Long-Term Care COVID-19 Commission Meeting

Dr. James Downar
on Friday, February 12, 2021

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MEETING OF THE LONG-TERM CARE
COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 12th day of February, 2021, 9:00 a.m. to 10:00 a.m

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BEFORE:
Frank N. Marrocco, Lead Commissioner
Dr. Jack Kitts, Commissioner
Angela Coke, Commissioner

PRESENTER:
Dr. James Downar, Head, Division of Palliative Care, University of Ottawa

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Kate McGrann, Co-Lead Commission Counsel, Long-Term Care Commission Secretariat
Alain Daoust, Team Lead, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst
Long-Term Care Commission Secretariat
Kavi Sivasothy, Counsel, Gowling WLG

--- Upon commencing at 9:02 a.m.

LEAD COMMISSIONER FRANK MARROCCO: Doctor, thank you so much for coming.

We have a court reporter and we will post a transcript so that people who are interested in the Commission's work and understand what we're doing and what information we're receiving. And to the extent that our questions disclose what we're thinking, they'll get sort of a hint as to what's going on in our minds.

So with that, we're ready when you are.

DR. JAMES DOWNAR: Okay, wonderful, thank you. And I'll try to go quickly through some slides and some material, just cognizant that I'm not going to claim that I've read all of your transcripts, but I have tried to read some of the reports that you sent out just to get a flavour for what you're hearing and the things you've recommended.

So I'm not -- there are probably more things that I could talk about, but I'm just trying to sort of -- you've heard people who know more than me about staffing levels and that

sort of thing. I'm not going to speak necessarily to that very much and that sort of thing.

Okay, so a quick overview. I just wanted to walk through some of the things that I saw as contributed to the long-term care crisis and I'll give you a bit of context for how I came to get the perception or get involved in the whole situation, from a provider level, from a facility level, and from a system level. So sort of three levels. I'm a physician, so I divide everything into threes.

And then talking in terms of suggestions for the future. I wanted to focus again on kind of talking about how we can work in the future towards better integration of long-term care with acute and primary care in the region to try to, you know, not just prevent this type of thing from happening again, but understanding that it is very likely that we will have crises again, being able to respond to them in depth.

We can't just have a strategy of purely prevention. We need to be able to respond.

I want to talk very quickly about some IPAC standards and some observations that I would share, and then spend a little time talking about things that we can do to try to improve the quality of end-of-life care that we provide in long-term care settings, because that's something that is very near and dear to me.

So by way of background, I'm the Division Head of Palliative Care at the University of Ottawa. I work at the Ottawa Hospital and Bruyère, and I'm also a critical care physician, so I work a little bit in the ICU at the General. I moved to Ottawa in the fall of 2018, moved from Toronto.

Probably I don't think I've actually set foot in a long-term care facility for probably 15 years or more prior to the COVID crisis. It's not my area. I'm very much an acute care kind of person and that's my setting and my practice.

In the early part of the outbreak, I got involved in helping with different committees and organizational levels, things looking at flow and ALC and where we could find

capacity to try to create capacity in acute care.

And then it rapidly became apparent that we were having a serious crisis in long-term care. And one of the local regional structures got set up that was trying to provide support for some of the long-term care facilities that were in crisis, and they were asking for clinical help and I volunteered and said I would go, along with a couple of other physicians, who I can name later, and our regional nursing group, the Regional Palliative Care Team, and some community paramedics, which I will also talk about.

To date, I think I've gone into something like ten or a dozen long-term care facilities that were in the middle of crisis in different ways, and I'll talk about the team structure and how we did that.

But got, I think, a pretty good chance to see the whole spectrum of experience, certainly in our region out in Champlain, which would include Ottawa, a little bit west of Ottawa, and eastern counties all the way to the Quebec border.

So some of the major contributors that I saw to the pandemic, to the crisis that we saw in long-term care. At the level of the provider there was a very, very inconsistent physician presence on the long-term care facilities and on the wards. In many cases I would say that that inconsistent presence was predating the pandemic. It was not something new to just the pandemic. So there were certainly many cases of physicians who had provided really, I think, consistent presence on the ward and coming in on a regular basis to assess their patients and writing notes.

And then some of them continued to do so right through the crisis and escalated their presence. Others, for different reasons that I'll explain, started to decrease their visits on the ward and were not physically present.

LEAD COMMISSIONER FRANK MARROCCO: Doctor, can stop you for a second there? As a doctor, how would you look at this situation? You know, you go to a long-term care home on a regular basis, they rely on you going there. Now you've got this problem with infectious diseases. They are at risk of losing their

life. How do you analyze whether it's okay for you to try to do it virtually or whether you have a moral or ethical obligation to go there any way? How would you look at it?

DR. JAMES DOWNAR: I'm -- I think we have to be super careful not to be revisionist in how we look at this. We are looking backwards with the knowledge of what actually did happen in long-term care.

LEAD COMMISSIONER FRANK MARROCCO: Yes.

DR. JAMES DOWNAR: I want to take our brains back to March and early April.

By March and early April, no part -- every place in the world that had experienced an outbreak, it was a crushing impact on emergency rooms, hospitals and ICUs. I had not heard a lot of talk about long-term care at all as being in crisis. And in fact our major focus, regionally and provincially, was actually trying to find -- trying to find ways to get long-term care to take patients out of acute care to make space for what we assumed was going to be the tsunami of sick patients, just like what had been seen everywhere else.

So I want to start with the perspective that I don't think a lot of people realized, until someways into April, anything that was going on in these homes and how bad some of the outbreaks got to be.

I think that, you know, had they been more present that might have been detected, but at the same time the going wisdom in medical -- in the community at that time, in fairness to everybody, was that there were a lot of people sort of saying, All right, I need to keep myself safe and healthy because I may be needed to go in.

Having to go in for rounds all the time, we were trying to minimize all the interactions, all the excess interactions with patients. Because if one patient got sick and three people came to see the person that day all three of those people could get sick. Did three people need to see that person that day? Maybe not, so let's reduce that.

I'm not saying I agree with that perspective. And in retrospect -- I think we all know what that sounds like in retrospect. I do want to be fair to some of the people at the

time that I think they certainly weren't the only ones thinking along these lines. And many -- the shift to virtual care has been across the board in terms of healthcare, you know, certainly in oncology and in other fields that care for vulnerable patients, immunosuppressed patients. There has been a heavy shift away from in-person visiting, so I just want to be fair in pointing that out.

But it became very rapidly apparent that this was not working at all, you know, provincially and regionally.

So when I went on my first visit you saw a completely overwhelmed facility trying to deal with many sick and acutely sick patients with grossly, sort of like, grossly understaffed due to, you know, people being off sick or not being able to work for different regions and they were overwhelmed. The notion that you were trying to monitor people virtually or be available by phone, which I put in quotations, that's not -- available by phone is nothing in this context.

None of these people -- like bedside staff have no -- have no time to call. They

have no ability to sort of triage and prioritize what they're doing and say, Okay, I'm going to call the doc about this and I'm going call the doc about that. Everything is on fire. They're just running to feed, change, and they're barely keeping up with the basics.

So the idea that they're going to have time to think and just kind of call somebody later and review, I think is probably not an accurate perception.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

DR. JAMES DOWNAR: The other thing I would say that we saw a lot of was this cross-covering of facilities. So I heard many, many times that you had a physician who would be covering some patients at this facility, some patients at that, some patients at the other facility. You know, I don't -- it wasn't uncommon to hear of people covering patients at four, five, six. I think one person actually covered at 11 facilities, was actually covering patients at 11 facilities. And so I would call them and I'd say, We're here. Are you able to come in?

