# Long Term Care Covid-19 Commission Mtg.

Fero International Inc.
on Thursday, November 26, 2020


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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending remotely, on the 26th day of November, 2020, 9:00 a.m. to 9:40 a.m.

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BEFORE:

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

PRESENTERS:
Sabrina Fiorellino, Chief Executive Officer,
Fero International Inc.
Alex Scopacasa, Chief Operating Officer
Fero International Inc.

PARTICIPANTS:

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

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 9:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, our -- I guess we're all here.

Alex, is it?

ALEX SCOPACASA: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So are you -- are you the person -- are you the person we're interviewing today?

ALEX SCOPACASA: It's Sabrina and myself, correct.

COMMISSIONER FRANK MARROCCO (CHAIR): How do you do? Good morning.

SABRINA FIORELLINO: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm Frank Marrocco. I'm one of the Commissioners. There's Dr. Jack Kitts --

COMMISSIONER JACK KITTS: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): -- and Commissioner Angela Coke. Janet is our court reporter, so she'll take down what goes on, and there's a transcript.

So I think you know, generally, the issues that we've been dealing with. We're looking back at what happened in Wave 1 as far as long-term care homes are concerned and more importantly,

looking forward to see if there are recommendations that we should be making to try to prevent a reoccurrence of that. We made one interim report. We may make and probably will make a second one before the end of the year.

So we're, you know, interested in -- one of the issues that presents itself is how you -- how you deal -- how you deal with homes that get into this kind of a situation, what are your opportunities to create a safe space on a temporary basis where you can remove people, and so on. So that's what we're about, and we're all here.

We tend to ask questions as we go along, if that's okay, rather than wait. You may be on -- you may be on mute.

ALEX SCOPACASA: Oh, we're -- can you hear us?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I can hear you now. So, you know, I think we're ready when you are.

SABRINA FIORELLINO: Perfect. Yeah, our preference is also for you to interrupt us as much as possible so it can be more of a dialogue. Just a note, just so we don't -- you understand we're actually -- we do practice social distancing

and masking, but we're in a bubble of two, so that's our full bubble, and that's why we often present together in the same room.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I assumed that, actually.

SABRINA FIORELLINO: So just a bit of background before we start, my name's Sabrina Fiorellino. I'm the CEO of FERO. My background, I'm a lawyer by training. I did several years on Bay Street in mergers and acquisitions, but a serial entrepreneur. My previous company was in construction. I've been in a number of different fields.

But when the pandemic broke and turned the world upside down, I decided, with a group of partners, that we had to do something to help. So it touched my family and continues to touch my family in a particular way. My mom is a double lung transplant recipient who is immunocompromised. Hospital, obviously, shut down transplant, and she couldn't go to her appointments. And I fully understood if she was at the wrong place at the wrong time, she wouldn't have gotten her transplant.

My brother's an anaesthetist. My

sister-in-law's a frontline worker. They have a baby at home, and, obviously, we -- family can't see each other under those circumstances.

My grandfather also, unfortunately, passed during the first wave in hospital. It was his first hospital admission, and I couldn't stay with him. And obviously, that was quite difficult for me.

I'll let Alex introduce himself, and then we can get into our slide deck and, you know, happy to field questions along the way.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine.

ALEX SCOPACASA: Hi, everyone. My name is Alex Scopacasa. I'm the CEO at FERO International. I have a background in project management and operations managements. I actually worked for Sabrina for a number of years and started -- started with FERO with her as well.

SABRINA FIORELLINO: Thanks. So I'm just going to go through the first few slides quickly. I think you understand the challenges even more than we do. We know the Canadian health system, both long-term care and acute care, is struggling to keep up with increasing changing

demands. Obviously, the pandemic has tested the limits of the system, and we understand there's been heroic efforts made by, you know, frontline workers in acute care and long-term care, but we just don't have the capacity to provide best possible care when faced with this kind of crisis.

