

Long Term Care Covid-19 Commission Mtg.

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



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9 Dr. Fred Mather, President of OLTCC;

10 Dr. Evelyn Williams, Past President of OLTCC;

11 Dr. Benoit Robert, Vice President of OLTCC;

12 Dr. Rhonda Collins, OLTCC Director.

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14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat;

19 John Callaghan, Counsel, Long-Term Care Commission

20 Secretariat;

21 Derek Lett, Policy Director, Long-Term Care

22 Commission Secretariat;

23 Lynn Mahoney, Counsel to the Ministry of Health and

24 Long-Term Care;

25 Ida Bianchi, Counsel, Long-Term Care Commission

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

4
5 ALSO PRESENT:

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

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, good afternoon, everybody.

5 DR. RHONDA COLLINS: Good afternoon.

6 DR. EVELYN WILLIAMS: Hi.

7 DR. FRED MATHER: Good afternoon.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

23 COMMISSIONER FRANK MARROCCO (CHAIR):

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

25 DR. FRED MATHER: Good. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

1 Thank you.

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

4 Ben, you're on mute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 The OLTCC's value statement is:

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

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

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

1 and education.

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

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

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

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

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

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

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

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

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

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

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

4 And the next slide.

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

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

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

23 Thank you.

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

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

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

6 Recommendation for the inquiry states
7 that:

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

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

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

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

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

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

13 THE REPORTER: Doctor, you're muted.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Thank you.

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

11 DR. RHONDA COLLINS: So --

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

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

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

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

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

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

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

14 COMMISSIONER KITTS: They are.

15 DR. BENOIT ROBERT: Yeah.

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

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

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

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

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

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

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

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

21 COMMISSIONER KITTS: Okay. Thank you.

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

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

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

3 DR. FRED MATHER: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 they worked in more than one location.

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

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

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

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

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

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

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

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

18 Okay. Rhonda?

19 DR. RHONDA COLLINS: Thanks. So --

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

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

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

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

19 COMMISSIONER KITTS: Thank you.

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

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

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

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

9 DR. EVELYN WILLIAMS: Oh...

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

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

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

18 DR. RHONDA COLLINS: I --

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

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

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

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

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

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

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

25 But we felt --

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

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

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

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

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

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

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

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

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

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

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

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

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

7 COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

16 DR. EVELYN WILLIAMS: The facility.

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

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

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

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

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

12 COMMISSIONER KITTS: So they're --

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

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

18 COMMISSIONER KITTS: Thank you.

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

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

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

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

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

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

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 COMMISSIONER KITTS: Dr. Mather?

14 DR. FRED MATHER: Yes.

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

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

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

1 even without a crisis?

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

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

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

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

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

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

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

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

12 COMMISSIONER KITTS: Thank you.

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

14 DR. FRED MATHER: Yes, please.

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

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

25 And so being able to communicate with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 psychogeriatric.

2 DR. BENOIT ROBERT: Yeah.

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

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

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

19 COMMISSIONER KITTS: Okay. Thank you.

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

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

1 second wave?

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

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

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

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

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

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

5 (BRIEF INTERRUPTION)

6 I'll get rid of that phone.

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

9 DR. EVELYN WILLIAMS: Right.

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

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

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

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

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

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

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

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

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

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

25 The ones that overlook are being used

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Okay.

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

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

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

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

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

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

1 full capacity, as a potential strategy.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Okay.

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

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

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 M-hm. Okay.

3 COMMISSIONER KITTS: Dr. Mather?

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Yeah.

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

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

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

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

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

5 COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

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

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

19 DR. FRED MATHER: Thank you.

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

22 -- Adjourned at 5:20 p.m.

23

24

25

1 REPORTER'S CERTIFICATE

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

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

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

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

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18 Dated this 30th day of September, 2020.

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WORD INDEX

< 1 >

1 32:17 58:24
10 51:10
14 23:11
15 51:11
16th 17:5
1988 7:6, 14
1st 13:23

< 2 >

20 6:12 19:3
2005 6:1
2011 6:1
2014 13:14
2016 12:23
2020 1:15 66:18
24 11:20
2nd 13:21, 23

< 3 >

30 6:9
300-and-some
16:22
30th 1:15 66:18
31st 13:22 16:5
34 32:6
39 5:14

< 4 >

4,500 61:17
4:00 1:16 4:1
40 12:17, 20
17:25
450-bed 7:18

< 5 >

5:20 1:16 65:22
50 6:19 26:13

< 6 >

60 35:3 57:2, 5

< 7 >

70 18:17
76(7) 16:12

< 9 >

90s 7:8
92 42:20

< A >

abilities 23:24

ability 19:15
50:16

absolutely
37:15 62:24
abstinent 63:17
abuse 14:9
academic 25:16
access 25:20
28:18 32:25
35:6 43:18, 22
44:12, 13 45:24
51:1, 14

accessible
48:14
accommodated
63:23

accredited 13:15
accurate 52:16
aches 24:22
acquired 43:10
Act 16:13

Action 9:3
activities 18:10
19:1 63:20
Acts 13:6

acute 23:21
24:2, 10 31:22,
24 34:1 35:22
43:17 44:9
55:23 59:23
64:19

add 15:11 22:8
43:13 58:17
62:14

addition 20:24
additional 7:24
37:1 50:15
59:19 60:7, 13
62:15

addressed 16:4
adequate 34:10
Adjourned 65:22

Admin 6:13
administration
39:20
administrator
13:10, 11 39:21
admission 14:8
17:16, 19 18:1
46:15

admissions 58:2
admitted 46:14
adults 24:16

advanced 8:13
18:23 20:1
27:8 49:9
advent 41:17
44:16
advise 13:8
advised 30:2
advocacy 12:7,
25

advocated 26:2
affair 16:18
afford 62:17
after 9:12 24:7,
9 40:2 44:18
55:8, 12, 13
56:18 64:22

afternoon 4:4, 5,
7 6:7 8:9 17:4
agent 58:5
ago 5:17 12:20

Agreement
35:14
ahead 5:2
15:25

ahold 64:16
aid 53:2
aim 18:19
akin 41:21
ALC 59:23
64:17

alcohol 63:15
algorithms
27:13

Alison 2:17
Allison 30:5
allocate 21:3
allow 28:17
35:21 51:25
52:8 56:12

allowed 29:1
allows 18:12
44:3, 4

alternate 52:6
amend 16:8
American 6:3
9:4
amount 49:21
and/or 18:18
anecdotally 29:5

