at the fundamental principles of transformative culture change that they are very consistent with the principles outlined in Ontario's Long-Term Care Act which states: (as read)

> "A long-term care home is primarily the home of its residents and is to be operated so that it is

a place where they may live with dignity and security, safety, and comfort, and have their physical, psychological, social, spiritual, and cultural needs adequately met."

And despite many regulations, millions of dollars over the last three to four decades, it's clear these fundamental principles in the Long-Term Care Act have definitely not been met.

And, as we all know, over the last nine months, COVID-19 has exposed the inherent weaknesses in the long-term care system, but it has also provided us an opportunity to shift our thinking and to transform the system right now.

So what exactly is transformative culture change? It's a philosophy that uses an emotion-based approach to care where residents, staff, and families feel part of a community and are treated with dignity and respect where there are small home-like environments, more direct hours of care for residents, where staff work full time, are well paid, and are trained in empathy and culture change, and where families and caregivers are recognized as an integral part of the team.

A leader from one of the innovative

models that have embraced transformative culture change shared her experiences with us. And I quote:

> "Small households where residents and staff live and work as a family with emotion-focused care have shown that residents do better, use fewer harmful medications, have better sleep, more happiness. There is weight gain, less pain, less staff illness and turnover as staff know the residents very well and are empowered to live a normal day with their residents."

And in fact, preliminary reports from the homes that have embraced transformative culture change have better -- have shown better outcomes both pre and during COVID-19.

So I will now pass it over to Marg and Barbara to fill you in on some elements of the current culture of care as compared to what care might look like if transformative culture change were to be implemented.

COMMISSIONER JACK KITTS: Just before you go on, Ms. Wright, what would you -- what would

you define as a small home or a small household?

KATHY WRIGHT: I think, ideally, it would be about 10 to 12 or 8 to 12. We know that this could be difficult for sure in all the existing buildings now that are being renovated because they're all built for 32 residents, but we'd also understand that some of the companies who have been implementing or launching now the Butterfly Models have managed to take the 32-bed unit and come somehow create two living spaces for 16 each. So I guess that's -- I mean, it's maybe not optimal, but it's certainly a lot better than the 32.

COMMISSIONER JACK KITTS: So are you saying that if you have one with 120, you'd make units within that facility, or those facilities should never be built?

KATHY WRIGHT: Well, I mean, I guess if we had the option of starting from scratch and building, it would be much easier and much cheaper to build the smaller units, I would think. But there are possibilities, as I mentioned, to -- actually, to separate spaces within larger -- in larger areas to make it work as well.

COMMISSIONER JACK KITTS: Okay. Thank

you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: You had mentioned that the -- you know, some of the homes that are following this model seemed to have had better outcomes during COVID.

Can you just elaborate a little bit on what you -- what specifically has contributed to that based on this model that you're describing?

KATHY WRIGHT: Well, I think it is partly due to the fact that there are -- they are a smaller number of residents, so there are fewer contacts being made with each other and with the staff. And I think they have somehow managed to isolate residents in an easier fashion because of that.

If you have private or semiprivate rooms as opposed to rooms -- you know, some of the older buildings have four residents in one room, it's very difficult to isolate the residents.

I think those would be probably the two most important ones.

Maybe Marg or Barbara might have some other comments on that?

MARGARET EISNER: I think one of the big things is the HVAC systems with the smaller units so you're not -- the circulation of air in the smaller units that helps lessen infectious disease. I think that's another factor that they found, yeah.

COMMISSIONER ANGELA COKE: Thank you.

MARGARET EISNER: Okay. If there's no further questions, then, maybe I'll just proceed. And I -- and thank you. I'd like to be speaking about staffing and inspections, those two elements.

And I'd like to start with the Long-Term Care Act, and it states that:

> "A long-term care home is primarily the home of its residents."

And so that begs the question, what is a home? And is -- our current long-term care homes, are they considered home? I would say that it really isn't.

Instead, our current long-term care homes give off an institutional feeling where staff are trained in clinical care, and they tend to carry out their functions in quite a regulated manner.

The current Long-Term Care Act supports person-centred language, but this is not what is happening in most long-term care homes today. Yes, staff need to be trained to support residents' health needs, but a home full of skills and competencies does not necessarily make a home.