And with limited beds and multiple outbreaks in LTC homes and other congregate living settings, you know, we tried to develop a solution to quickly and safely increase capacity where it's critically needed to protect frontline workers, and above all, obviously, to ensure residents can safely and effectively receive the care that they need.

So what we do is, instead of trying to fit residents or patients into existing infrastructure that just doesn't work under the current circumstances, we create flexible infrastructure that can be flexible around residents' changing needs.

We created by hard shell, scalable mobile units, and we have breakthrough technology to support long-term care and acute care.

We -- our hard-shell units have everything needed for high quality and comfortable

resident care, and we help to mitigate cross-contamination within congregate living during an outbreak so residents can be effectively cared for while keeping frontline workers and fellow residents safe.

The other thing that we've done is constantly collaborate with the frontlines to develop new solutions and to adapt our existing offerings to meet their needs. So we've had a number of meetings with acute-care providers and long-term care providers and associations to ensure that our solution is what they want because they're the frontlines, and they know better than we know.

Our units themselves, so this is -- we create them out of shipping containers. We can create custom enclosures, but because shipping containers are the most cost efficient, we start with that. They're also the most scalable and rapidly deployable. The units are pressurized, so -- and they're meant to help with surge capacity and bed shortages to deal with outbreaks. I think some of the countries that have been most successful in dealing with LTC outbreaks have decanted their homes, and so we've tried to create a solution that allows for rapid decanting where

and when needed.

The units can serve as isolation to accommodate infections where there's space constraints and that design requirements of the existing infrastructure limit the ability of operators to separate infected residents from those who are well. For some residents, this can eliminate the need to transfer the residents to hospital. Units, obviously, can be customized for a large variety of uses, and we can create full-scale nursing stations, communications capabilities, and more.

And our goal is always to work with long-term care operators as well as acute-care hubs and government to produce tailored solutions to challenges in relation to both physical space and staffing.

ALEX SCOPACASA: So a little bit about our units and the capacity of our units: Each proposed unit would provide approximately 600 square feet to each -- to two residents, and they actually are separated from one another. The units can be scaled up or down to a fully connected solutions to ensure residents are isolated safely and comfortably. So what we --

COMMISSIONER FRANK MARROCCO (CHAIR): Excuse me, Alex. Is each unit -- how many -- like, one person per unit, or how does that work?

ALEX SCOPACASA: The units actually interconnect using our proprietary technology to provide a larger living space. So you're not just putting one resident in one unit. We're interconnecting the units to provide a large living space.

SABRINA FIORELLINO: I think -- I think what you were getting at, Frank, is do we put multiple residents in the same unit, and the answer is no. Each unit has their -- each resident has their own space, and the way our system is created is that each unit has their own HVAC, which we'll get into, but I'll just address it now since you raised it.

Our HVAC does up to 30 air exchange an hour, so we exceed CDC requirements, and there's no cross-flow of air between any of the resident rooms. That was extremely important for us to ensure that if -- you know, we try to decrease viral load as much as possible and ensure that even if there's only sick residents in these units, frontline workers continue to be safe and the air

doesn't spread throughout the unit to make sick residents sicker.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

ALEX SCOPACASA: Yeah, so going from that point there, just continuing on, unless there's any other questions?

COMMISSIONER JACK KITTS: Well, let me -- let me see if I understand. So I think the picture there has -- looks like three units -- three separate units joined by one walkway. And in each of those units, each of those units is 600 square feet, and you have two people in a unit; is that right?

SABRINA FIORELLINO: Oh, I will -- maybe what -- I'm just going to go down through the slide deck so I can show you, and then we'll go back up.

Okay. So here's a more zoomed-in picture you can see. So on the right, you see a hallway in between. On the right side of the hallway, there's two resident rooms here.

Each of the resident rooms is 300 square feet, so 600 square feet together.

COMMISSIONER JACK KITTS: Yeah.

SABRINA FIORELLINO: Each resident room has a bedroom and a living room and a washroom. However, the air between those resident rooms doesn't cross between the two rooms. Each of those rooms has its own HVAC. Each of those rooms achieves 30 air exchanges an hour. Each of those rooms is independently temperature controlled from minus 50 to plus 50 and dehumidified.