My advice and the advice of -- in discussions with my colleagues in the organization, we thought it best that I don't come in because if I come in there then I won't be able to go into any of the other facilities, because I become a vector and there's a risk of me transmitting COVID. But unfortunately that means that they don't end up going in anywhere.

So I would say, Look, I mean, if your other ten facilities go into outbreak, we'll cross that bridge when we get there but right now we're dealing with a problem here. You can go here and provide virtual support to the other places if you want but somebody needs to be here.

And I think it was very, very apparent that there were -- there was -- I think a broad acceptance of the idea that you didn't need to be on site for some of this care, which I don't think was inconsistent with other aspects of healthcare at that time. There was a really strong push towards virtual care and not doing in-person visits, for the reasons that I've said, but I think it was a major contributor in retrospect.

LEAD COMMISSIONER FRANK MARROCCO: Do you have a situation where a doctor concerned about either getting sick themselves and then transmitting? Do they have an obligation to figure out how to put on protective clothing and keep themselves safe but at the same time attend? I mean, how do you --

DR. JAMES DOWNAR: Well --

LEAD COMMISSIONER FRANK MARROCCO: I'm trying to relate it to the legal -- I know that you can't relate one profession to another, I understand that. But I'm -- it's through that professional filter that I'm trying to sort this out.

DR. JAMES DOWNAR: It's hard for me to say what was the drive. Like I think there were -- this is clearly a setting where most of the staff did not have a strong familiarity with IPAC practices. And I -- the physicians probably were high on that list of, you know, in operating in that context.

Anybody can throw on a set of gloves, again, but actually the process of doffing, taking off without contaminating yourself is quite complicated. And the further you get from

an acute care facility the harder that becomes.

So you need lots of little stations set up throughout your facility to doff, take your stuff off, there needs to be garbages and laundry bags, every, you know, every few rooms so that you can do it very easily. They need to be stationed with the supplies everywhere. It takes a while to set it up. And if you've ever done it before, most of these facilities wouldn't have done it at all. You might have done it for a small area in the building but not the whole building for sure.

And, I mean, we had others like in my division in Ottawa, the home visiting palliative care, how you go into somebody's home -- like, you're driving to their home; you get out; you put your stuff on; you walk into the house; everybody in the room -- in the building could be contaminated, as far as you know. And then you're trying to come out of the building, take off your stuff, somehow figure out how to dispose of it when you're in the middle of, you know, Kanata, in a snowstorm, and somehow get into your car, which is the car that you also use to drive your kids around, and not

contaminate your vehicle.

It's -- I mean, there are gradations of challenge. I would say the home-care people had it worst. Long-term care was a struggle. But I think for us, when I think back to SARS I had never heard of an N95 mask before SARS. Somebody handed me one and said, This an N95 mask and I nodded knowingly and then had to go look up what N95 meant.

You put it on. There's stuff -- little laminated sheets, you just like follow the instructions. It's not that complicated. But, of course, you need to practice it and you need somebody to show you how do it and check you, right? So the structures were simply not there.

LEAD COMMISSIONER FRANK MARROCCO: Okay, that's helpful, thank you.

DR. JAMES DOWNAR: Those were big issues in terms of the inconsistent presence and the notion that being available by phone was adequate, that was a problem.

The other big thing that stuck out to us was that there was very inconsistent knowledge or application of what I would

consider to be standard of care end-of-life practices.

So many -- there was some facilities where people had -- so someone's approaching the end of life, which for in a long-term care facility median survival is about 12 to 18 months. So it is a facility -- a long-term care facility should be very familiar with end-of-life care. It happens a lot and most people die on site, they don't get transferred for it.

At the same time, there were many facilities that had no -- I found a number of facilities that didn't really have standardized order sets in place, which is pretty common. Just, you know, an opioid medication, a sedative medication, something for secretions and something for agitation if the person gets agitated. Pretty standard things and they didn't have it.

And one of the first places we went into they had the order set but it was abundantly clear when we were talking to the staff that they had never administered, by injection, any of the medications on this list.

There was no -- unable -- people having inability to find a syringe; inability to find a needle; no familiarity with how to administer it; didn't know where the medications were in the building. That was a bit of an eye opener for me that, you know, you really -- it wasn't that it was just that the physicians weren't ordering it, but even if the physician did order it the remainder of the staff had no idea how to give it, indicating that they hadn't really ever done it. And that's quite concerning, right?

You should at the very least have some people in your building, at least one, but for a larger facility more than one, who was able to give injectable medications and have some expertise in that area.

So very, very inconsistent practices. Somewhat, at times, outdated attitudes towards these medications. Still the belief that some of them are potentially life shortening, which we have very -- as good evidence as you could hope to have that they're not. People should have no hesitation giving comfort medications for symptoms in 2020. And that's a really

important thing.

I can talk a bit more about some strategies for how to address this later because we came up with some.

COMMISSIONER JACK KITTS: I was going to say that, did this inconsistent or lack of knowledge of end-of-life care exist pre-COVID in your mind?

DR. JAMES DOWNAR: Absolutely. I don't think anyone got particularly better at end-of-life care thanks to COVID, but it didn't get worse.

The problem is that it's -- I think we -- and I went to other facilities where it was really good, just to be clear. There were other facilities that had a number of experienced, skilled individuals on site, had no hesitation to prescribe and give these medications and it was like, beautiful. It was amazing to watch. As a palliative care physician I was impressed.

COMMISSIONER JACK KITTS: With the median time 12 to 18 months to end of life, you would think that end-of-life would be a -- an important part. Are you going to talk about

recommendations on what you might do going forward to help that?

DR. JAMES DOWNAR: That's part of the second part of this.

COMMISSIONER JACK KITTS: Okay, I'll let you go there.

LEAD COMMISSIONER FRANK MARROCCO: Ms. McGrann, you wanted to ask a question?

KATE McGRANN: Before you leave this slide, could you just briefly explain what a "standardized order set" is, for those of us who aren't familiar with the terminology?

DR. JAMES DOWNAR: So generally speaking, most facilities like acute care facilities and in-home care, for example, if somebody is felt to be close to death rather than write out by hand this sort of customized order set where people might have, you know, different doses, different medications, we have this sort of what we call a "symptom management kit" or "SMK". It's a standard order form for the whole region. And there are similar ones in other regions.

And they will include, as I said, an opioid, usually a sedative, some sort of

medication for agitation that would also work nausea, and then something for oral secretions and anticholinergic medication, and there may be other medications on the list as well.

And you just literally check the ones you want, and then the nurses -- so the physicians become comfortable with this in a standard order set that's protocol driven, it's all good. And the nurses become comfortable with the idea of what drugs they're giving, doses they're giving, et cetera, and they're used to it. So it becomes something that is not abnormal or concerning or, Oh, am I doing the right thing? Am I giving too much? People feel comfortable and confident that they're doing the right thing and they shouldn't be afraid of the medications.

But, yeah, there are many -- there were a number of facilities that simply did not have these. And that, to me, I think for a facility of this nature there really shouldn't be -- that shouldn't be happening.

But it goes beyond just having the order form. You have to make sure that your staff can actually give this stuff as well

because it's not helpful if you don't have staff that's meant for injectables.