Angela 2:5
annual 16:18,
19 19:22 39:5
annually 13:16
anorexia 24:21

another's 28:23
anticipate 50:18
anticipation
30:7
antiviral 30:16
anybody 10:13
apartments
60:19

apologize 22:24
appear 56:3, 7
applied 40:24
appraisals 41:9
appreciate 60:4
65:6

approach 17:17
38:1 52:25
53:3 58:6

approaches
19:24
appropriate
27:1, 15 34:7
42:16 43:7
52:19 62:19

approximately
8:15 18:4
April 7:19 57:2
area 7:7 40:16
54:13

areas 38:8
arrangements
28:23

asked 26:18
47:6

asking 11:13
28:6 60:11
aspects 51:23
assess 6:20
assessment
14:11 52:8, 9
62:4

assessments
26:4 51:25
52:17 54:15

assessor 6:2,
18 8:21
assiduous 45:19
assigned 36:8
assist 50:6

assistance
63:20

Assistant 2:17
7:12
assisted 60:20,
25
associate 6:14

associated
59:12
Association 6:4
9:4 25:3 29:16
assuming 16:15
43:9 60:5
assuring 41:7
asymptomatic
24:7, 13

attended 29:20
attendees 16:22
20:3
attending 1:14
6:10 7:13 8:16
14:4 17:21
21:12 22:11, 19
33:22 36:15

attendings
14:13

attention 33:3
atypical 24:16,
20

availability 61:4
available 31:17
50:5 51:4 52:1
57:15 62:23
average 18:3

avoid 27:15
43:3
aware 24:15
33:21

< B >

back 9:13
12:17 20:4
23:4 30:4 31:1
36:20 40:1
55:20, 21 57:11
59:22 64:10, 11
65:7

backfill 51:18
background
5:13

backup 50:9
ball 54:5
based 52:18
53:13 54:23
62:3

basic 39:2
63:20

basically 10:19
34:18
basis 39:5
bathroom 23:14

<p>63:22 Baycrest 27:12 BC 27:11 beds 55:5 57:3, 20 58:2, 8 59:4, 18 61:17 beginning 24:6 36:21 61:8 believe 10:7 12:10 49:18 Ben 7:4, 6 beneficial 59:1 benefit 44:15 benefits 59:12 Benoit 2:11 7:3, 5 17:14 20:21 21:9, 15, 19 46:7 54:2, 7 best 23:24 26:25 33:25 34:21 38:1, 16 40:9 50:19 better 40:2 53:7 Bianchi 2:25 bidirectional 34:3 big 49:13 55:15 bio 33:11 bit 5:9 22:24 32:7 57:7 blessed 57:22 board 7:22 8:8, 20 12:23 bodies 25:2 breakdown 32:12 breakout 56:24 breath 24:18 BRIEF 56:5 bringing 65:4 brought 17:20 32:17 build 46:21 buildings 64:16, 18 built 41:25 56:8 Bye 65:21</p> <p>< C > Callaghan 2:19 called 9:12 14:3 16:19 30:6 34:19 57:22</p>	<p>Canada 8:6 33:10, 12 canoe 49:22, 24 capacity 18:15 19:13 23:21 57:2, 6 60:1, 9 61:7, 21 CARE 1:7 2:18, 19, 21, 24, 25 3:2 5:6, 7, 10, 13, 14, 22 6:12, 18, 21, 25 7:7, 10, 18, 22, 23, 24, 25 8:3, 4, 5, 13, 14, 17, 18, 19 9:1 11:15, 18, 22, 23 12:1, 5, 8, 15, 18, 21, 24 13:4, 6, 9, 10, 14 15:2, 22 16:1, 2, 12, 20, 24 17:16, 21, 23 18:8, 16, 23 19:5, 8, 24 20:1, 2, 17, 19, 23 21:3, 4, 20 22:1, 3, 9, 10 23:21 24:2, 4, 10 25:5, 8, 14, 19 26:3, 25 27:8, 9 28:5, 10, 11, 13, 17 29:22 30:14, 22 31:12, 14, 18, 23, 24 32:8, 18 33:1, 9, 12, 14, 19 34:2, 4, 20, 21 35:9, 23 36:9, 18 37:1, 5, 12, 15, 23, 25 38:2, 7, 11, 13, 16, 24, 25 39:18, 19, 20, 25 40:9, 12 41:1, 6, 12, 17, 23 42:4, 5, 14, 21, 25 43:3, 9, 18 44:9, 16, 18, 25 45:3, 17, 20 46:4, 8, 9, 12, 14, 16, 17, 19, 25 47:4, 12 48:1, 4, 12, 19, 21 49:9, 16 50:19, 23 51:10, 23 52:11, 14, 20, 22, 24, 25 53:7, 8, 9, 11, 13, 21</p>	<p>54:10, 16 55:5, 6, 11, 18, 23, 24 58:7, 9, 21 59:18, 23 60:15, 20 61:17, 23, 25 62:4, 10, 12, 15, 17, 23 63:8, 16, 24, 25 64:3, 25 carefully 65:10 caregivers 46:20 care's 52:25 carried 12:6 carry 29:13 38:18 45:4 46:3 carrying 43:1 45:18 case 30:14 42:15 58:10 cases 27:7 28:10 29:2 49:8 54:12 56:17 58:11 Centre 6:11 7:16, 17 certain 28:18 certainly 4:18 24:24 CERTIFICATE 66:1 certification 7:24 8:13 38:21 39:4, 14 Certified 66:3 certify 66:4 CHAIR 4:3, 8, 17, 23 5:1 6:23 7:20 9:6 10:18 11:4, 9 35:25 36:7 38:3 54:20 56:1, 10, 21 57:12 58:15 59:9 60:2, 10 61:11 63:1, 4 64:6 65:1, 17, 20 chairman 5:24 challenges 23:15 32:14 59:16 challenging 59:5 chance 4:16 change 15:10, 18 26:5 45:13 50:17 51:18 changed 51:10</p>	<p>changes 14:18 31:16 50:2 52:4 65:14 chapter 17:19 charitable 12:19 CHARTERED 66:25 chemo- prophylaxis 30:14, 15 chief 33:8, 11, 15, 18, 24 34:6, 22 36:8 37:3 41:1 chiefs 40:18 choose 31:22 Christopher 30:5 chronic 17:16 46:16 63:15 Church 64:18 City 6:25 clarification 27:21 clear 26:21 clinic 44:13 62:5 clinical 14:6 16:23 28:25 50:6, 8 52:16, 23 53:2, 5 clinician 6:10 42:14 clinicians 4:13 5:7, 11 7:23 11:15, 24 20:10 38:25 39:13 40:7 41:12 42:25 43:6 closed 57:23 closely 18:7 CMO 37:14 CMOH 37:16 Co-Chair 9:2 co-founder 6:22 cohort 19:15, 17 59:5 cohorting 19:16 23:15 29:4 32:5 35:21 Coke 2:5 4:10 54:21, 22 co-lead 8:25 collaboration 33:4 39:17, 18</p>	<p>40:11 44:4 50:22 51:4 collaborative 12:11 31:23 58:20 colleagues 4:15 12:21 17:8 28:23 collective 9:22 58:5, 6 College 5:25 6:2, 18 8:21 25:2 Collingwood 4:19 Collins 2:12 4:5 8:8, 9 20:8, 11 22:22, 23 23:4 27:19, 20 28:1, 12, 20 29:18 31:1, 7 32:20 33:8 34:17 35:10, 13, 19 36:1, 5, 13 38:5 43:13, 15 50:10 58:17 59:15 60:8, 16 62:14 Columbia 5:22 combination 26:3 come 23:12 28:6 43:17 49:15 54:11 55:20 57:20 65:7 Co-Medical 7:16 comes 37:11 49:21 coming 27:22 commencing 4:1 comment 17:11 21:9 COMMISSION 1:7 2:18, 19, 22, 25 3:2 4:11 9:11 Commissioner 2:4, 5, 6 4:3, 8, 9, 10, 17, 23 5:1 9:6 10:18 11:4, 9 16:3 20:12, 15 21:5, 14, 16, 22 22:5, 21</p>
---	--	--	---	--