A long-term care home turns into a home when people want to be together, when they feel comfortable with each other, and I think staff in long-term care homes must be adequately trained to connect on an emotional level with each resident, and this takes emotional intelligence.

And I think developing emotional intelligence in staff should be the primary competency that we need to invest in, and so we need to hire staff not only for clinical skills but also for their ability to show and develop emotional intelligence.

We know that staff in long-term care are forced to focus on completing tasks rather than providing holistic care. Staff are overworked. There just doesn't seem to be enough time in the day to get it all done. There's been an increase in number of residents with chronic health problems. There's been higher rates of dementia.

This all contributes to the understaffing problem. These issues lead to stress, contribute to high staff absenteeism, turnover, and injuries.

When completing tasks is the main focus, then it takes away from other aspects of care such as observation and early detection of COVID.

Leadership in long-term care homes has traditionally been a top-down approach rather than bottom-up. I think shared decision making needs to be the norm where all staff feels valued, and they can all contribute to the decision-making process.

Frontline staff like personal support workers, they're the ones that are best positioned to detect changes in their residents' needs.

However, staff fear reprisals under the current inspection system. They spend a lot of time documenting the tasks that have been carried out.

What is needed is a structural change in policies and procedures that shift culture in long-term care to one that prioritises emotional well-being of residents, a person-centred approach, if you like, based on residents' needs and not just standards of operating procedures.

So the question is, how do we enact a culture change in how care is delivered in long-term care that will hopefully prevent or reduce infectious diseases in the future?

So I believe it requires a move from our current siloed approach to care to one that is directed towards a person-centred approach, and it shifts the culture to prioritise emotional well-being of the residents.

We need to be able to flatten the hierarchy of staff so that all staff are valued, viewed, and respected as team members. Shared decision making is really important amongst staff especially to decrease fear of reprisals, and that would result in better bottom-up reporting, better care planning, better care provision.

And we need to hire staff for emotional intelligence, and we need to shift the pool, the talent pool, to focus on valuing and supporting our residents. Critical thinking skills and observational skills are important. We need to hire for those so that they can detect problems early and then faster implement the things that need to be done.

And we need to return the role of the

long-term care inspector back to the role of the compliance advisor who works in partnership with government and providers of care where they can work together, where they can all help improve care that's being given.

But above all, we need to focus on delivering quality-of-life care based on the individual needs of residents, and I think if this happens, it will go a long way to making a home for our long-term care residents. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

BARBARA SCHULMAN: Shall we carry on? Or are there any other questions before --

COMMISSIONER FRANK MARROCCO (CHAIR): No. I think we should carry on. We'll just -- you know, we will -- if you don't mind, we'll interrupt and ask questions as we go, and so if --

BARBARA SCHULMAN: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): -- nobody's saying anything, it's because we don't have any questions.

BARBARA SCHULMAN: Okay. Good. Thank you. I'm going to be speaking about design which is a very critical respondent for transformative

culture change. And some of the questions that Dr. Kitts has already posed, we've answered, but I will repeat them as I think they bear repetition.

So currently, the resident units are usually 32 beds with long hallways that are often cluttered with laundry carts, drug carts, and food carts, and with lacklustre walls. These large units have proven to lend themselves to the transmission of infectious diseases as witnessed most recently with COVID-19. Overall, a very institutional environment, there is seldom anything warm and kind about the settings in today's long-term care homes.

However, with transformative culture change and its relevance to COVID-19, there would be a shift, as has already been said, from a ward-like institutional environment to a small home-like environment with approximately 8 to 12 residents. This type of environment supports a culture of person-centred care and shared living spaces. Private and semiprivate bedrooms and bathrooms are also a feature of this type of design.

Why would this make a difference? There would be contact with a small number of

residents and staff daily, reducing the potential spread of an infection. Families can be involved with less chance of infecting a large number of residents and staff and with a positive impact on lessening their loved one's feelings of isolation, depression, and of being locked in a prison.

And I'd like to quote now from a husband whose wife is in a long-term care home where the Butterfly Model was implemented:

> "The whole idea that family members should be excluded from visiting a loved one is not conducive to good care even in the COVID-19 circumstance. There are statistics available that show the COVID-19 outbreaks at long-term care centres are not due to visitors, but rather the workers."