LEAD COMMISSIONER FRANK MARROCCO: Doctor, before we leave this, one of the things we observed early on, and we included it in one of our interim reports, was the need for a proper, detailed inspection process to ensure that there's compliance with proper practice.

How would you test for this, assuming you regulated it or you required it? How would -- the reason I ask the question is because you have an inspector who's not able to, in all likelihood, not able to do this because they just don't have the knowledge.

DR. JAMES DOWNAR: So we don't need to make this harder than it needs to be. I don't want to jump too far ahead in this but it's one of the things I'm going to talk about. There's a lot of data available already to us about prescribing practices and end-of-life practices for patients in Ontario, through the ICES databases.

So we started going in in April, mid-April. By the end of April we were already kind of planning a project.

So Ottawa actually has some real international experts' in analysis of big data and administrative databases. And to do so in a real-time or close to real-time manner where you can actually see how, for example, individual facilities are practicing.

So you can -- the same way that you might have seen an audit of facilities and what is their rate of using antipsychotics? And you can plot them all and compare, and people can benchmark their performances and simply look and say, Oh, look, I'm using way more than my neighbours. Yikes. Maybe I should do -- I should bring it down a bit.

You can do the same thing for prescription practices at end-of-life. And it's actually -- the data's already in the system. It's not hard to do. So we actually put in a grant application and have now a funded project to try and move this forward.

Again, it would be ideal if this would be something, for example, included -- it's an easy, easy metric to include as a quality metric for a long-term care facility because the data's already there. It's just, you know, you

literally just need somebody to build the algorithm to pull it.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

DR. JAMES DOWNAR: I'll talk about that at the end. I have a few infomercial products that I want to plug but I'll try not to be too overt on that.

So jumping to facility-level factors, and I think I kind of alluded to some of these. Well, I'll be honest with you, like, people have highlighted management issues I think a lot. That's what I've read in the media, et cetera. I promise you that when I saw the leaked Canadian Army report that we saw with all those horrific stories, there's nothing in that report that I didn't see with my own eyes in places I went into. So I didn't get a rosier view of the world than anybody.

But frankly, I don't actually think management issues were the major problem most places that I saw. There were certainly some facilities where management was clearly overwhelmed by staffing shortages. And it became quite a problem because you -- it was

very obvious that the managers were trying to replace sick or missing staff from this pool of reserves that had completely dried up.

They were calling all day to try to find extra bodies, and calling agencies and nobody was able to come in. And eventually the managers, most of whom were former nurses, just put the phone down and went out to the ward and started working because that's all they could do.

And so you saw these poor managers who couldn't do management because they were too busy just preventing a disaster in their own building. And I just really think it's important to acknowledge how hard some of these people worked to alleviate the disaster.

And I think to say that it could have been a management -- management could have done things differently, I think that's being unfair. I think -- in you have nobody to come in to the building what are you supposed to do? That's not a management failure, I don't think. There could have been better preparation, I think, around some IPAC practices. I think that's broadly acknowledged. But in general, I would

say that the management, I think, were doing their best in the situation that I saw.

There were some single exceptions, which I'm not going to name the buildings, but there were some that were very resistant to help, for reasons that I don't think I fully understand. I think there might have been some fear of being shamed or being sort of publically, sort of, singled out for any lapses of care in their building.

That -- it usually took me a very short amount of time on the phone to kind of overcome that and make it very clear that we were going to come and help them. And they ultimately -- I think everywhere -- every place we went ultimately they were very welcoming of our help. And most cases they -- the only reason they hadn't called our team to help them is because they didn't know the team existed.

And that's part of the problem, is that many of the managers kind of felt that they were alone, they had no help. Who could they call? There's never been a history of, you know, teams -- response teams to go and help. If you need staff you call the agency, and

there's never a time when the agency doesn't have staff. And this was an unprecedented crisis which just overwhelmed people.

The staffing issues, the COVID and self-isolation, et cetera, the -- I think you probably heard this already. What really became a problem was when I think the rule to stop people from moving between sites, like nurses and PSWs, unfortunately that became very problematic for certain places that weren't able to offer the same salaries as others. So people just simply dropped, you know, they just went to the home that could pay them the most.

So homes that were -- and I'm not going to say for-profit or not-for-profit, I'm not going to get into that discussion here. But there were homes that were not able to offer the same salary and they got heavily affected by that rule. So some of them, I think, were disproportionately bad. And that might be a contributor to some of the results that we saw here.

I think it was a well-intentioned rule though to stop the transmission of virus, unfortunately I think it kind of backfired. And

I have to be fair, I don't think it was predictable how that would backfire the way that it did. It was a very reasonable thing to do in the circumstances, it just unfortunately didn't turn out to be the right thing.

LEAD COMMISSIONER FRANK MARROCCO: But would you say, based on what you observed, it would be fairly -- it would be clear early on what this, let's call it an unintended consequence of the rule, was?

DR. JAMES DOWNAR: Yeah.

LEAD COMMISSIONER FRANK MARROCCO: So you have to, my words not yours, you have to pivot quickly and realize you've done something that you didn't intend to do?

DR. JAMES DOWNAR: You're -- I think you're correct in what you're saying. I do -- again, I'm -- ultimately you guys have heard a lot of input from many people. You've seen a bigger perspective than I have.

My impression was, having been in that building and watched the managers, just the sheer just exhaustion and desperation that they arrived at when, you know, when you're operating at a 30 percent staffing level, right?

So 70 percent of your staff aren't coming to work. You've been working 16-hour shifts for 14, 20 days in a row; sleeping in your building because you don't want to go home and give COVID to your family.

I met a manager who brought her daughter to work to help in the facility. It was stunning to me.

Like, you're right. If they knew who to call to tell them, but I think in many cases people in decision-making situations may not have even been aware that this was going on. Because I think at this point people just stopped calling for help, or signaling some of the issues, because it was sort of a learned helplessness moment. They just -- nobody was picking up the phone and nobody was answering them so why waste your time? You should go and feed and change your patients because that's at least something you can do.

That was my impression, and I may be wrong in that but that was my impression.

LEAD COMMISSIONER FRANK MARROCCO: Did you run into the problem created by simultaneously banning family visitors?

DR. JAMES DOWNAR: So I've recently published a piece arguing for -- that we really have to stop these restrictive rules around visiting, particularly at end-of-life. I think it's become very harmful, and it's definitely not clear to us anymore that that's protecting our patients or our families from anything.

The number of times that an infection comes into a building or goes out of a building through a visitor is probably very low. In April we didn't know that.

So again, I have to say with the benefit of hindsight, yeah, those visitor restriction rules probably didn't help a lot and they certainly caused emotional problems and certainly workload problems for the buildings.

But when you're dealing -- I have to -- I really want to be careful not to be too revisionist on this, to remember what the world looked like at the beginning of April and late March when we were looking at the sort of apocalypse that was unfolding in northern Italy, China, Paris, New York and major cities in the U.S.

I don't think we really had any notion

of what we were dealing with and every piece of data we had was very, very scary. So I think an overreaction -- we can call it an overreaction, in retrospect. I have to acknowledge that it might -- I think it seemed not unreasonable at the time. That's my impression. But again, I do not have the 30,000 foot view.

But I didn't -- I remember at the time being concerned about it, if I have to remember how I felt about it at time that's how I felt.

One thing I will flag in the facilities also, the IPAC training and the PPE supplies. So PPE supplies initially were terrible, as I think many people know. And suddenly they got really, really good.