<p>27:20 28:9, 19 32:16 33:7 34:12 35:8, 12, 18, 25 36:7 38:3 41:13, 15 43:12 53:18 54:3, 19, 20, 21, 22 56:1, 10, 21 57:12 58:15 59:9 60:2, 10 61:11 63:1, 3, 4, 6 64:5, 6 65:1, 17, 20 commissioners 5:6 20:9 committed 12:20 Committee 5:25 6:24 8:22 communal 59:3 communicate 43:25 communication 40:11 communities 35:3 Community 6:15 7:21 22:1 54:9 COMPANY 66:23 comparison 39:1 Complaints 8:22 14:10 complete 16:10 completed 5:15 33:23 completes 9:7 completing 5:11 complications 18:19, 20 component 13:19 15:5 components 14:24 comprehensive 12:14 computer 23:5 concept 33:9 concern 50:24 concerned 27:23, 24 concerns 38:2 conclusion 53:9</p>	<p>condition 26:6 31:16 47:19 50:17 52:4 conference 13:3 16:4, 19 17:2, 10, 22 19:22, 23 conferences 8:2 confidence 15:13 confident 47:24 confidential 42:18, 21 confidentiality 39:11 congestive 47:19 Congregate 9:1 18:9 conjunction 8:19 connection 22:25 29:11 31:9 42:19 conservation 24:5 consider 4:22 consist 24:21 consistent 32:1 35:20 construct 60:4 consult 13:9 37:25 consultation 43:10 consultations 42:12 contact 14:24 content 47:5 continue 7:10, 13 10:1 45:21 continued 13:2 38:7 41:25 continuing 51:7 contract 35:15, 16 contracted 35:11 contracting 23:12 25:24 61:9 contractor 35:17 contracts 16:9 contributed 8:3</p>	<p>contributing 65:16 control 14:12 19:20 29:22 37:9, 17 38:21 39:6 46:2 convalescent 62:3 convalescing 44:18 conversation 20:2 31:17 44:3 conversations 23:25 27:8 32:22 35:7 coordinated 32:13 50:6 57:8 58:19 coordinating 34:1, 10 coordination 40:12, 22 41:2 49:1, 3 53:20 coordinator 6:24 cope 57:14 corporation 22:16 correct 21:8 27:25 66:15 cost 62:12 cough 24:18 Counsel 2:19, 23, 25 3:2 couple 9:8 14:2 27:10 37:20 39:9 57:1 64:8 course 6:23 8:4, 5 13:5, 13, 17, 18, 21, 22 14:15, 20 15:3, 12 16:14 39:12, 24 40:3 45:11, 19 51:8, 12 courses 14:2 cover 28:23 coverage 25:21 34:10 covered 14:23 30:10 COVID 7:19 9:2 27:8 COVID-19 1:7 5:6 11:17</p>	<p>30:12 41:16 45:15 CPR 39:3 created 12:19, 24 13:13 23:15 37:4 58:3 creation 12:18 credential 41:10 crisis 40:25 41:17 42:1 critical 14:10 20:2 crowded 60:14, 17 CSR 66:3, 24 curious 59:10 current 5:10 6:23, 24 16:23 50:7 currently 5:18 49:7 curriculum 6:23 13:24 15:7 33:23 cutting 22:25 < D > daily 26:14 63:20 data 26:15 Dated 66:18 day 1:15 13:17 51:19 66:18 days 17:3 23:11 26:13 50:15 64:11, 12 deal 4:18 9:17 60:21 dealing 64:9 death 18:5 decade 64:4 decades 37:19 decant 56:2 decanted 56:25 57:5 64:20 decanting 35:22 55:16 58:8, 22 64:14, 17 decide 58:8 deciding 43:6 decisionmaking 15:17 52:16 decisions 50:8</p>	<p>decommissioned 64:16 dedicate 21:25 dedicated 12:10 28:15 definitely 32:21 37:13 61:3 delirium 24:21 dementia 18:17 19:18 23:18 47:5, 15 49:9 63:14 demonstrate 15:15 demonstrated 32:17 dentists 49:14 Department 6:15 43:4 44:1 departments 27:16 40:19 41:22 43:1 depends 35:5 deployed 58:10 depth 14:23 17:19 Deputy 2:17 Derek 2:21 dermatologists 49:12 described 51:13 designed 8:5 18:25 19:14 despite 28:20 determine 44:10 develop 16:24 32:12 developed 35:20 42:5, 18 development 38:23 47:16, 23 48:24 develops 47:15 diagnosis 50:6 diagnostic 43:21 49:19 50:11 diagnostics 50:4 52:14 dialogue 26:17 42:24 die 17:25 difference 32:19</p>
---	--	--	---	--