ALEX SCOPACASA: Yeah, so these -- this room here, there's a dividing wall in the centre of these units. The HVAC units are all serviced from the outside, so you have your electrical room and your HVAC room serviced from the exterior, and each of these resident rooms has its own HVAC and electrical room that gets serviced (phonetic) from the outside so there's no air that ever crosses between each room.

SABRINA FIORELLINO: Is that -- is that more helpful?

COMMISSIONER JACK KITTS: There's four patients in a square there?

SABRINA FIORELLINO: That's right.

COMMISSIONER JACK KITTS: Yeah.

SABRINA FIORELLINO: But all independent air handlings per each room.

ALEX SCOPACASA: Yeah.

COMMISSIONER JACK KITTS: And is that square the 600 square foot unit?

SABRINA FIORELLINO: No. Each resident room is 300 square feet, so this would be -- in this iteration, you have, I believe, 40 feet by 40 feet.

ALEX SCOPACASA: So you have 1, 2, 3, 4, 5 containers connected together. There's a wall that is a completely open concept here, so there's no dividing wall between here. There's just a dividing wall to separate the actual residents.

SABRINA FIORELLINO: They're like a real room, as an example. It's a real 300 square foot, like we mentioned, with its own HVAC.

COMMISSIONER JACK KITTS: Okay. As we go forward, are we talking about just the two beds and the HVAC? Is that the unit -- is that the unit you're going to be talking about? Or are you going to be talking about the whole square?

SABRINA FIORELLINO: No. So we can -- I can show you if we go down. So this is what a solution could like look when you put units together to create a full, let's say, decanting solution. So the idea would be to -- for example,

we partner with the University Health Network to test our units to ensure they're safe for use, so both Toronto General and Toronto Western, both on the acute-care side and the long-term care side.

And so the idea is, for example, the UHN has 15 long-term care homes. We would find a central location to put down our hub where any COVID-positive resident from any one of those homes could be decanted into one of our spaces, and then we'd work with UHN and maybe the MEST teams to staff the units to ensure there's a manager on site, a physician, and then appropriate nurse -- nursing staff. We have our own staffing solution as well, but understand that we need to work with both acute care and long-term care to make it work effectively.

COMMISSIONER FRANK MARROCCO (CHAIR): So when -- so when you put -- and I don't want to get ahead, you know, if you want me to wait with the question, just say so.

SABRINA FIORELLINO: No. Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): But -- so when you put the unit down, one unit, it will create two spaces that function as two separate rooms would function in a hospital?

SABRINA FIORELLINO: That's right. Completely separate, complete -- the air is completely separate.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

SABRINA FIORELLINO: Yeah, you got it.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

SABRINA FIORELLINO: You got it.

COMMISSIONER ANGELA COKE: So just -- sorry, just to confirm what I'm seeing, so there's the bedroom, and then there's some sort of living area; is that what you said?

SABRINA FIORELLINO: Yeah.

COMMISSIONER ANGELA COKE: Okay.

SABRINA FIORELLINO: We can create it any way required. If it's only bedrooms that are required, we can create that and put patient lifts in all of the bedrooms and whatever equipment is required.

If we require bedroom and living room and washroom, we can create that. If we require nursing station or supply rooms, clean and soiled utility rooms, those are easy for us. It's almost like Lego blocks because they're separate air

handling for each unit. So the beauty is we can also scale up and scale down where outbreaks exist, so we can receive a phone call and say we need four resident rooms tomorrow; and then, you know, ten days later, we need another six resident rooms because the outbreak is getting worse, we can deliver those and connect them, and then we can scale down in the same manner.

COMMISSIONER ANGELA COKE: So, sorry, just one other thing: You mentioned that you also have a staffing solution. Is that an HR supply agency or something that goes with it?