So actually even fairly early on going in there, regionally in Ottawa, the TOH and the other hospitals I think did a very good job of creating a central supply and trying to make sure that everybody had supplies. I don't know that that happened all over the province. In Ottawa it was slick. It was, I think, very slick.

And now I go into long-term care homes they've got better PPE than we have at the

hospitals so I'm a little jealous.

But the -- one thing I would flag is to cohorting. There's been a lot of discussion around cohorting. And early on we saw a number of practices, that I think have been highlighted to your Commission already, of patients -- mixed rooms with patients who are positive and patients who are negative, and how that can obviously contribute to a spread of the infection.

I think that's really, really important to cohort and move people around to try to limit the spread of the infection. The problem became that actually I think our efforts to cohort might have actually made the problem worse in some cases and I certainly saw this.

So I just want to flag this. This is not an argument against cohorting, but we have to cohort maybe in a slightly different way.

So you have bed A and bed B. You decide to swab everybody. Bed A comes back positive, bed B comes back negative, but it takes you four days or three days to get the results. So when you get the results back you see that A is positive and B is negative. So

you take B and you move B over to the clean wing and put him in a room with somebody else who's negative.

The only problem is that he's now spent three days in a room with somebody who's positive. He's now positive. So B was actually positive, it's just that your swab, because it was three days old, said he was negative. So you took a positive patient and put him in your clean area.

And I've seen that happen probably a couple of times where these -- the people who were moved into clean areas suddenly the clean areas started to explode a bit.

And so I think if you're going to do this you probably need three zones, you need hot, warm and cold. So if you're moving people out of rooms where there were known to be positives, put them in a zone where they're with other people moved out of rooms known to be positive so they may well be. And then the people who are never exposed to positives don't put anybody in there until you're a hundred percent sure that they're negative to sort of limit spread.

That's not doable in every facility, but I can certainly think of at least two examples where we -- our efforts to cohort and limit infection actually may have made it a little bit worse. So it's more complicated than it looked.

LEAD COMMISSIONER FRANK MARROCCO: And I take it the four-day turnaround time is a contributing factor?

DR. JAMES DOWNAR: And unfortunately -- in the early days -- it's gotten a little bit better but it's still a problem. The turnaround in long-term care is not fast.

So in the old days you do your run list. You send to Public Health the list of who had the symptoms; they write back and say, Okay, swab this person, this person and this person. You have to then -- you at the home have to fill out a requisition, send it back to the same guy who just told you to order swabs. So they send you swabs for those people. You swab. You send it back to them. They wait. They run the test and then you get the results. So it's like a six-step process between finding somebody

symptomatic and getting the result. That really took a long time.

So from the time that somebody got symptoms until you even got a swab in your hand to swab them could have been at least a day in the early goings, and all due to the way in which these things happened outside of the facility.

It's a little better now but we are -- in certain areas, in facilities where I'm working in recently we're seeing like three-day turnarounds.

LEAD COMMISSIONER FRANK MARROCCO: So in the example you gave you'd actually have to add a day or so on to the turnaround time?

DR. JAMES DOWNAR: This is the problem with the cohorting. And I think people talk about the importance of the rapid testing or the bed-side testing. I can see that being very helpful for cohorting purposes, that you can immediately start cohorting based on that. The tests aren't perfect but waiting for the more accurate test, waiting four days, kind of undoes your efforts unfortunately.

So unless there are any questions,

I'll move on to system level factors that I found.

I think we have very much come to appreciate the interdependence of long-term care and acute care. That if acute care is in crisis and totally swamped long-term care is in trouble, because they're going to be getting a lot of sick patients and transfer and get asked to take on a lot; and they won't have anywhere to send their sick patients, which is a problem.

But vise versa is a problem as well. When long-term care is in crisis they're going to potentially -- it's a whole tinder box full of frail, elderly individuals who are very -- who are definitely at risk of becoming acutely ill and need a significant escalation in their care. And that's a lot of people who could suddenly get sick in a hurry.

And we're relying on them for bed flow when patients cannot be discharged to long-term care, you get an increase in your ALC numbers in the acute care, which chokes off your hospital's functional capacity.

The two sectors are so interdependent that crisis in one causes a crisis in the other,

and I think we have to recognize that from now on.

As a result, I think we have to look at our resources not in silos but as regional, as team resources, that we're all a team.

And long-term care, for obvious reasons, like you can't -- you cannot operate a long-term care facility that always has the capacity to suddenly deal with 40 or 50 acutely ill people with COVID. That just would not be a viable model on any level.

There's no reserve in long-term care and there would often be very little reserve in any system that would be sustainable.

And then suddenly when all these people get acutely ill, though there's only one sector that has any significant number of people with the experience and expertise to deal with a surge in acute illness, and that's the acute care sector.

So really, I think there wasn't at the start any mechanism to allow staff to go and support each other, like, for acute care staff to go and support long-term care. They set that up and they set it up fairly quickly, which was

good. They did it only for long-term care unfortunately, not retirement homes which became a bit of a problem sometimes.

But really the idea of -- but then I was going into facilities, and I'm familiar with the electronic medical records used in long-term care is PointClickCare, but I didn't have a log-in, and none of us had a log-in for PointClickCare. So we had to constantly ask the staff to log in and tell us what's going on. We couldn't check any of it ourselves, so it was still quite inefficient. We couldn't write notes, for example, in the electronic notes.

And this sort of -- the siloing became apparent it showed up in a lot of different ways. And then when we were trying to transfer patients into acute care there was no mechanism to send patients like straight -- distribute patients appropriately to different COVID wards. We had to send them all by ambulance, 911.

And the first day that happened, rather than being able to distribute a bunch of sick patients to different hospitals I had to send them all to the nearest hospital, and I got an earful about that one. But, you know, and

understandably so.

I mean, if I was running that hospital and suddenly this guy from a totally different hospital had just grabbed a bunch of sick patients and thrown them at my hospital I'd be pretty upset too.

We eventually set up these mechanisms to do proper distribution, but I think those mechanisms probably need to be more formalized and more -- they need to be made permanent.

So, you know, we have to have an ability to move and support and supplement long-term care homes if they get in crisis, and I have some suggestions on how to do that in the second part of the presentation.

LEAD COMMISSIONER FRANK MARROCCO: The problem you're talking about, you just described, would I be wrong in thinking that if there was pandemic planning going on in the years between SARS and today that many of these problems should occur to people -- reasonable people thinking about planning for a situation like this?

DR. JAMES DOWNAR: I'm not sure I know what a reasonable person is anymore,

Mr. Marrocco. Honestly, I'm not sure I can answer.

LEAD COMMISSIONER FRANK MARROCCO: All right. But a person who's well-informed about Public Health and is thinking about how you plan for a pandemic.

DR. JAMES DOWNAR: I'm also involved in provincial pandemic planning for ICU and ICU triage, and I can tell you that just trying to figure out the pandemic plan for that sector alone is an insane amount of work. It's a really staggering amount of work to think about how to just handle your own sector.

And the fact that -- you've got everybody's just trying to sort out their own thing and they aren't necessarily thinking about everything else. And you get several months into it and somebody will say, Oh, did you talk to the ambulance guys? No, I didn't talk to the ambulance guys.

LEAD COMMISSIONER FRANK MARROCCO: But you would agree perhaps, you tell me, but would you agree you can't be doing that and dealing with a pandemic at the same time?