<p>different 6:19 9:15 19:9 22:8 28:13 32:6 33:14 57:13 59:24 61:16 63:24 differently 30:3 54:25 difficult 19:17 49:8 50:19 54:11 dining 18:9 directed 23:10, 23 direction 15:18 25:8 directions 26:21 Director 2:12, 21 5:18 6:23 7:15, 17 8:15 13:5, 7, 8, 10, 11, 13 14:15, 24 15:3, 14 16:14, 16 21:12 22:11, 15, 18 33:23 34:14, 18, 19, 20 35:2, 17 39:22, 24 44:18 45:8, 10 51:8, 12 Directors 6:4 7:20 8:8, 20 9:4 12:23 13:15 15:8, 20 16:9 20:17, 22 21:6 28:5 29:23 33:22 34:7, 13, 23, 25 35:2, 9 36:16 37:6 39:19, 25 40:1 41:7 discharge 14:9 discover 24:19 discuss 42:15 discussed 25:9 40:10 disease 47:10, 11, 20 48:18 disproportionate 58:11 distancing 23:19 Division 6:11 doctor 5:2 17:13 doctors 25:15</p>	<p>27:22 31:12 document 31:5 documentation 14:10 38:15 doing 4:24 7:7 8:14 10:4 15:19 21:2 26:22 27:1 54:25 65:14 dressing 63:21 drew 33:3 drug 30:16 drugs 55:21 Drummond 2:17 due 48:23 dying 53:14 55:12, 13 < E > earlier 48:18 50:9 early 7:8 23:7 25:1 48:21 52:8 ease 46:22 49:15 easier 45:24 59:7 easily 10:15 economical 62:22 economist 62:12 educated 47:24 education 12:6, 8 13:1 51:7, 22 educational 13:3 16:17 effective 32:13 41:19 effectively 14:21 effects 41:16 efficacy 31:21 efficient 18:11, 25 efforts 34:1, 10 57:8 58:20 Eileen 16:3 Elderly 5:25 7:24 8:14 38:24 47:2 Electronic 50:20, 21 emergency 27:16 40:18 41:22 42:13, 25</p>	<p>43:4, 16, 19, 21 44:1, 10 emotional-based 38:13 emphasis 39:16 48:17 emphasize 26:19 48:3 employees 35:9, 11 empty 55:5 encourage 27:14 encouraged 19:2 24:5 end-of-life 23:24 27:9 end-stage 47:10, 11, 20, 21 end-staged 47:18 48:17 engage 14:22 engaged 32:23 engagement 15:16 engaging 23:24 ensure 34:6, 10, 20 38:10 45:11, 24 46:9 51:25 53:12 ensuring 33:25 53:3 entirely 31:9 environment 10:3 14:6, 8 18:7 34:25 36:23 59:24 62:19 envision 49:2 epidemiology 37:9 equipment 27:6 45:25 equivalent 47:18 especially 24:20 estimated 19:2 evaluated 15:12 evaluations 16:25 Evelyn 2:10 4:6 6:6, 7 11:6 14:1 21:23 29:6, 9 34:16 35:15 55:2 56:9, 15 64:8</p>	<p>everybody 4:4 65:21 evidence 30:15 evidence-based 12:14 evolving 17:9 exacerbated 23:9 examine 27:5 example 21:1 26:24 27:10 40:16 44:17 46:18 47:13 51:13, 15 56:24 57:21 58:18 64:15 examples 40:21 excellent 12:5 53:11 exceptional 38:12 excluding 25:12 27:22 exclusively 25:23 executive 13:11 28:5 34:18, 20 39:21 exist 36:9 existed 23:8 32:12 33:13 expected 47:1, 11 expecting 24:24 expensive 45:1 experience 6:9 29:25 33:5 36:17 37:20 62:3 experienced 7:19 20:10 29:22 33:19 experiences 11:16 39:23 expert 49:8 54:12 expertise 19:24 20:4 experts 29:20 explain 13:25 44:1 Exposure 48:11, 19, 20, 23 expressed 32:24</p>	<p>extension 52:13 < F > facilitating 35:7 facilities 5:21 6:20 50:5 51:3 56:25 facility 7:18 34:16 35:16 57:4, 11 fact 28:21 30:20 failed 33:10 failure 47:19 fair 49:21 families 17:22 24:1 31:13 46:21 61:9 family 5:16, 25 6:8, 15 7:10 8:12 19:7 20:22 21:17 25:4, 9, 16 46:10, 20 48:13 family-centered 15:2 faster 45:20 fatigue 24:21, 23 favourable 4:22 fear 23:12 25:13, 24 28:7 61:9 February 13:21, 23 feedback 16:21 37:16 feeding 63:21 feel 35:19 38:19 39:16 40:25 44:15 45:8 felt 7:8 11:20 30:25 fever 24:18 fewer 59:6 61:17 field 56:8 final 16:5 17:18 finally 11:21 38:5 finances 62:1 find 10:3, 14 60:7 first-hand 29:25</p>
---	---	--	---	--

<p>Firsts 15:6 float 49:25 flow 34:3 focus 10:5 18:8 24:5 28:24 37:8 46:8, 16, 25 47:9 focussing 38:15 follow 61:14 following 24:17 45:6 follow-up 44:22 foregoing 66:6, 14 foremost 53:10 foresee 40:7 Forest 5:21, 22 formal 53:16 forth 66:8 forum 7:21 forward 26:8 44:15 59:2 found 27:12 57:21 founded 7:21 four-bed 23:14 61:19 fracture 44:13 fractures 44:22 frail 18:1 47:2 frailty 17:20 18:22 46:13 48:17 49:20, 22 50:3 Frank 2:3 4:3, 8, 9, 17, 23 5:1 9:6 10:18 11:4, 9 35:25 36:7 38:3 54:20 56:1, 10, 21 57:12 58:15 59:9 60:2, 10 61:11 63:1, 4 64:6 65:1, 17, 20 Fraser 27:11 Fred 2:9 4:7, 14, 21, 25 5:4 7:2 8:7 10:16, 23 11:7, 11 15:24 20:7, 14 22:7, 22, 25 23:3 26:9 29:8, 10, 19 31:1, 3 37:18 38:18 41:14 42:2</p>	<p>43:14 44:14 53:15 56:15, 23 57:18 61:13 63:10 65:12, 19 freeboard 49:23 frequently 47:14 51:17 fresh 43:8 Friday 17:4 full 19:9 27:6 55:7 59:22 60:1, 14, 17 full-time 20:19, 24 21:1 function 62:10 functional 44:20 fundamentally 14:16 fundamentals 14:3, 23 funding 46:24 47:4 future 40:24 61:18 65:16</p> <p>< G > general 18:17 30:20 54:22 generally 33:14 43:24 geriatric 53:22 54:9, 14 62:4 geriatricians 49:11 geriatrics 44:5 Gillese 16:3 45:7 give 14:21 17:1 26:22 40:16 56:23 givers 46:10 giving 26:21 glamorous 48:1 Glebe 7:17 goals 20:1 27:9 31:14, 18 goals-of-care 23:25 good 4:4, 5, 7, 25 6:7 8:9 29:13 31:4 41:12 42:5, 6 51:13 54:8 governing 25:1</p>	<p>Government 51:6, 21 grants 13:3 great 4:18, 24 9:17 17:7 32:11 37:16 53:2 60:21 greater 12:25 greatest 18:12, 13 greatly 50:6 group 25:10 54:10, 14 63:22 64:2 groups 45:13, 23 grow 48:23 guess 63:11 guidance 25:10 34:9 37:5, 16 46:1 guide 10:24 30:23</p> <p>< H > half 9:21 17:3 hall 29:23 halls 28:4 29:17 hand 23:20 57:9 handheld 52:11 happened 9:12, 13 happening 11:17 55:4 56:13 happens 50:3 happy 47:5 haunt 38:7 hazard 63:11 head 6:11 headaches 24:22 headwind 50:2 Health 2:23 6:13 7:16 13:12 27:11 31:25 32:3, 6, 10, 18, 23 33:16 34:2, 5 36:3, 4, 11 37:8, 21 38:2, 8 40:13, 19, 23 41:24 50:20, 21 58:21</p>	<p>Healthcare 5:24 12:2 14:17 19:19 47:24 48:3, 7, 16, 24 51:5 52:1, 5 58:14 hear 42:2 heard 28:3 29:5 45:12 61:16, 22 hearings 9:20 heart 47:19, 20 heavily 18:6 19:6 Heights 5:21, 23 Held 1:14 help 41:2, 11 44:10 47:4 49:15 56:18 helpful 9:23 helps 41:7 heterogeneity 60:18 heterogeneous 52:2 Hi 4:6 higher 41:5 highest 12:13 highlighted 65:11 highly 18:11 history 12:17 holds 9:20 Home 5:19, 20 7:11 13:7 17:15, 21 20:20 21:7, 13, 20 22:4, 13, 15 23:11 34:14 35:9 36:25 39:20 42:14 44:17, 21 45:11, 15 46:13 49:13, 15 50:5 52:3 53:9, 10 54:11, 15 55:6, 15, 25 56:11, 19 62:2, 10, 15, 18 63:8 64:25 home-like 18:7 homes 6:25 16:13 19:6 20:4, 17 21:10, 11, 18 22:9, 10, 20 23:9, 13, 22</p>	<p>25:12, 18, 23 27:22 28:2, 13, 14, 15, 16, 24 29:25 34:8, 11 36:22 40:5, 22 42:21 45:17, 21 51:17 52:2 54:16 58:7 60:15 61:9 62:7, 8 63:8 Honourable 2:3 hope 4:16, 21 17:8 45:16 48:15, 22 hopefully 44:21 Hospital 7:14 8:17 21:20 23:23 25:16 36:24 41:23 44:12, 25 55:6 56:17 57:1, 2 58:20 59:17, 20 62:5 64:16, 17, 19, 23 hospitals 24:4 27:17 32:10, 18, 23 39:9 40:12, 23 41:10 43:1 56:8 57:6, 14 58:7 59:22 64:15 hours 11:20 55:19 HQO 15:6 Humber 64:18 hygiene 23:20</p> <p>< I > Ida 2:25 idea 34:22 37:14 63:7 Ideas 15:6 26:21 56:2 identified 23:6 25:22 29:3 illness 20:2 image 49:21 imagine 49:10, 14 imaging 44:24 49:19 impact 59:16, 17 impairment 63:14</p>
--	---	--	--	--