SABRINA FIORELLINO: Yes, that's right, but I think we would still need to work with, you know, the LTC provider, the acute care hubs, potentially a MEST team to make sure that there's proper management, there's at least one physician; and our recommendation would always be to have dedicated staff servicing this unit also to ensure that there's no cross-contamination through staffing.

COMMISSIONER ANGELA COKE: Okay. Thank you.

SABRINA FIORELLINO: You're welcome.

ALEX SCOPACASA: I'm just going to back

up to where we were just to continue off there.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

ALEX SCOPACASA: So as we were saying, so each resident will be isolated from one another, and then residents will actually be able to communicate with their families through sophisticated video-conferencing software or in person through large transition privacy glass windows while the patients -- while the residents or patients are being safely isolated.

So you can't see it in this render iteration, but in each resident room, there will be a large transitional privacy glass window that will allow for in-person visitation. Once you clear the glass up, you can see the person on the other side, and then we've also made it safe for residents to visit because not only is our air HEPA-filtered coming in, but also, it's -- the exhausted air is HEPA-filtered as well, so no visitors are getting sick walking by the units from the air.

COMMISSIONER FRANK MARROCCO (CHAIR): So you filter the air as it comes in, and you filter the air as it goes out.

ALEX SCOPACASA: Yes.

SABRINA FIORELLINO: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ALEX SCOPACASA: And then we had mentioned part of our proprietary technology is that each room has two independent rooms that can be pressure controlled separately. So in a hospital setting, you can have one room acting as a negative -- in negative pressure, the other room beside it acting in positive pressure so you can be doing a procedure on one side and then have an ICU bed on the other side in -- or any long-term care home, you can have both units acting in negative pressure.

So this is a unique technology that's available through our proprietary technology that's not available in Ontario health facilities right now, only in our facilities.

So the units can be cooled and heated to accommodate Canadian weather fluctuations, as we mentioned, plus 50 to minus 50, and it also includes dehumidification, so we're able to handle the Canadian extreme weather fluctuations. And I mentioned that the air is filtered, incoming and exhausted, and we can achieve up to 30 air

exchanges per hour in our units.

On the interior of our units, we have all medical-grade finishes, no seams, no drywall, and making the units very easy to clean and sterilize in the hospital settings or in long-term care settings. So we don't use any drywall, any wood. All our wall is green-grade powder-coated aluminum to allow for high flash points of over 2,000 degrees to making it very fire retardant, and obviously, all these seams -- there's no seams in the rooms to allow for infection control.

SABRINA FIORELLINO: So -- in what we always propose to deliver in a long-term care setting is resident rooms that, obviously, don't look like this but look like real room rooms, like bedrooms and living rooms and are just as comfortable as an existing home would be.

But we would propose to deliver also some treatment rooms where more aggressive treatment could be provided to avoid having a resident go to hospital where, you know, they could do vitals every hour and provide some additional level of care if they could avoid the hospital visit.

So in these type of rooms that, like I

mentioned, UHN's tested, there's oxygen suction, medical gas lines available. We have hospital-grade headwall units. Throughout our whole system, all of our electrical outlets operate on independent circuit breakers so you can't overload any outlet.

We also have a dedicated UPS backup system to ensure that equipment's not affected by any external power failures. As Alex mentioned, we have a wireless communication system for residents and frontline workers to communicate with resident families and remote medical professional access to residents by camera and monitoring capability which assists when there's limited staff.

So you --

COMMISSIONER FRANK MARROCCO (CHAIR): Does that -- you can also -- you could also do that not just where you needed physicians but with any kind of staff.

SABRINA FIORELLINO: That's right. Yeah, they could --

COMMISSIONER FRANK MARROCCO (CHAIR): Could it be organized in such a way that if, say, my father was in one of those units, that -- and I was at home on the Internet, that I could, sort of,

take a look and make sure that he was okay and then go off and --

SABRINA FIORELLINO: Yeah, we'd create a secure login for family that would be verified ahead of time that would allow family access with resident consent or if a resident is unable to give that consent so long as there was -- you had the Power of Attorney for personal care --

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

SABRINA FIORELLINO: -- for example, gave consent, then we could allow secure access to that.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So then in terms of checking on the welfare of the family member or the loved one, you could do it yourself randomly as long as you had an Internet connection.