DR. JAMES DOWNAR: This -- if we --

had we been properly prepared for this, it would have been -- required years of preparation to be ready for this.

This is not something that we should have had to do overnight or in a matter of weeks. This is something that would take many years of preparation.

And to your exact question, yeah, I think, you know, we had a number of pandemic plans and other things set up previously. I don't know all of the details of them but I know that they hadn't been tested or checked in a long time. And in pretty much every case that I'm aware of we -- every sector that I know of was just starting from scratch. Even if there was a plan, none of us knew where it was or what it was.

LEAD COMMISSIONER FRANK MARROCCO: And I took from what you said earlier, it's a difficult process to plan for these kind of contingencies, and obviously you can't do it when you're being overwhelmed by sick people.

DR. JAMES DOWNAR: That's correct.

LEAD COMMISSIONER FRANK MARROCCO: Anyway, thanks.

DR. JAMES DOWNAR: No, of course.

So in terms of suggestions for the future, and again this is -- I hope none of this is too blue sky. I tried to make them as concrete as I could. But I think you really do need to have formal links between long-term care and local family health teams, or Ontario health teams, but especially not just to family health teams and Ontario health teams, but to acute care facilities, right? You need to be able to tap into expertise around acute illness management, IPAC and staffing, and there's only one place that could possibly come from, which is the acute sector.

And it also enables you to then take the idea -- there's been a lot of talk recently about transfers and transferring patients. The notion of transferring patients is very complicated. And I really -- I want to push back on the idea that transferring a patient is the same thing as good care and not transferring the parent is bad care. I think that's very, very much mistaken.

There are many reasons that people don't want to be transferred to acute care,

which are very reasonable. Sending a frail senior to an overloaded emergency room where they're going to wait on a stretcher for a very long time is not a decision to be taken lightly.

But in many cases, for example, with COVID you only really needed to provide some fairly straightforward, basic supportive care; fluids, steroids and oxygen. And long-term care homes can do that. All you really needed to do was make sure that they were properly staffed and you could even send people over with that expertise and with that equipment so the patients wouldn't have to move.

Sending -- don't send patients to acute care, send acute care to the patients. And it's actually a much simpler and more efficient approach to the problem.

The other thing is that when your staff start to -- if you have -- our long-term care physician staffing group is in the, I will say, in the final third of their career, if I can put it gently. We have many, many people, physicians who are -- who themselves would be at high risk of death from COVID if they were to catch it.

So when this happened a lot of older physicians, and co-morbid physicians, just wouldn't go in to facilities for their own health sake, and that's very reasonable, but there was nobody else to call.

If you're part of a family health team you have a bigger group of people, you can cross-cover, you can help each other, and there wouldn't have been, I think, the same staffing issues there.

I think also I would be remiss if I didn't mention some of the non-physician staff who could step in here. Nurse practitioners physician assistants in particular. There were a number of facilities that had nurse practitioners on site, and one that I'm working with now that has a physician assistant and they're excellent. They don't have a large number of people that they follow. They focus on them. They do spend a lot of time at the bedside. And they're just as capable of doing the core care for -- that these the patients require as a physician would be.

And it really helps you deliver on this really important point that I'm trying to

convey, which is boots on the ground. You need to physically be present in the building. Being available IS not good enough. You need to be present.

And as the numbers start to climb not only just coming in every couple of weeks or every week, but actually going in every day is critical. And I'll talk about our rapid response teams and how we achieve that, but I think that's a really, really key point.

COMMISSIONER JACK KITTS: James, so I recall early on in wave one you sending me a note about boots on the ground were essential. You weren't going to help these people, and you talked about a lot of co-morbid conditions because of COVID that were probably contributing to death, dying with COVID, as opposed to because of COVID.

So my question to you would be along the lines of the IPAC recommendations on hub-and-spoke models and having an IPAC specialist in the home responsible for good IPAC practices and IPAC readiness.

I can't help but think that given the end-of-life frequency in the long-term care

home, and they're frail and elderly, that something about -- an IPAC -- sorry, a palliative care specialist on site in the home similar to the IPAC, and it would be, I think, a hub-and-spoke model where palliative care at your level in the academic centres, palliative care in the community, palliative care in community hospitals, could form a network in the region to ensure that either a nurse practitioner, or maybe a physician assistant, or maybe another -- someone in the home is a specialist and is ensuring that those order sets, those connections to acute care and stuff are all made, as opposed to bringing in SWAT teams and reacting anymore.

DR. JAMES DOWNAR: And you're like -- I feel like you're setting me up here to -- I think the -- as you are very aware, in Ottawa and Champlain region we have the Regional Palliative Care Team, which is a team of about 13 nurse practitioners and advanced practice nurses that cover the entire region according to -- just actually they're geographically distributed. And their job is to support family doctors in the homes. We're doing home visits

and patients at home followed by community practicing GPs.

But also long-term care facilities and retirement homes to provide this end-of-life care. This is a model that we should have across the province. It is so vital. I know from where I previously worked that that didn't exist. It is a night-and-day difference. So having those people there for the usual end-of-life provision is of vital importance.

I should note that I don't think every facility needs to have a palliative care person all the time. Palliative care -- certainly palliative care for most of the people who are coming to their end of life in a long-term care home it's not very complicated. You don't necessarily need a specialist to manage it. It should be considered part of routine medical care that every provider should be able to do it.

Because then the other thing, of course, is that a lot of this is going to happen on weekends and after hours. So having a sort of consultant model might not necessarily get you what you need when you need it. And it does

also convey the message that you need this person to do the end-of-life care versus the idea that everybody can do it and there's been support available.

But your point is very well taken, Jack, and I think vital steps moving forward as part of a comprehensive plan of improving end-of-life care in these long-term care facilities would be to make sure that every facility has a clearly-identified person who acts as their consultant.

COMMISSIONER JACK KITTS: So we've heard from many advice on how to try and prevent the virus from entering the home, recommendations; also how to keep the virus from spreading once it gets in the home.

But we haven't talked about, you know, the army sent the letter out. You said you saw all the same things. And we're kind of looking at how people passed in the home and how we could make that more -- make that better.

DR. JAMES DOWNAR: And that's a great segue to the "strike teams". And again, we didn't look at these -- these weren't palliative care strike teams per se, they were sort of

clinical response teams. And we call them "strike teams" or "SWAT" teams because it sounds nice, but really it's about clinical response.

We had physicians and nurse practitioners and RNs on the team. So people with lots of experience in acute and palliative care, so myself, but we also had Dr. Valerie Charbonneau, an emergency room physician with a lot of palliative care expertise. We had Andrew Willmore also going in. We had -- and I'm just talking about Ottawa. So you already heard, I think, from Amit Arya back in the fall, and he was part of a team similar to this out in Osler in the Peel Region.

But the community paramedics, oh my goodness, if there's one big recommendation -- I don't know who came up with the idea of using paramedics but they need a medal. These guys are fantastic. They can do anything. They show up at a moment's notice in teams of four with pretty much everything you would ever need, and they are not afraid of anything. So they will go in and they were a key part of our team.

We did a sort of mass casualty response where we formed a group, we got a cart,

we put our equipment on and we just walked through the building just sort of going in room after room. One person was taking notes and three or four people were just jumping into rooms, doing quick, focused assessments to see if people were stable, unstable, symptomatic, asymptomatic. We check their oxygen level. If we needed to do other investigations we would do them. And we would quickly go through and flag anybody who had concerning findings and come back and decide what to do. So often we would escalate their treatments, add oxygen if we needed to, we would add medications if we thought necessary. Often giving fluid was the thing that we would do.