<p>Implementation 8:24 implemented 24:10 implication 19:12 important 31:18 50:24 53:1 impression 60:12 improve 13:14 14:6, 17 15:22 49:16 51:23 improved 40:13 42:10 49:1 53:20 improvement 14:22 15:10 improvements 14:19 32:21 improving 42:7 inappropriate 27:15 43:3 incendiary 56:24 incidents 14:10 include 12:1 20:1 32:10 42:13 48:18 included 27:7 30:20 includes 7:11 13:24 14:7 31:13 38:21, 23 51:24 including 19:9 30:1, 13 40:19 51:8 incognizance 47:14 increase 15:18 23:21 51:3 increased 15:13, 17 incredibly 55:22 independent 35:17 60:19, 22 61:3 indicate 47:21 indicator 47:12 indicators 15:1 46:25 47:6, 8 indiscernible 29:2, 21 individual 60:23</p>	<p>individuals 44:19 62:9 63:13, 19 infection 14:11 19:20 29:21 37:8, 17 38:20 39:6 46:2 59:19 information 34:4 51:2 52:18 63:11 informative 65:5 infrastructure 45:14 initial 17:21 injuries 47:21 injury 47:16, 17 in-person 19:5 26:4 28:22 51:25 Inquiry 4:11, 19 9:11, 19 16:2, 5, 6 45:7 instance 44:13 instances 22:14 institution 18:8 institution-like 36:23 instrument 14:11 instrumental 33:25 insufficient 62:8 Integrated 57:19 interactions 18:13 19:3, 4, 15 interactive 13:18, 22 interdisciplinary 40:6 interest 48:22 interested 54:10 65:15 interim 10:1 internal 44:6 internet 22:25 31:9 interprofessional 12:11 interrupt 36:1 INTERRUPTION 56:5 intervention 31:16</p>	<p>interventions 18:21 interview 10:6 introduce 4:16 5:2 6:6 14:14 investigates 9:19 investigating 9:25 10:4 Investigation 8:22 investment 33:17 invitation 5:5 involve 44:9 involved 15:9 62:4 involvement 14:18 involves 13:17 58:6 IPAC 32:5 37:13 39:14 iPads 28:16 isolate 59:5 isolating 23:16 29:4 32:5 isolation 23:20 35:21 58:1 issue 61:21 issues 40:7 41:7 47:22 62:6 < J > Jack 2:6 January 13:22 job 4:24 31:4 John 2:19 join 29:12 joined 4:15 journey 46:23 joys 48:3 July 16:5 30:5 Justice 37:18 61:14 < K > Kate 3:2 keeping 52:24 Kendall 30:6 key 38:16 kind 9:9 10:5 50:1 Kitchener 5:19, 22, 23</p>	<p>Kitts 2:6 4:9 20:12, 14, 15 21:5, 14, 16, 22, 24 22:5, 21 27:20 28:9, 19 32:16 33:7 34:12 35:8, 12, 18 41:13, 15 43:12 53:18 54:3, 19 63:3, 6 64:5 knowing 51:20 knowledge 14:21 15:13, 21 16:23 36:18 39:10 48:20 knowledgeable 30:22 33:20 < L > laboratory 43:20 49:18 50:4, 9, 12 52:10, 14 lack 25:13 32:7, 25 36:14 lake 49:24 larger 26:23 late 57:7 Lead 2:3 9:2 15:9 20:8 leadership 12:12 15:1 22:17 28:2 30:23 34:8 39:17 40:6, 20 41:2 51:13 leading 4:12 LEAP 8:4 learned 30:2, 11 54:23 leave 27:3 62:22 legislation 39:11 length 18:3 lessons 54:23 Lett 2:21 level 41:5 46:13 levels 19:14 liaise 34:24 liaising 34:2 44:8 liaison 37:15 Licensees 16:8</p>	<p>life 31:20 39:2 46:9 47:1 49:16 63:18 lifetimes 9:18 limited 19:16 link 10:12 literature 62:21 lives 17:19 living 36:21 60:20, 25 61:3 63:21 local 8:1 36:3, 4, 10 49:10 57:5 locally 7:22 location 26:1 long 17:12 33:13 50:1 longitudinal 37:20 longstanding 52:25 LONG-TERM 1:7 2:18, 19, 21, 24, 25 3:2 5:6, 7, 10, 13, 14, 22, 23 6:12, 17, 25 7:7, 18, 22, 23 8:3, 4, 14, 18, 19 9:1 11:15, 18, 22, 23, 25 12:5, 8, 15, 18, 21, 24 13:4, 6 15:22 16:1, 2, 12, 20, 23 17:15, 23 18:16 19:8 20:17, 19, 23 21:3, 4, 25 22:3, 9, 10 24:4 25:8, 14 29:22 30:14, 22 31:12, 24 32:8, 18 33:1, 9, 11, 14, 19 34:1, 4, 21 35:9 36:9, 18 37:5, 15, 22, 25 38:2, 7, 25 39:18, 20 41:1, 6, 12, 23 42:14, 20, 25 43:3, 18 44:8 45:17, 20 46:4, 12, 14, 16 48:1, 11, 19, 21 49:16 51:9 52:22, 24 53:7, 9, 12, 21 54:10, 16 55:5, 6, 11,</p>
--	--	---	--	--