SABRINA FIORELLINO: That's right. Yeah, that's right. So I think we've already mentioned the units can be scaled up and scaled down. If we have a fleet of units ready to deploy, they can be operational within hours. They require minimum-type site preparation, so -- and we -- we've done that intentionally to ensure that

there's not a hundred workers on site who are going to get sick, that they can be connected and up and running very quickly and easily. And we can accommodate a broad -- a broad variety of medical needs such as entry units, hallways, anterooms, nursing station, pharmacies, medical gas, pour generation units, utility rooms, restrooms.

We can, obviously, rapidly deploy anywhere in Ontario with truck, train, or plane, and like I mentioned, we require minimum time to install. Our units are all prefabricated. We've created the collaborations with some of the biggest medical device suppliers in the world, and we don't take a markup on any of those supplies. It's just a pass-through for us, but it's so we can provide a turnkey solution to ensure that we can streamline the process.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just interrupt you? And sorry to keep doing this.

SABRINA FIORELLINO: No problem.

COMMISSIONER FRANK MARROCCO (CHAIR): But I want to make sure I understand this. If you have the container --

SABRINA FIORELLINO: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- then you said you can deploy virtually immediately. What does that mean in terms of if somebody called you this morning at 9 o'clock, you had the container available, how quickly can you -- can this happen?

SABRINA FIORELLINO: So 24 to 48 hours. Obviously, if it's, like, a 35-bed or 36-bed solution, it takes some amount of time. It's literally us loading it onto a truck or multiple trucks; driving it to site; taking the crane; putting it down on site; connecting them together which takes less than 15 minutes; and then connecting either to generator power or site power, to municipal water or our own septic system, above-ground septic system; and then, if required, connecting to mini-bulk gas systems, so it's actually meant to be rapid, as rapid as you can get for a modular solution.

COMMISSIONER FRANK MARROCCO (CHAIR): Is it -- is it difficult -- is the supply of containers difficult?

SABRINA FIORELLINO: So there are some difficulties worldwide in container supply, but we've gone to great lengths to secure a supply of

containers. Our issue is that we need to be able to build them ahead of time. You know, at full ramp up, we ourselves can build 60 rooms a month. We've created a network of other manufacturers in Ontario who can get us up over a hundred rooms a month, but we do need ramp-up time to get there.

And so until we're able to build units ahead of time, it takes some time for us to build before we deploy. Once they're built, we can deploy immediately.

COMMISSIONER FRANK MARROCCO (CHAIR): We had here the President of the Hospital in Windsor, and he was explaining how they took an auditorium and created a hundred rooms. So if you were going to -- if you were using your system, and you wanted to create a hundred rooms, can you -- can you give me an idea of how long that would -- that would take? Assume you had the land --

SABRINA FIORELLINO: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): -- next to the -- next to the hospital. There's land there. How long are we talking here?

SABRINA FIORELLINO: So from not having built any units, I would say three months, three months to get down the hundred rooms and have them

operational.

COMMISSIONER FRANK MARROCCO (CHAIR): And if you have units?

SABRINA FIORELLINO: I would say less than a week.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So that would be 50. You would need to have had 50 units?

SABRINA FIORELLINO: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. And do you always have an inventory of units, or no?

SABRINA FIORELLINO: No. So one of the things, you know, we've been looking for is for government to stockpile the units, so for them to fund a government stockpile that we can build and maintain and deploy for them if and when required.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

Commissioner Kitts.

COMMISSIONER JACK KITTS: For a hundred beds, you'd need 50 units, right?

SABRINA FIORELLINO: Correct. Correct.

COMMISSIONER JACK KITTS: I gather you don't go vertical with these.