The other aspect is that the private or semiprivate bedrooms and bathrooms would make it easier to isolate any residents infected by a virus, which Kathy mentioned previously; and as Marg indicated, small households in the existing 32-bed units can be designed in zones so that HVAC can be isolated to prevent the spread of disease.

A small household can be completely shut down to prevent the cross-contamination to other households.

We need to design for resident, family, and staff well-being. Although COVID is part of this, we need to look beyond that.

Also, let's not forget that flu outbreaks are a pretty regular occurrence in long-term care homes, so these changes are not just for COVID-19, but for other types of outbreaks. We are not just designing for a once-in-a-century event, and residents would know and feel like they are living in a warm, caring environment which looks and feels like home.

Early evidence shows that there are fewer COVID deaths and cases in those long-term care settings that have a transformative model. Examples: Malton Village in Peel, Henley House in St. Catharines, and Henley Place in London, and there are more details about this in our Appendix III of the brief.

So our message overall about design is we cannot afford to continue to perpetuate the current design of long-term care homes. We must change the design from an institutional to a

home-like environmental. The magnitude of the proposed design change is nothing short of the magnitude of the opportunity that the Commission has to chart the future course of long-term care in Ontario.

The design element is one of the critical components of transformative culture change with or without COVID. There is nothing home-like about the majority of our long-term care homes today. Thank you.

COMMISSIONER JACK KITTS: Can I just ask a question? And it's similar to the question I asked Ms. Wright. So we have 626 homes in the province now. We won't be building all new ones, so I'm trying to figure out what you're saying in terms of the large homes with, you know, a hundred, 200 residents, and it sounds like the wards are 32 or 36 beds per ward.

So are you saying that if those homes can't be replaced, they should be modified or redesigned to house 10 to 12-bed units that could be isolated in the case of COVID with separate HVAC units, and so no more than two people per room and either private or semiprivate bathrooms?

Would the rest of the time those

residents be eating and convening and meeting other residents in a common area? So are you talking about these units, these homes being just, sort of, bed and bathroom, or is there something more to it?

BARBARA SCHULMAN: There would be -- it won't be as easy in the redesign of the existing models, but they will -- if you were to go to the places where, like, Malton, and I haven't been there, but that's what they have tried to do.

I'm not sure to what extent there would still be common living areas for all the residents in that what was formally a 32-bed unit.

And, certainly, for eating purposes, the 8 to 12 would be those residents that would eat together even if they had to have different times for meals.

COMMISSIONER JACK KITTS: So they'd share a common kitchen, but everybody wouldn't gather in the same place at the same time.

BARBARA SCHULMAN: They wouldn't gather in the same place at the same time. You'd have 8 to 12 that may have a shift in wherever the dining area is, and then subsequently, the next -- the next zone would go in and have their meal as well.

COMMISSIONER JACK KITTS: Okay. Thank

you.

BARBARA SCHULMAN: But I think probably we could learn from how those organizations have already proceeded. My recollection is, for the ones like Henley House and Henley Place, that they've actually installed some cross-corridor barriers, but I'm not familiar with the actual design.

COMMISSIONER JACK KITTS: Thank you.

U/T KATHY WRIGHT: Yeah, I think that's a good question, and we could check again with the Glebe Centre here in Ottawa. They launched the Butterfly Model and then, unfortunately, had to be put on pause because of COVID right in the middle of their training. But they have managed on their units because it's such an old building, they could not afford to tear down walls and so on to make smaller units. So they have managed to separate and just have two completely different living spaces.

But, anyway, your detailed questions make good points, and it would be interesting to speak to them on how they've actually accomplished that, but...

U/T COMMISSIONER JACK KITTS: I think you

can always get back to us. You've already contacted; you submitted a report, so you can get back to us with that information.

BARBARA SCHULMAN: Okay. Good.

KATHY WRIGHT: So I just have a couple of concluding remarks, if that's okay?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. Go ahead.

KATHY WRIGHT: So Ontario's Long-Term Care Home System is, in many ways, operating on the flawed premise that if we just have more rigorous inspections, hire more inspectors and more staff, all will be fixed. We believe that nothing could be further from the truth.