24 58:7, 20
59:18 60:14
61:17, 23 62:10,
17, 23 63:8, 16,
25 64:3, 24
looking 10:1
24:17, 25 36:17
44:18 59:2
looks 9:12
loss 24:23
lost 29:6, 8
lot 25:12 26:17
27:3 37:22
50:24 55:13
60:22
Lynn 2:23

< M >
made 18:6
29:24 32:19
65:15 66:10
Mahoney 2:23
Mainpro 13:16
maintain 39:13
major 16:17
majority 22:12
25:9 61:2
making 28:22
39:13
manage 27:14
40:7 54:25
62:18
managed 64:19
management
13:18 14:25
20:3
managing 26:16
27:7 38:1
mandate 45:10
Marocco 2:3
4:3, 8, 9, 17, 23
5:1 9:6 10:18
11:4, 9 35:25
36:7 38:3
54:20 56:1, 10,
21 57:12 58:15
59:9 60:2, 10
61:11 63:1, 4
64:6 65:1, 17, 20
Marocco's
37:19 61:14
masking 24:8,
14
Masters 6:13

match 18:6
47:7
Mather 2:9 4:7,
12, 14, 21, 25
5:4 7:2 8:7
9:8 10:16, 21,
23 11:7, 10, 11
15:24 20:7, 14
22:7, 22 23:3
25:17 26:9
29:8, 10, 19
31:3 37:18
38:18 41:13, 14
42:2 43:14
44:14 53:15
56:23 57:18
61:13 63:3, 10
65:4, 12, 19
Mather's 62:20
matters 8:2
13:9
maximize 19:14
McDonald 3:7
10:7 11:5 66:3,
24
McGeer 30:5, 10
McGrann 3:2
McKaya 3:7
66:3, 24
meant 36:22, 23,
25 47:3
measure 47:9
measures 43:2
Medical 5:18
6:4, 21, 22, 24
7:15, 20 8:15
9:4 12:15 13:4,
7, 8, 9, 13, 15
14:15, 19, 24
15:3, 8, 14, 15,
20 16:9, 14, 16
18:21 20:17, 21
21:5, 11 22:10,
15, 18 25:3
28:11 29:16
30:21 31:6, 10,
16 33:8, 11, 15,
18, 21, 23, 24
34:6, 7, 13, 14,
19, 22, 23, 25
35:1, 2, 8, 17
36:3, 9, 11, 16
37:2, 3, 5, 7, 21
39:18, 24 40:1
41:1, 6 44:17

45:8, 10 48:12,
16 51:2, 8, 12
medicalizing
53:13
medication
52:22 53:1, 5
Medicine 6:15
8:18 25:24
44:6 48:13 51:9
MEETING 1:7
31:11
meetings 40:18
meets 31:18
member 6:3 9:3
members 12:1
19:7 26:15
27:12 34:24
membership
26:24
memory 60:20
62:5
mention 26:10
33:10 38:6
mentioned
18:24 19:13
23:17 25:14
39:15 50:9
52:2 64:2
messaging 32:1,
4
method 39:12
M-hm 63:2
middle 9:16
mild 29:2 63:14
minimal 50:8
Minister 2:17
Ministry 2:23
mission 12:6
mitigate 48:5, 23
mix 22:2
mobile 49:20
model 18:12, 24
modules 15:3
monitoring 53:1
month 5:12
35:1
months 42:10
morbidity 35:24
mortality 35:24
Mount 30:6
move 26:7
55:10 59:23
moved 61:7
moving 30:19

multidisease
18:18
multiorgan
18:18
multiple 19:19
21:18, 21 25:15
27:24 40:8 59:4
municipal 5:19
municipality
22:16
muscle 24:22
mute 7:4
muted 17:13

< N >
national 8:2
35:5
nature 50:8
near 61:18
necessarily
21:6 61:6 62:16
necessary 26:2
35:22 38:10
51:11
needed 27:2
30:22 50:21
57:20
needs 15:9
31:11, 25 32:14
35:20 37:13
39:16 40:13
41:18 55:20
57:19 58:5, 19
61:25
needs/the 55:20
NEESONS 66:23
neglect 14:9
neighbours
26:18
Network 42:8
networking 17:7
neurocognitive
63:13
new 19:24 58:2
newer 52:11
nice 46:11
52:7 54:17
nonurgent 26:4
Normally 9:11
notes 66:15
not-for-profit
11:24 12:25
nourished 63:16
novel 33:9
nuisance 45:1

number 18:12,
13 19:2 21:24
30:17 55:12
58:11 59:18
61:15, 18 62:8
numbers 19:16
numerous 8:23
nurse 12:1
14:4 15:20
42:15 55:18
nurses 48:8, 9
nursing 38:9
48:12

< O >
observation
40:4
observations
11:16 30:20
31:5 63:12
occasionally
50:10 51:16
occur 44:4
48:4 50:2
occurred 9:14
occurs 50:24
October 17:3, 5
offer 15:7
48:21 49:7, 11,
12 50:19 54:15
offered 13:16
17:2 53:25
offering 16:17
offers 49:6
office 5:17
officer 33:9, 11,
16, 19, 24 34:6,
23 36:3, 9, 11
37:3, 7, 21 41:1
oftentimes
50:13
older 23:13
24:16
OLTCC 2:9, 10,
11, 12 8:20
12:4, 24 16:14
26:2 28:4
34:24 48:15
49:2
OLTCC's 12:9
45:10
OLTCP 13:2
one-day 14:12
ones 22:2
57:25 64:1