SABRINA FIORELLINO: We do. We do go vertical. The only limitation to vertical stacking is that we would have to put in an elevator, and so it would slow down our install time. So our preference is to stay horizontal, but if we need to go vertical, we can. We just need TSSA to approve the elevator system.

COMMISSIONER JACK KITTS: I'm just trying to imagine how big a hundred beds would be all on the one level. Is there -- how big is that?

SABRINA FIORELLINO: So every, let's say every unit, which is two rooms, is a footprint of 8 by -- oh, sorry -- 40 by 16, so then you can extrapolate from there.

COMMISSIONER JACK KITTS: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): How -- well, let me -- maybe you can extrapolate from there.

SABRINA FIORELLINO: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): But I would be here all day --

COMMISSIONER JACK KITTS: That sounds like --

COMMISSIONER FRANK MARROCCO (CHAIR): -- attempting to extrapolate from there. How big

an area would you need if you were going to -- if you were going to build a hundred -- if you were going to create a hundred beds? And let's assume you were going to do them side by side rather than vertically. How big an area are you talking about?

SABRINA FIORELLINO: So what we can do -- so 600 square feet times a hundred beds, right?

ALEX SCOPACASA: So depending on, obviously, the facility.

COMMISSIONER FRANK MARROCCO (CHAIR): 60,000 square feet, then?

SABRINA FIORELLINO: That would be 60,000 square feet plus if you require nursing stations or communal washrooms, et cetera, so that's what you would hit, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): You would hit 60, or you would be in excess of 60?

SABRINA FIORELLINO: We'd be in excess of 60.

COMMISSIONER FRANK MARROCCO (CHAIR): So a hundred? Seventy-five?

SABRINA FIORELLINO: I would say less than a hundred. I would say 70, 75.

COMMISSIONER FRANK MARROCCO (CHAIR):

So that's the -- that's the piece of land that I'd have to have is this 75,000 square feet.

SABRINA FIORELLINO: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): And then I could get -- how -- all right. I'll ask -- okay. Fine. I got it.

SABRINA FIORELLINO: All right. Yeah. We can -- we can essentially do it, for example, on a football field or something that's available that's central. So, for example, I'll give the UHN example. They have 15 homes. We find a football field that's sort of central to all of those 15 homes, and we would put it there, and that would be fine for us.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. All right. I actually was thinking of football fields. A lot of schools have them and so on. Anyway, okay.

SABRINA FIORELLINO: So we -- I think we had mentioned that, you know, we've created -- we've ensured that we have also a supply of medical equipment so that we can deliver that, things like patient lifts, et cetera, that are required in the units. We're, again, fully -- we can be fully operational at any location, you know, of

government or an LTC provider can offer.

Again, I think we mentioned this, that we're highly customisable to accommodate unique needs of each home or each hub, and we can connect to existing facilities if required or be completely standalone. So if there's an existing facility that just needs a few beds, we can create a hallway module to connect to that facility and add a few beds. But if we need a full decanting solution, we can do that too. I think we showed you these renders.

ALEX SCOPACASA: So, yeah, to add to the point of the question of square footage and everything, we can -- we can expand these units in any direction either vertically, horizontally, out to the side, any footprint that is required, anywhere from a 20-bed to a 40-bed and depending on the facilities that are required as well. If they're washrooms or staffing rooms or clean and soiled utility rooms, we would be able to, you know, deploy, let's say, the 30-bed solution in different areas to act as the general hub for a certain amount of facilities to isolate.

COMMISSIONER JACK KITTS: So are you saying that for functionality, because I can't

imagine a hundred bed horizontal, that the walk from one end to the other would be terrific, so you said you -- you'd mentioned 20 to 40-bed units. Is that what you're thinking, then, the right size is for these?

SABRINA FIORELLINO: So the one you see here is 36 beds.

COMMISSIONER JACK KITTS: Okay.

SABRINA FIORELLINO: And so what we can do -- and we would never, sort of, have a situation where we'd build them all in a row. We'd, sort of, build down here, and there would be hallways coming through this way and up here again, so it's not too long. It's, sort of, almost like a full square with hallways going vertical and horizontal, so you're never -- you'll never have that long walk from all the way from one end to another.