And then we would also assess how the home was coping. And if we felt that they could be managed on site we probably would keep them there. If we were concerned that the home wasn't going to be able to cope we would transfer and we would call their family members and update them on what we were doing.

And we could do a home -- so one home we did had 135 -- I think 131 or 135 positive cases and we assessed every single one of them

in an afternoon; transferred a few of them; managed a few of them, and called the families, not 131 people but everybody who was sick we called their families. And we did that in about six hours. So you can do this.

You can't -- it's not -- obviously the people who are looking good and aren't having issues you're not spending a lot of time on them. But if you need to respond, if there's a home with 130 something positives you need to be very efficient with your time.

And we would also connect with -- we had regional supports where we would have physicians who were able -- weren't going to be part of the initial assessment teams but be part of the follow-up. And they would sort of go in every day and supplement the on-site care and make sure that the patients who were sicker were being managed appropriately in teams and if they needed to be transferred they'd be transferred.

We would work with the IPAC and the management teams from the region, as well, to try to help. And I was very proud to be a part of this publication with the paramedics. This actually appeared in a paramedic journal just

describing some of what we did. And really proud of that. It was a great -- it was a great model and quite successful, I think, in terms of supporting teams and delivering care.

And I don't -- I sent this slide -- this is very much -- we didn't randomize ourselves. Like, we didn't go into some homes and not other homes and then measure outcomes. You have to be really careful not to over interpret this data. But when you don't randomize and you're just looking at homes that you went into, one of the types of analyses you can do to try to decide if you helped was to compare homes that you went into early in the outbreak versus homes you went into later in the outbreak, and you can try to infer whether you had some benefit.

And from this analysis, I just did quickly, so this is 14 homes that we went into. I think we went into almost 20 in total but I was able to get data from 14 of them. So 719 COVID-positive residents, 243 of them ultimately passed away.

But there was a very strong correlation between the time to deployment, so

the number of days between when the outbreak was declared and the day that we first went in, and the mortality rate, which is on the Y-axis. So you can see if we went in in 10 or 12 days or less the mortality rate was substantially lower, and way lower than the regional average.

So I feel like this kind of model -- and again this is not proof of benefit obviously, but it is consistent with the idea that I think what we did was effective.

And as you respond quickly and do even just basic supportive care, when there is a big outbreak and things get bad, as part of your sort of defense in depth, if you will, that you actually can effect positive outcomes for the people affected.

COMMISSIONER JACK KITTS: James, can you go back? So is this the -- is this the makeup of the teams that went in? They had all this or is this what you're talking about the future?

DR. JAMES DOWNAR: This is what we did.

COMMISSIONER JACK KITTS: Okay.

DR. JAMES DOWNAR: This is what we

did. And I think it's a model that can be repeated in the future for sure everywhere. There's no reason we shouldn't be able to do this everywhere in Ontario.

COMMISSIONER JACK KITTS: Who's the quarterback of this team?

DR. JAMES DOWNAR: Currently me, but I hope that doesn't last. In wave one it was part of the incident management or the incident response structure. So it was a sort of combination of administrative lead and a clinical lead. So we had Kevin Peters and Suzanne Madore and Andrew Willmore and Valerie Charbonneau. And I was one of the people involved in organizing and finding the clinical people to go in.

Right now I would say probably it's Claire Ludwig regionally with the LHIN and she's doing a lot of the co-ordinating. I find the physicians, she helps find the community paramedics. We have our regional palliative care nurse team that's already in the picture and we can throw together a team very quickly and deploy.

COMMISSIONER JACK KITTS: So what

you're saying is this is the framework for the team. They should know who they are, who's in charge, and just with a flick of a switch they go into action?

LEAD COMMISSIONER FRANK MARROCCO: I just want to spend a second on who's in charge, which seems to me to be fundamental to the success of virtually everything we've been talking about since July when we were called into existence.

The people in charge of this, I think, and I'm asking you for your view, have to be people who are prepared to make a decision. This is not a policy discussion or something that can be spread over a long period of time. You need a decision maker.

DR. JAMES DOWNAR: Correct.

LEAD COMMISSIONER FRANK MARROCCO: And so do you have any ideas on where, if you were doing it provincially, where do you look for that person? How do we make sure -- maybe you can't, but how do you try to make sure that the person in charge is a decision-making type?

DR. JAMES DOWNAR: I think you're asking an excellent question. And I think that

to a certain degree -- and I thought a lot about this since the start. I think we had a lot of success out in Ottawa compared to some of the stories I've heard from other parts of the province, and I'm not going to name which ones, I'm not going to name those parts of the province.

But I think what you have in Ottawa is you have a very obvious structure based around an extremely large hospital which is the, sort of, giant ivory tower for the region; and with the usual sort of rural and community jealousies and things that go on when you have a structure like that. But boy is it effective when you have a problem, because everybody knows where to turn to, right? And I think the organizational structure came together very quickly in that region and was highly effective at enacting stuff when -- we didn't wait for instructions from above, we just grabbed and we just -- everybody kind of knew their job.

And our current structure was great, in a way, because a lot of the regional infrastructures were dismantled sort of at the end of the summer and no longer really

operating.

As we got into the fall in wave two it wasn't really a problem for us because we already knew the players. And we just kind of all just go on together again just sending texts and emails and we got the teams back together, even in the absence of an official structure.

So my one piece of advice on that basis would be, I think you need to let regions figure out their model and who's in charge. I don't know that this model would necessarily work in downtown Toronto where you have multiple large hospitals and it's not clear who's necessarily in charge there. It might be a bit more challenging.

But many regions of Ontario have kind of within that region, or within that sub-LHIN or LHIN you have a big centre and an obvious kind of focus point. And I think trying to keep it nimble, don't make it too big but just have a few effective people.

And I think it's very helpful to have somebody with acute care or emergency training in charge. Frankly treating this -- like my own mass casualty training from ICU, which I got 15

years ago and have never thankfully had to use until now, was vital. This isn't something you learn in internal medicine, in palliative care, in family medicine. We don't learn this stuff.

LEAD COMMISSIONER FRANK MARROCCO: It's not policy driven. This is action.

DR. JAMES DOWNAR: Yes. And that's -- which is necessary. I mean, policy people by their nature, and this is not a criticism, policy people need to be deliberative, they need to think, they need to send lots of drafts around, and they want to get it right before they release it.

In this moment you needed something that was a little more, let's just put something on the ground and modify as we go and sort of -- this sort of rapid cycle -- rapid cycle change in improvement. And I think it's highly effective.

KATE McGRANN: Quick question about the homes that you went into. How were they identified? How did your team know where they were to go next?

DR. JAMES DOWNAR: So we kind of had a structure based out of the region that was

connected with Public Health departments. And Public Health had obviously ready steady counts of where the positives were coming back. So we knew which homes were having positive cases among the residents and among the staff. And whenever an outbreak was declared it was like a big green light on the dashboard and they sort of deployed.

And initially a lot of the regional deployment was management and IPAC, but when it became apparent that these homes were getting overwhelmed we started to pull in the clinical groups. So we became the three-headed monster that would go in and we were separate.

We would always talk to each other because our -- like IPAC would go in and train everybody, but we were actually at the bed side seeing what they were doing. You know what? These guys need another bunch of reminders, or the PPE stations are not stocked properly, they need to be stocked better. Or they still got the giant fans. I don't know what it is with these giant fans but everybody -- in some of these units they just had fans blowing constantly and it's really concerning. So we

had to go and physically remove them because no matter how many times IPAC told them to take out the fans they just kept going with the fans.