<p>ongoing 26:17 38:22, 23 45:9 51:22 online 13:19 39:12 onset 40:17 57:23 on-site 49:7 52:10 Ontarians 12:5 Ontario 5:5, 7, 10 6:3 7:23 11:15, 22, 23 12:18, 24 15:25 20:25 25:3 29:16 33:16 34:5 42:8 61:18 open 5:8 opening 17:4 operated 5:20 22:16 operators 28:18 51:6, 21 61:1 opinion 49:8 54:12 opportunities 48:11 62:15 64:22 opportunity 6:19 17:7 26:23 32:11 opted 23:11 optimal 38:11 58:8 optometrists 49:14 order 12:25 13:14 15:19 22:17 27:10 45:14 52:15 organization 11:24 12:20 26:14, 20 61:5 organizations 33:15 61:6 orthopedic 44:23 orthopedics 44:5 OTN 42:6, 7 Ottawa 7:7, 13, 14 49:5 54:13 outbreak 7:19 23:10 30:17 35:20, 23 36:5</p>	<p>38:1 55:15 64:12 outbreaks 29:25 30:1 outcomes 47:2, 11 outreach 49:6 53:23 54:15 outside 20:19 64:1 overall 19:12 overloaded 49:22 overlook 57:25 oversaw 26:11 oversee 22:15 oversight 30:21 31:6, 10 37:3 41:6 < P > p.m 1:16 4:1 65:22 pain 20:2 palliative 7:11, 25 8:5, 17 17:16 19:24, 25 21:20 37:12 38:24 46:8, 16, 18 55:18 Pallium 8:6 pandemic 8:24 11:17 20:10 23:7, 8 24:7 26:12, 14, 16 29:15 30:12, 24 40:4, 15, 17, 20 42:7 43:6, 11 45:6 57:24 58:4 61:8 pandemics 40:25 part 15:14 19:23 37:13 38:22 42:4, 23 45:25 participant 16:1 participants 1:14 2:15 15:14, 16 participated 29:15 participation 15:17</p>	<p>particular 10:5 37:11 particularly 9:23 24:16 26:5 28:7 38:10 51:9 partner 54:5 partnered 15:5 partners 32:9 parts 42:3 part-time 19:21 pass 17:11 passionate 65:13 pathogens 45:15 patient 20:25 55:20 patients 55:12, 13 57:17 59:23 63:7 Pearls 13:4 16:20 19:22 peer 6:2, 18 17:7 people 17:25 21:2, 11 30:18 36:21 40:19 46:14 47:20 53:13 54:11 55:10, 24 59:10, 11, 14 61:7, 22 62:16, 24, 25 63:23 64:17, 22, 23 percent 17:25 18:17 35:3 42:20 57:2 percentage 63:7 performance 15:1 41:8 performed 50:14 Perley 7:15, 17 permission 65:7 permit 19:16 person 27:5 39:21 60:6 personal 27:6 33:5 45:25 46:19 54:15 61:25 person's 17:15 ph 30:6 pharmacist 53:5</p>	<p>pharmacists 12:2 48:9 52:23 53:2 phone 23:2 29:13 31:8 56:6 physical 23:19 physician 6:9 7:13 8:12, 16 12:12 13:8 17:21 21:6, 12 22:11, 19 25:13, 18 33:20 34:11 37:25 42:13 44:10 Physicians 6:1, 2 11:25 12:1, 19, 24 14:4, 18 15:20 16:1 19:8, 19 20:16, 22 21:25 25:2, 4, 8, 10, 11, 20, 22 26:22 28:3, 6, 17, 21, 22 29:1, 24 33:22 34:4 36:16 37:6 43:16 48:10 51:14 52:3, 5 physiotherapists 48:9 picture 13:20 piggyback 54:17 pipeline 48:2 place 18:23 44:6 52:7, 20 59:13 61:24 62:19 66:7 places 43:22 45:17 57:16 plan 18:23 35:20 36:6 planned 52:9 Planning 8:25 20:1 27:9 57:19 platform 28:16 42:17, 22 platforms 17:9 28:14 42:7, 9 45:3 pleased 10:16 plenty 62:7 plus 53:21 point 15:25 26:10 27:21 30:11 36:20</p>	<p>45:12 52:11, 14, 18 62:20 PointClickCare 42:19 pointed 25:17 points 64:9 Policy 2:21 poor 47:17 population 18:14 24:20 populations 19:9 position 19:21 35:14 37:4 42:14 positive 14:18 23:10 32:19 41:16 58:1 possibility 39:8 possible 18:7 27:14, 23 49:19 50:19 52:9 58:8 post-course 39:24 postgraduate 5:15 48:13 potential 58:21 59:16, 21, 24 60:1 potentially 60:25 PPE 14:12 24:3 25:14 27:1, 25 45:19 55:7, 19, 21 Practical 13:4 16:19, 23 48:8 practice 5:16 7:11, 21 11:25 14:6 19:10 20:19, 23, 24 21:1, 17 22:1 25:23 34:21 practiced 7:6 25:15 practices 22:3 23:20 25:16 32:5 33:25 practitioner 42:15 practitioners 12:2 14:5 15:21 25:5 precedent 9:17 pre-COVID 23:9</p>
--	--	--	--	---