COMMISSIONER JACK KITTS: That sounds good. Thank you.

SABRINA FIORELLINO: You're welcome. So FERO, obviously, can't do this on its own. You know, we need, sort of, collaboration from government and otherwise. I think we believe that a well-thought-out emergency strategy is required now. We believe COVID-19 will be with us for some

time and that long-term care homes require assistance even post-pandemic due to bed shortages in the entire health system.

We believe, especially, that a collaborative approach is required between long-term care and acute care, and we believe that this idea requires socialization to ensure all parties are on board to work collaboratively and create uniform standards across areas of overlap between acute care and long-term care.

From a safe infrastructure perspective, FERO is able to act as a hub and move COVID-positive residents out of homes as well as take pressure off emergency departments. So FERO can provide units that treat residents that require additional medical support where vitals can be taken every hour and where aggressive treatment can be provided without sending residents to hospitals.

And in that manner, we can act as both an input and an output, so we can act to decant residents' homes and to move residents out of hospitals into FERO units before they're ready to return to their homes.

As we mentioned before, we're able to provide some staffing, but understand that a

collaborative approach is required which ensures strong managers are present. We, obviously, recommend that existing homes assign designated staff including physicians and nurse practitioners to work in the FERO hubs. We can work with long-term care homes and acute-care hubs. We can assist with providing clinical managers and logistics.

We've already had these conversations, so we're just letting you know what we think based on our conversations. And we can ramp up and ramp down, so as fast as we can add beds, we can remove them and move them to different sites if required. We also believe that MEST or the Mobile Emergency Support Team could be moved into a FERO unit as the MEST teams include managers.

Overall, we understand that there's difficulty in filling management roles in the sector but that this endeavour requires strong decisive leadership to make strategic and just-in-time decisions proactively. And we also believe Ministry of Health and Ministry of Long-Term Care need to work collaboratively and closely with one another and with long-term care and acute-care providers for any solution,

including FERO's, to be successful.

COMMISSIONER FRANK MARROCCO (CHAIR): So how mobile -- how mobile is it? Let's assume you created this 36-bed facility in Kingston, only they don't have any cases. There's been a mistake; people mistakenly thought there would be, and there aren't, but there's a problem somewhere else, and so somebody wants to move the whole thing. How long would something -- how long does that take? I appreciate it depends on the distance, but how long does that take?

SABRINA FIORELLINO: Less than a week for sure.

ALEX SCOPACASA: So it's just a matter of us disconnecting the units and then putting them on a truck and shipping them out to the next site.

So the great thing about our units is, like you said, if someone made a mistake and, you know, they don't have as many cases as they thought they would, they can decrease on a bed-by-bed basis, so rather than putting up fixed infrastructure like a tent, let's say a hundred-bed tent, and then that -- that site requires an extreme amount of onsite trades to be present in order to put up that tent and that infrastructure,

to take that -- to set that up and take that down requires several weeks to mobilize and demobilize; whereas our solution requires, you know, such -- much less time to mobilize and demobilize.

SABRINA FIORELLINO: I think the other thing is we don't have to fully demobilize. As an example, if there's still, you know, let's say, ten residents that require care, we can leave five units and move the rest somewhere else, so it's very flexible in that manner.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. So you could -- in the example I gave, you could leave a few units in Kingston just in case if that were the consideration, move the rest of them there because it's all -- they're all detachable.

SABRINA FIORELLINO: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I know that this is kind of an odd, awkward question, but is -- can you give me a sense of what the cost of what you're -- a person's looking at if they decided they wanted to do this?

SABRINA FIORELLINO: Sure. So our rooms range from a hundred thousand to 300,000, 300,000 being the most sophisticated ICU room that runs oxygen suction and medical gas lines,

et cetera. You know, our visitation pods, obviously, are much less expensive than that if, you know, it was only a visitation pod that was required, but we're --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I was thinking more of a situation where you had residents in a long-term care facility who've tested positive, and you wanted to remove them to -- if -- in the interests of containing the spread of the disease, so that kind of a unit. What -- where is that on the range that you were talking?