I brought this data mostly to sort of show because I think it's helpful to have, but I was pretty happy to see that, and in sharing it with the team to show that I think we probably did have an effect.

COMMISSIONER JACK KITTS: Can you share that with us?

DR. JAMES DOWNAR: I sent my slide deck in already but I'll send it again.

COMMISSIONER JACK KITTS: I mean the document, the publication.

DR. JAMES DOWNAR: Yes, I can send you the publication, yes.

We talked about IPAC training.

I'm told that the Hong Kong nursing homes have a really good model for this, for how to actually do routine audits. And, again, I think there are probably people who know more about this than me. I'm just going to mention it, and I'm sure you've heard clever suggestions on how to achieve --

LEAD COMMISSIONER FRANK MARROCCO:

We did hear from someone from Hong Kong and I must say I've been going on like a broken record about it, but we did get some insight from them on how they handled it.

DR. JAMES DOWNAR: They've done well for themselves, there's no question about that.

One thing I would flag, which I'm not sure I've seen coming up on a lot of radar, is I actually think though that our focus on IPAC training has been on nurses and physicians. I actually think we maybe need to spend a little more time working on kitchen staff and PSWs as well. Not because I think they did a worse job or that they're not doing a good job on IPAC, it's just that the consequences of a breach when you're a kitchen staff member are much greater than the consequences if you're a physician.

So physicians, and even nurses, don't necessarily go into a lot of -- they don't do close care for everybody. But I saw a number of facilities where the management was actually really good. They were very organized, staffing was great, and all of a sudden one day they've got a few people develop symptoms, they swab and they've got 30, 40 positives. And you're

thinking, Oh my goodness, how did you get 30 or 40 simultaneous positives? You've got no visitors for three weeks how did this happen? Well the chef, the cook had COVID and he was asymptomatic.

So sometimes it's just one person -- like, it's one nurse in that building, or one PSW in that building, or one RPN, or the manager had asymptomatic COVID, maybe two or three cases, maybe a handful. But if the cook -- if the chef gets COVID and has -- or has a breach, then you can infect everybody in the building.

And also looking at simple things like the distribution of food trays and the picking up of food trays. So, you know, I'm standing in a hallway watching somebody go down and they're going into each room and trying to drop off a food tray, but they're going right to the person and going right to their bed side and coming right back out. And they can't literally regown each and every time. They're dropping off a hundred food trays. So if they touch anybody or breach at any point that's the opportunity to spread COVID to the entire building. It's that person right there. Nobody else does what that

person does. So I'm not saying that person does a bad job, but if that person makes a mistake, it's critical.

So little things like if you put just a little tray table by the door so they can drop it off, they don't even have to go in the room. They put the food tray on that table and they can drop all the food trays off on the table; then come back, gown up, go into one person's room and help them.

The person who's helping feed them just goes into that room and that's when the person actually gets close, feeds that person, then takes the tray, puts it back on the little tray table at the door, degowns and everything. And then when it comes time to pick them up you just bring the cart down, grab, grab, grab, grab. You don't go into any rooms. You just reach in, grab the tray. And examples like this.

There's probably some -- you can get somebody from Toyota, or whatever, to tell you how to do this, like at nice slick process.

These sound like tiny details but I truly believe that it would have been little

details like this that when you see the 135 cases suddenly overnight, that wasn't a visitor, and it definitely wasn't a nurse. To my mind, that could have only been related to people whose job involved going into many different rooms.

And I'm not -- please, please don't -- I don't want to be sounding like I'm going after kitchen staff or PSWs. I don't think their technique was any worse than anyone else's. It's just that they are the ones who actually physically interacted with hundreds of people.

I mentioned the cohorting issue of three and not two. I won't go into that again.

I had alluded to some suggestions for clinical care and a couple of the projects that we worked on. So one of them I really want to highlight. So again, as I'm saying, we have very, very internationally-renowned big data researchers looking at creating tools and flags to identify people who may be nearing the end of their life.

I'm working on one of those for the in-patient setting, acute care. But one of my colleagues Amy Hsu and Dr. Peter Tanuseputro,

here in Ottawa, have developed something called the "Respect" tool which is based on RAI data, so routinely collected data in every long-term care facility, and you can punch that data into a model and you can really accurately identify people's risk.

So you can pluck out the people who are at highest risk of death in the coming months, for example, and you can use that flag to drive standards of practice around end-of-life care to make sure, Okay, if you're getting -- if you're flagged by the system, let's double check your meds, and make sure you're on the right things. Let's have a nice conversation with you and your family, just to make sure that everybody's on the same page, et cetera.

You wouldn't be able to do this for everybody. It's a lot of work to do for every single person, but if you were very selective in making sure that these were parts of routine care that you would do, the same way that you would do a RAI assessment every three months, you would be doing a sort of high-risk assessment for progression or transition to end

of life and making sure that you're sort of checking a few boxes.

It helps you prepare and it helps you make sure that everyone's ready for something, so that -- and it doesn't have to be COVID. It could be influenza, it could be any number of things, or it could be none of those things and just a natural progression of a chronic illness. But it's having these automated and reliable tools that help move you to a place where you're doing it as a proper -- like this is the classic model of quality improvement and quality assurance is having routine and routinizing things that you think are important, rather than just waiting for them to sort of happen by chance or by people remembering it.

So that's a project I really want to flag.

COMMISSIONER JACK KITTS: Can you just tell us what is in the RAI data that would be helpful in doing that?

DR. JAMES DOWNAR: Gosh, Jack.

COMMISSIONER JACK KITTS: Just at a high level.

DR. JAMES DOWNAR: Let me send you --

there's a website that I can direct you to, projectbiglife.ca I think it is. But I can send you a one-pager on the actual model, but it would include a lot of things like age, co-morbidities, number of medications that they're on, assessments of other things, so like looking at transitions and changing trajectories of level of support. The number of things that they would need support doing, for example.

They're just routinely collected pieces of data that if you plug them in the computer can spot the patterns.

COMMISSIONER JACK KITTS: Yes, okay, that's very good, thank you.

DR. JAMES DOWNAR: And again, one of the class of things being a serious illness conversation, or sometimes a standardized conversation tool. And you can say, like, every time "Respect" flags you you can say, Okay, if Respect flags you as being at high risk of death in the next six months, or nine months, or pick your number, then natural processes that must occur is a series illness conversation, a sort of med safe or medication review, for example, and ensuring that a comfort medication or a set

is available, if it's consistent with a quality of -- with the goals of care of the person, et cetera.

And it's things like this that you can introduce as regular, routine parts of care and just have them driven by a reliable tool that can, I think, make a lot of difference for patients, because we're clearly missing some.

And then specifically for end-of-life skills I think there should be a very clear -- every single person, if you have a facility, your nurses and your RPNs should be -- should have some training for symptom management. Simple things like the insertion of a subcutaneous line. So this is like an intravenous line but it's -- you don't need to find a vein you can just sneak it under the skin. It's really small. It doesn't hurt. You can put it on just the back of the shoulder where the patient barely even feels it because there are fewer nerve endings back here, and you can administer all the medications you want. You can do fluids. You can give anything for comfort that way. And the nurses -- you don't need somebody to attach a needle every time. So

people who are maybe not trained to give injections can give medications through this. And it's very simple and should be, I think, uniform.

