

Long-Term Care COVID-19 Commission Meeting

Dr. James Downar
on Friday, February 12, 2021



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

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6	MEETING OF THE LONG-TERM CARE
7	COVID-19 COMMISSION
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15	--- Held via Zoom Videoconferencing, with all
16	participants attending remotely, on the 12th day
17	of February, 2021, 9:00 a.m. to 10:00 a.m
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1 BEFORE:

2 Frank N. Marrocco, Lead Commissioner

3 Dr. Jack Kitts, Commissioner

4 Angela Coke, Commissioner

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6 PRESENTER:

7 Dr. James Downar, Head, Division of Palliative

8 Care, University of Ottawa

9

10 PARTICIPANTS:

11 Alison Drummond, Assistant Deputy Minister,

12 Long-Term Care Commission Secretariat

13 Kate McGrann, Co-Lead Commission Counsel,

14 Long-Term Care Commission Secretariat

15 Alain Daoust, Team Lead, Long-Term Care

16 Commission Secretariat

17 Jessica Franklin, Policy Lead, Long-Term Care

18 Commission Secretariat

19 Angela Walwyn, Senior Policy Analyst

20 Long-Term Care Commission Secretariat

21 Kavi Sivasothy, Counsel, Gowling WLG

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 capacity to try to create capacity in acute
2 care.

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

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

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

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

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

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

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

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

10 LEAD COMMISSIONER FRANK MARROCCO:
11 Yes.

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

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

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

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

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

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

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

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

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

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

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

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

11 LEAD COMMISSIONER FRANK MARROCCO:
12 Okay.

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

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

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

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

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

8 DR. JAMES DOWNAR: Well --

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

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

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

1 an acute care facility the harder that becomes.

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

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

1 contaminate your vehicle.

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

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

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

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

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

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

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

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

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

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

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

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

1 important thing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 LEAD COMMISSIONER FRANK MARROCCO:

4 Doctor, before we leave this, one of the things
5 we observed early on, and we included it in one
6 of our interim reports, was the need for a
7 proper, detailed inspection process to ensure
8 that there's compliance with proper practice.

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

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

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

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

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

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

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

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

3 LEAD COMMISSIONER FRANK MARROCCO:

4 Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 LEAD COMMISSIONER FRANK MARROCCO:

7 But would you say, based on what you observed,
8 it would be fairly -- it would be clear early on
9 what this, let's call it an unintended
10 consequence of the rule, was?

11 DR. JAMES DOWNAR: Yeah.

12 LEAD COMMISSIONER FRANK MARROCCO:

13 So you have to, my words not yours, you have to
14 pivot quickly and realize you've done something
15 that you didn't intend to do?

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

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

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

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

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

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

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

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

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

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

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

25 I don't think we really had any notion

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

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

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

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

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

1 hospitals so I'm a little jealous.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So unless there are any questions,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 understandably so.

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

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

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

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

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

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

3 LEAD COMMISSIONER FRANK MARROCCO:

4 All right. But a person who's well-informed
5 about Public Health and is thinking about how
6 you plan for a pandemic.

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

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

21 LEAD COMMISSIONER FRANK MARROCCO:

22 But you would agree perhaps, you tell me, but
23 would you agree you can't be doing that and
24 dealing with a pandemic at the same time?

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

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

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

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

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

23 DR. JAMES DOWNAR: That's correct.

24 LEAD COMMISSIONER FRANK MARROCCO:
25 Anyway, thanks.

1 DR. JAMES DOWNAR: No, of course.
2 So in terms of suggestions for the
3 future, and again this is -- I hope none of this
4 is too blue sky. I tried to make them as
5 concrete as I could. But I think you really do
6 need to have formal links between long-term care
7 and local family health teams, or Ontario health
8 teams, but especially not just to family health
9 teams and Ontario health teams, but to acute
10 care facilities, right? You need to be able to
11 tap into expertise around acute illness
12 management, IPAC and staffing, and there's only
13 one place that could possibly come from, which
14 is the acute sector.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 DR. JAMES DOWNAR: And you're like --
17 I feel like you're setting me up here to -- I
18 think the -- as you are very aware, in Ottawa
19 and Champlain region we have the Regional
20 Palliative Care Team, which is a team of about
21 13 nurse practitioners and advanced practice
22 nurses that cover the entire region according
23 to -- just actually they're geographically
24 distributed. And their job is to support family
25 doctors in the homes. We're doing home visits

1 and patients at home followed by community
2 practicing GPs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. JAMES DOWNAR: This is what we
23 did.

24 COMMISSIONER JACK KITTS: Okay.

25 DR. JAMES DOWNAR: This is what we

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

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

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

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

25 COMMISSIONER JACK KITTS: So what

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

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

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

17 DR. JAMES DOWNAR: Correct.

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

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

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

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

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

1 operating.

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

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

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

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

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

5 LEAD COMMISSIONER FRANK MARROCCO:

6 It's not policy driven. This is action.

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

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

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

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

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

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

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

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

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

9 COMMISSIONER JACK KITTS: Can you
10 share that with us?

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

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

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

17 We talked about IPAC training.

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

25 LEAD COMMISSIONER FRANK MARROCCO:

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

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

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

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

1 thinking, Oh my goodness, how did you get 30 or
2 40 simultaneous positives? You've got no
3 visitors for three weeks how did this happen?
4 Well the chef, the cook had COVID and he was
5 asymptomatic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. JAMES DOWNAR: Gosh, Jack.

23 COMMISSIONER JACK KITTS: Just at a
24 high level.

25 DR. JAMES DOWNAR: Let me send you --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 I think that's really, really important.

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

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

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

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

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

1 LEAD COMMISSIONER FRANK MARROCCO:

2 Well, we've certainly had it impressed upon us
3 that it is a very important place.

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

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

17 And I don't see that there's any
18 reason why we couldn't potentially recommend
19 that for our colleges, our colleges of nursing
20 and physicians, to get licensed like once every
21 10 years you need to take a refresher or
22 something like that.

23 LEAD COMMISSIONER FRANK MARROCCO:

24 It wouldn't be unheard of to just have some
25 mandatory continuing education component.

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

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

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

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

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

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

9 LEAD COMMISSIONER FRANK MARROCCO:

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

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

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

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

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

10 LEAD COMMISSIONER FRANK MARROCCO:

11 Well, Doctor, thank you very much.

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

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

22 LEAD COMMISSIONER FRANK MARROCCO:

23 Well, that's encouraging to know I think for us,
24 and we will continue on. We haven't completed
25 our recommendations. There will be one other

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

4 COMMISSIONER JACK KITTS: Thank you.

5 COMMISSIONER ANGELA COKE: Thank you.

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

11 LEAD COMMISSIONER FRANK MARROCCO:

12 And I assume you have a contact for either
13 Ms. McGrann our Executive Director or Alison
14 Drummond, and they'll make sure we see it.

15 DR. JAMES DOWNAR: Absolutely.

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

18 COMMISSIONER ANGELA COKE: Thank you.

19 -- Meeting ended 10:22 a.m.
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25

1 REPORTER'S CERTIFICATE

2
3 I, HELEN MARTINEAU, CSR, Certified
4 Shorthand Reporter, certify;

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

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

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

14
15 
16

17 PER: HELEN MARTINEAU
18 CERTIFIED SHORTHAND REPORTER
19
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