Yes, the system needs proper oversight of good clinical care, as Marg had mentioned. In no small part, this is because those coming into homes now are more vulnerable than ever with at least a few chronic conditions that require expert clinical care.

But while these regulations measure outputs of fluid each meal -- at each meal and so on, they ignore the value of life offered to people living in the homes: (as read)

"What is needed is laughter,

friendship, energy, tenderness, freedom, and hope. In other words, let the residents live until they die.

It is possible to offer the medical side of care without sacrificing our sense and purpose of life, the need for relationships and the connections that can counter the isolation and feelings of hopelessness that many feel with or without COVID-19 in our long-term care homes."

And I would just say that was a passage I took from Moira Welsh, a reporter from the Toronto Star who's done an awful lot of work studying the long-term care homes.

So it seems like our time for major reform, the opportunity is now. We would like to ask the Commission to recommend the Ontario Government commit to move towards transformative culture change in all Ontario's long-term care homes.

This commitment could start by examining the long-term care homes that have

already embraced transformative culture change to determine best practices and lessons learned including how they have managed financially within current budgets and the current legislation.

The commitment could also include revisiting the new builds that are being fast tracked to ensure Ontario does not end up with the same old institutional designs that, once built, will be with us for the next three or four decades.

Bringing about transformative culture change would result in the most profound change of Ontario's Long-Term Care Home System ever. Obviously, this cannot happen overnight, but we do have to start somewhere. And it can be done, and, in fact, it is being done already right here in Ontario, as we have said, by a few leaders who have taken the leap and the risk to improve the lives of residents, staff, and families.

There are currently 11 long-term care homes in Ontario that have either implemented or launched the Butterfly Model of care resulting in transformative culture change.

What keeps us up at night is the fact that we will lose this window of opportunity while there is so much awareness to make a lasting

change. This kind of profound change, if we don't do it now, the system will stay the same for another three decades or until another tragedy strikes.

So what is needed now, we feel, is the political will, and we urge the Commission to help make this happen. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

Thank you.

COMMISSIONER ANGELA COKE: I just have a question. You mentioned there are a few or a number of homes that have embarked on this journey. I know culture change is not an easy or quick fix.

KATHY WRIGHT: Right.

COMMISSIONER ANGELA COKE: But I'm just curious, for those who have been through this experience, what has proven to be the most critical success factors? You know, what are the conditions that have enabled some of them to be successful?

KATHY WRIGHT: That's a good question. I think -- and I'll ask Barb and Marg to jump in as well, but I think the key factors, I believe, is having the buy-in from the leadership. It has to be -- as Margaret said, it's not just training the

frontline staff. It's a whole organizational shift where they need to buy in and believe in culture change.

And I think we did ask one of the leaders at one point what she thought the two -- one of the two major areas were, and she said that really having the small home-like environment along with staff who understood culture change, staff and leaders who understood culture change, were the two key elements.

Marg and Barbara, were there any other things?

MARGARET EISNER: No. That's absolutely right, Kathy. The leadership is key, and the commitment of the leadership to keep trying, and I think the same -- other leaders have said to us that you have to keep trying because it's not easy, so you don't give up, and you take the small wins.

But they also hire staff who have -- and they do empathy training, and they help them so that they can see the needs, emotional needs of their residents. So they do a lot of training, cross-training, and so on with staff to get them to that point.

KATHY WRIGHT: Barb, I don't know --

BARBARA SCHULMAN: Yeah, I mean, we just haven't had the champions that we've needed for long-term care, and the more we can get who are going to provide that leadership and bite the bullet, because it is a risk -- there's no guarantee. I think in the case of those homes that have adopted the Butterfly Model, somehow they've been able to work it out within their budgetary constraints to purchase what comes as a package for implementation.

But they have had the leadership that has taken and driven them to go to do this, and then they have this excellent training program, or so it seems, for educating the staff, and that's for all the staff throughout the organization, and to continue that training so that it's not once you have a little bit of turnover, that commitment to culture change is going to disappear. It's a philosophy. It needs the leadership, the will, and hopefully, we'll have more and more champions down the road who are going to support this cause.

COMMISSIONER ANGELA COKE: My other question was, in terms of the homes that have gone this route, have they been from across the spectrum

privately -- you know, private, municipal not-for-profit?