SABRINA FIORELLINO: That's closer to the hundred-thousand-dollar range for sure. It also depends on if negative pressure is required, if you require that pressurisation or not. If the pressurisation is required, it's a bit higher than the hundred-thousand-dollar mark. If not, we can -- we can stay closer to the hundred-thousand-dollar mark per room for sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts.

COMMISSIONER JACK KITTS: Is that a hundred thousand per one pod which has two beds?

SABRINA FIORELLINO: It's per room, so

it's 200,000 per pod.

COMMISSIONER JACK KITTS: Okay. So 200,000 per pod, and do you -- do you -- do you have -- the purchaser buys it. Do you lease them?

SABRINA FIORELLINO: We do lease them absolutely, sell, lease, finance, et cetera.

COMMISSIONER JACK KITTS: And what about other people in your market that are not healthcare? Do these have a use -- like, you say they're flexible, so they don't need to be hospital beds.

SABRINA FIORELLINO: Yes.

COMMISSIONER JACK KITTS: They could be something else. Do you have a market for that as well?

ALEX SCOPACASA: We could provide -- so we -- not only does our infrastructure do hospital beds and provide facilities for long-term care, but as a stockpile, if government were to purchase them, we could repurpose them for infrastructure in remote communities or Indigenous communities where the infrastructure is lacking. We can also use them for, you know --

SABRINA FIORELLINO: Social housing.

ALEX SCOPACASA: -- social housing,

schools, correctional facilities, and the list goes on. And I can let Sabrina talk more about that.

SABRINA FIORELLINO: Yeah, the idea was always that COVID was limited, and so we understand that the need is now and there may not be a need, let's say, a year from now, but they could be repurposed in a number of manners including to deal with ALC bed shortages, temporary shortages for LTC beds, also to deal with surgical backlog to repurpose for infrastructure in Indigenous or remote communities for social housing for the homeless, et cetera, so -- or they could be stockpiled by government like a civilian stockpile similar to a military stockpile where they could be deployed for future pandemics or natural disasters or mass casualty events.

COMMISSIONER JACK KITTS: That's excellent. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): The -- have you had an opportunity to demonstrate in a long-term care facility or situation the -- how efficient this is?

SABRINA FIORELLINO: So not yet. Like, I had mentioned, we've partnered with the University Health Network both on the acute-care

side and the long-term care side. You know, we've requested funding from government so that we could deploy the units to UHN so they can be used in a clinical setting on the long-term care side and the acute-care side so we can demonstrate how effectively they work.

COMMISSIONER FRANK MARROCCO (CHAIR): And in terms of how effective they can work, UHN is obviously satisfied that they would fulfill a need for UHN, or they would never have entered into the agreement with you in the first place.

SABRINA FIORELLINO: Yeah, they've sent us a written report that said that the units are suitable for use. They've either sent that to government or are in the process of sending that to government, so, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, is there -- I don't know that we have any further questions. I -- on behalf of us all, I thank you for this because this is a, sort of -- this is a concrete example of -- in the context in which we're functioning, a short-term solution to -- or a potential solution to a problem that we have been confronting all the way along both in terms of a need to deal with people who are COVID

positive, and also there's this ongoing issue of the shortage of the -- a number of beds and an anticipated shortage -- an anticipated worsening situation over the next few years as the baby-boom generation gets older.

So this is very informative from our point of view, and thank you both very much for a very helpful presentation.

SABRINA FIORELLINO: Thank you, Commissioner Marrocco, and to the rest of the Commissioners as well for giving us the opportunity to speak with you today.

ALEX SCOPACASA: Thank you, guys.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Good-bye now.

SABRINA FIORELLINO: Bye-bye.

-- Adjourned at 9:40 a.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 27th day of November, 2020.

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