I talked about these comfort medication forms already, or comfort medication order forms, and I can give you an example if that would be helpful.

But then this study I mentioned, when we sort of flagged this as an issue. We've got a project that we're trying to get going where we're actually going to be using administrative data collected provincially to indicate how our homes are performing.

So some homes, what's the rate -- of people who die in that home, how many of them or what proportion had a symptom-management order set ordered, for example, or got medication X ordered?

And again, we don't want to sort of name and shame homes. This is really more about working with these people and saying, Okay, the provincial average is X. It probably should be almost a hundred percent, but the provincial average is X and you're here. So you'll

probably at least be here and almost certainly be here. Let's talk about why.

And we're actually going to do some studies about homes that are performing well, and identifying the factors of why using qualitative means of homes that are performing maybe a little less well, let's go in and figure out what's going on there and see if we can identify that and help to address that.

I think this is a project that could be very easily turned into a quality metric, or a provincial initiative that could lead to some really meaningful positive change.

That's all I had to talk about today, but I'm happy to answer any other questions, or if you want me to clarify anything there.

COMMISSIONER JACK KITTS: Just on that quality metric. There are quality metrics for IPAC preparedness and this is -- this is similar.

Wouldn't you say it's somebody in the home who is responsible to make sure that people are trained for the symptom management, insertion of these lines, all of this? And it could be -- but it would have to be someone who

has been tagged with that responsibility, as Commissioner Marrocco said.

We spent a long time trying to identify who is the most responsible or accountable person, and I think for palliative care and the things you've discussed that might be a very important role.

LEAD COMMISSIONER FRANK MARROCCO: A nd it can't be somebody who has this tacked on to a whole series of responsibilities.

DR. JAMES DOWNAR: Well, I would actually say that the thing about this is -- so if you're structuring it as, okay, is this a structural team? A structural intervention? Like following the Donabedian kind of model?

So this would be having an IPAC process in place, having a person, having an order sheet, et cetera. But then also tracking how often it gets used. How often are we doing audits, et cetera. And then looking at infection rates and looking at medication use as the sort of outcome of your interest.

And I think it lends itself nicely to having a metric in all three sort of piles, the sort of structure, process, outcome piles. And

I think that's really, really important.

I would say that for some of the stuff, symptom management and subcutaneous lines, I would actually suggest that maybe don't make that one person's job. That should just be the minimum bar to get hired. If you want to work here you've got to put in a subcutaneous line and you've got to be familiar with or taken a course in palliative care symptom management. Because it's actually pretty simple. This wouldn't be a lot to ask, I think, of anyone.

COMMISSIONER JACK KITTS: No, I'm more referring to someone in the house to make sure that the structure, process and practice is done, not someone to do this but someone to -- a compliance person for palliative care.

DR. JAMES DOWNAR: A champion or something. I think that's an excellent idea.

LEAD COMMISSIONER FRANK MARROCCO: And I take it this course would be like one day?

DR. JAMES DOWNAR: Oh, it wouldn't even need to be a day. There's a long-term care course offered by Palliative Care Canada, again based in Ottawa. I'm not even from Ottawa but I'm very impressed with the place.

LEAD COMMISSIONER FRANK MARROCCO: Well, we've certainly had it impressed upon us that it is a very important place.

DR. JAMES DOWNAR: It is. But again, they offer a course specifically geared towards long-term care providers on this, and there are others too. But these are not things that take a full day. You can do them -- break them up into modules. They can be done in mini courses. It's very feasible.

And a lot of us -- it can built, for example, in the U.S. now as part of your accreditation, or as part of your certification as a physician, every five years you have to undergo some type of palliative training or symptomatic training and specialties.

And I don't see that there's any reason why we couldn't potentially recommend that for our colleges, our colleges of nursing and physicians, to get licensed like once every 10 years you need to take a refresher or something like that.

LEAD COMMISSIONER FRANK MARROCCO: It wouldn't be unheard of to just have some mandatory continuing education component.

Doesn't have to take up weeks of your life. It can be two or three days a year when you have to do a certain amount of continuing education. A lot of it can be delivered to the desktop. It's fairly straightforward I think.

DR. JAMES DOWNAR: Every year, and I'm not going to embarrass Jack, my only -- so at TOH, every year I have to take these electronic learning modules, or ELMs, which every physician kind of dreads because they're very long, and some of them cover things that -- there's a hand washing ELM. And I think it's great, like I need to be able to wash my hands. Washing hands is important. Do I need to take the hand washing ELM every year? Probably not.

LEAD COMMISSIONER FRANK MARROCCO: You're starting to sound like the typical professional practitioner who's busy.

But I must say, I'm more sympathetic with the CEO of the hospital who may have mandated this as a result of previous things I did in my life.

DR. JAMES DOWNAR: My point is, I don't think this is Jack's idea to make me -- but I guess what I'm getting at is that there

are actually already well-established mechanisms for ensuring regular training in a sort of bite sized, desktop-delivered or laptop, or even device-delivered training things. And it comes -- it's trackable, you know who's done it, you know when they've done it, you don't get recertified until you've done it. It's an easy structure to build on to.

LEAD COMMISSIONER FRANK MARROCCO: And you just have to make sure that whoever owns and runs long-term care homes understand that this is part of the working day and people should be paid while they're doing their continuing education for the year; it's not something they do on their holidays.

DR. JAMES DOWNAR: That's right. And the other thing is, in all of the homes that I've been into I've never had one person even make a half of a comment or an insinuation that they didn't think that this wasn't important. Everybody recognized the importance of this. Everybody was deeply supportive, particularly the incorporation of palliative care.

Now, also to Jack's point, since April, we -- I ended up getting some more

palliative physicians in Ottawa funded by the government. And one of the people I hired actually her role is purely going to be sort of focus on enhancing palliative care within the long-term care homes within the region and work on this.

I think it's of a critical importance and everybody sees that value. So I think you're going to be pushing an open door.

LEAD COMMISSIONER FRANK MARROCCO: Well, Doctor, thank you very much.

DR. JAMES DOWNAR: Thank you. And thank you for the work you're doing, guys. It's been nice to read this stuff. I think it's such a political topic unfortunately right now.

I must say, I've been impressed by the reports you guys are putting out. They seem very balanced and not, I think, overly -- I think you guys -- the recommendations you've been making really align with what I think the people I work have seen.

LEAD COMMISSIONER FRANK MARROCCO: Well, that's encouraging to know I think for us, and we will continue on. We haven't completed our recommendations. There will be one other

report but this is very, very helpful. And thanks very much and thanks for taking the time to put this together.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

DR. JAMES DOWNAR: I'll send you the information on the Respect tool as well. I'm sorry, I meant to send that earlier but I have a one-pager on the medication audit project if that would be helpful.

LEAD COMMISSIONER FRANK MARROCCO: And I assume you have a contact for either Ms. McGrann our Executive Director or Alison Drummond, and they'll make sure we see it.

DR. JAMES DOWNAR: Absolutely.

COMMISSIONER JACK KITTS: Thanks for what you're doing too, James.

COMMISSIONER ANGELA COKE: Thank you.

-- Meeting ended 10:22 a.m.

REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing meeting was taken before me at the time and date therein set forth;

All discussions had by the participants were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and accurate transcript of my shorthand notes so taken. Dated this 12th day of February, 2021.

PER: HELEN MARTINEAU

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