BARBARA SCHULMAN: There have been, and it's only more recent in our work that we were fortunate to meet and be -- it was suggested we be in touch with Joan Lalton (phonetic), and PrimaCare, they've had -- implemented the Butterfly Model in Henley House and in Henley Place. And I believe their new home -- I can't recall -- maybe where it's coming up in Brampton or Waterton, they're going to try building from scratch to adapt the Butterfly home.

KATHY WRIGHT: With smaller units.

BARBARA SCHULMAN: Right.

KATHY WRIGHT: Yeah.

COMMISSIONER JACK KITTS: So I think what I've heard, then, is that the vision, the culture that you're trying to create is defined in the fundamental principle that Ms. Wright read right off the top, right? That's the culture you're trying to create is written there in the Long-Term Care Home Act as the fundamental principle. And you say that you need the right leader to lead that change to that.

You need compliance officers or

inspectors to become compliance officers because as you've said, we're not meeting the promise of that fundamental principle today, so you need compliance, and then you need to train the staff.

And I think you said that the patient acuity is much higher than it has been, but you -- and you -- and the staff are trained, skilled, to deal with the physical -- physical health of the residents, but you feel they need more training on the mental and emotional aspect of well-being.

And finally, a means to that end is creating 10 to 12 -- 10 to 12-person units where they could feel more like a home. Does that capture it?

KATHY WRIGHT: M-hm. Yeah. Yeah. That's good.

BARBARA SCHULMAN: That's it.

KATHY WRIGHT: If I could add just one thing about the staffing, we heard from the project manager who opened the first official Butterfly Model in Ontario, Mary Connell, she mentioned when they were doing the training, they used the staff -- or they were just doing it on one unit, and it also was a very old building, I understand.

When they were doing the training,

because the training is not task-oriented and so on, which is what the staff are used to, there were a few staff who just could not grasp what was being asked of them in terms of having, I guess, that emotional intelligence that Marg was talking about, and they had to -- they had to move them into another unit because they just couldn't -- you know, and this is -- this is how difficult, I think, it is for some people and how important it is to try and have the right hiring practices and the right qualifications in the first place because some staff just -- some people just can't get it, right? And they're just -- it's just too hard to make that change.

COMMISSIONER ANGELA COKE: M-hm. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think that we've asked all the questions we wanted to ask. On behalf of the three of us, I want to thank you for the presentation.

I must say, in all of the presentations that we've had up to now, no one has really touched on a transformative culture change as an important consideration for us, and so it's very helpful to get that kind of suggestion because I really don't think we've had it.

We're well aware of the possibility of the -- of the -- of a home having an institutional nature to it. That's unfortunate, but your presentation, at least, helps direct us towards how we might -- how we might reconsider that or prevent that sort of trend.

So thank you very much, and we will -- oh, one other thing: You have a website, and if you do, I was wondering if we could have a link on your website so that any of your members who want to find us could easily do so, and I don't know if that's possible, but we would appreciate it if it is.

KATHY WRIGHT: Well, most unfortunately, locally C.A.R.P. Ottawa does not have a website. All the local C.A.R.P. Ottawa branches are a hundred percent volunteer-driven.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

U/T KATHY WRIGHT: And not to say that some haven't managed -- if they managed to get a few volunteers with the technical expertise that they have done it. We have not to date. We could see, perhaps, if we could get it put on the national website.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that would be -- that would be -- that would achieve the same purpose from our perspective, so thank you very much for at least looking into it.

KATHY WRIGHT: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): And just let us know.

KATHY WRIGHT: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): But, in any event, thank you all very much. And we'll continue our work, and if you -- don't feel that you can't get back to us if something occurs, just contact us through our executive director and tell us what -- you know, tell us whatever it is you want to tell us if something occurs to you after.

KATHY WRIGHT: Thank you so much.

COMMISSIONER FRANK MARROCCO (CHAIR): I know that always happens to me after I say something. I think -- I leave, and I said, yeah, I wish I had said something else. Don't hesitate to get back to us if you feel the need to do that.

KATHY WRIGHT: Okay. Thank you.

MARGARET EISNER: Thank you so much.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye.

MARGARET EISNER: Bye.

-- Adjourned at 11:41 a.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 27th day of November, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

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