<p>predominantly 37:8 preexisted 23:7 preliminary 9:25 preparation 14:4 prepare 23:22 30:13 40:24 prescribing 30:16 presence 29:1 PRESENT 3:5 5:5 presentation 11:14 24:16 53:16 presentations 17:8 presented 8:1 PRESENTERS 2:8 President 2:9, 10, 11 5:10, 11 6:5 7:3 pressure 47:16, 17, 21 59:19 prevent 18:19, 20 24:1 35:23 45:14 59:18 63:18 prevention 19:20 29:21 37:9, 17 38:20 39:6 46:2 primarily 25:6 primary 12:21 25:4 primer 14:3 51:14 primitive 47:8 prior 8:18 46:15 priority 47:25 privacy 39:11 private 61:19 private-pay 62:17 privy 24:14 problem 10:2 problematic 43:5 problems 23:6 29:11 65:10 proceedings 66:6</p>	<p>process 25:1 41:10 53:14 professional 38:23 professionals 12:3 13:12 38:8 47:25 professor 6:14 7:12 prognostic 47:17 program 13:16 14:25 16:24 17:4 programs 48:13 49:2, 3 53:21, 23 58:3 progression 18:20, 21 47:10, 15 promote 51:7 promoted 26:17 40:14 prompt 64:10 promptly 10:3 protective 27:6 45:25 provide 12:25 19:23 21:20 22:17 25:20 26:25 34:8, 9 37:4 38:12 51:6 52:10 54:12 55:17, 23 provided 11:1 13:15 19:25 26:14 27:10 37:1 54:18 58:9 providers 52:1, 5 provides 12:13 42:9, 20 providing 13:3 25:5 27:8 34:3 38:16 40:8 41:2 42:21 53:22 62:15 province 6:20 22:9 49:4 provinces 41:5 provincial 8:2 9:2 PSW 38:9 PSWs 48:8 Psychiatry 54:9</p>	<p>psychogeriatric 49:6 53:23 54:1 public 9:14, 20 31:25 32:3, 10, 18, 22 34:2 38:2 40:12, 19, 23 41:24 58:21 publishing 10:8, 9 pull 11:2 purpose 14:20 15:18 put 10:12 55:19 puts 59:19 putting 10:9 31:19 < Q > qualities 45:11 quality 6:21 12:13 13:14, 17 14:16 43:2 46:9, 25 47:1, 6, 8, 12 49:16 question 20:13 21:24 34:12 37:19 42:3, 23 53:18 54:8, 23 61:14 questions 11:13 26:18 53:17 65:8 Quick 34:12 35:21 44:12 53:6 64:10 quicker 44:13 quickly 50:3, 17 quite 19:10, 15 21:24 22:2 48:2 49:25 52:2 61:20 < R > ramp 59:22 range 20:25 60:18 rapid 35:23 readily 45:2 48:14 50:5 readmitting 58:24 ready 10:21 real 44:14 49:3 reality 17:12, 24</p>	<p>really 9:22 14:5 18:1 32:13, 17 57:19 58:19 61:23 65:5, 6 reason 36:2, 10 60:3 reasons 28:7 receive 12:5 17:16 53:11 receiving 32:4 recertification 39:7 recidivism 63:18 recognizes 32:14 recommend 40:11 45:10 Recommendatio n 16:6 45:7 recommendation s 10:1 24:17 25:4 26:24, 25 38:19 45:5 46:1 recommended 24:8, 9 recorded 66:11 records 50:20, 21 recredentialed 39:9 recruitment 41:11 47:23 redesign 59:2 redevelopment 59:2 redirected 24:4 reduce 28:25 30:17 59:7, 11 reduced 61:19 reducing 31:19 59:17 referred 11:18 reflect 47:4 reflects 18:1 regard 32:4 33:1 Region 5:20 8:24 36:10 regional 7:20 8:1 49:1 53:21 54:14 57:19 regions 33:16 37:20</p>	<p>registered 48:8, 9 regular 40:17 41:9 49:6 regulated 18:6, 25 regulatory 14:8 rehab 44:20 64:24 reinstatement 52:21 53:4 related 45:15 63:15 relating 8:3 49:8 relationship 31:12, 24 40:2 41:21, 23 42:24 relationships 35:2 46:21 48:4 relatively 45:17 released 16:4 relevant 61:15 reliable 49:18 reliant 19:6 rely 19:25 remarks 66:10 remote 44:24 remotely 1:15 remove 57:16 renew 39:4 repatriated 57:10 repetitive 8:11 rephrased 18:4 replicate 17:10 report 16:5 26:14 34:13, 14, 17 40:1 REPORTER 17:13 66:4, 25 REPORTER'S 66:1 reporting 26:15 reports 9:13, 20 26:16 42:6 represent 63:22 representing 11:25 requested 50:13 require 16:10 37:2 52:6 required 16:11 38:21 39:4 47:4</p>
---	--	--	---	--

<p>requirement 45:9 51:18 requires 13:6 19:4 37:2 44:22 Research 42:19 resemblance 4:20 reserved 53:12 residences 60:13, 18 residencies 59:25 60:6 resident 14:8, 11 15:2, 6 17:22 19:3, 4 45:1 55:20 resident- centered 38:13 residents 12:16 15:22 17:18 18:16, 22 19:17 21:7 22:12 23:16, 18, 23 24:1 25:19 28:24 29:4 31:11, 13, 15, 20 35:22 38:11, 14, 17 44:15 45:21 46:10 47:5 49:17 52:22 53:10, 11 56:19 57:5, 11 58:1, 25 59:6 resources 24:3 26:23 27:7 43:19 55:14 58:12 respectful 31:23 respiratory 27:4 respond 10:2 responsibilities 33:21 36:15 responsibility 43:10 responsible 21:7 25:19 rest 20:5 restoration 44:21 restraints 14:9 result 19:10 52:19 results 43:20 50:10, 15, 23</p>	<p>retainment 41:12 retention 47:24 48:24 retired 5:16 retirement 59:25 60:6, 13, 18 61:8 62:2, 7, 8, 10, 18 return 20:4 returning 44:21 Review 8:22 reviews 52:22 rewarding 48:2 Rhonda 2:12 4:5 8:7, 9 20:11 22:23 23:4 27:18, 19 28:1, 12, 20 29:7, 8, 12, 18 31:1, 4, 7 32:20 33:8 34:17 35:10, 13, 19 36:5, 13 38:5 39:15 43:13, 15 58:17 59:15 60:8, 16 62:14 Rhonda's 29:11 rid 56:6 Rideau 7:16, 18 rights 14:8 53:11 risk 14:25 Rivera 61:1 RNs 51:18 Robert 2:11 7:3, 5, 6 17:11, 14 20:8, 15, 21 21:9, 15, 19 23:17 46:5, 7 53:19 54:2, 7 57:21 64:2 Robert's 36:20 role 16:15 22:18 36:8 roles 36:15 rolling 54:6 room 58:25 59:4, 7, 11 rooms 23:14 59:3, 6 61:2, 19, 20 roster 20:25 roughly 18:5 19:3</p>	<p>rounds 27:1, 2, 5 routine 27:3 routinely 45:22 RPNs 51:18 < S > safe 45:17 safety 14:25 same-day 43:24 sat 8:23 scale 15:16 scheduled 19:11 schools 48:12, 16 science 26:16 screen 11:2, 10 screening 45:18 seamless 50:23 Secretariat 2:18, 20, 22 3:1, 3 11:1 Section 16:12 Sector 9:1 15:9 18:6 23:22 24:2, 8, 10 32:2 33:12, 20 36:14, 19 37:11 50:25 sectors 34:2 51:5 sector-specific 25:11 secure 42:17 send 56:18 sending 44:2, 3 seniors 60:19 September 1:15 66:18 serve 19:8 service 49:11, 19 59:22 services 14:19 33:2 35:14 49:12 52:10 54:17 set 8:13 15:7 66:7 sets 27:11 setting 58:11, 13, 14 63:24 settings 25:15, 18 28:25 40:8 severe 30:1</p>	<p>share 10:24, 25 11:2, 12, 21 20:4 26:20, 23 shared 23:14 59:3 60:24 sharing 20:9 30:1 46:3 short 52:15 64:3 shortage 27:25 shortages 23:8 38:6 48:6 Shorthand 66:4, 15, 25 shortness 24:18 short-stay 57:22 58:3 short-term 44:20 show 15:12 shows 30:16 sick 27:4 55:9 side 5:3 sign 35:13 47:14, 17 significant 32:19 silos 32:12 similar 40:25 49:11 simply 48:23 50:11 Sinai 30:6 single 25:18 28:24 34:11 61:2, 4 site 25:25 28:6 64:18 sites 19:19 21:21 27:24 28:8 52:6 60:22 situation 9:10, 15, 23 49:10, 14 50:16 situations 26:5 size 20:25 skill 15:7 34:7 skills 14:21 15:21 skin 47:18, 22 slide 14:14 15:4 26:7, 10 29:14 31:5 38:19 slides 10:24 slow 64:24 small 50:2</p>	<p>smaller 21:2 22:13 25:18 smell 24:23 socializing 18:9 19:1 software 42:20 somebody 36:17 44:2, 3, 11 47:13, 15 55:18 somebody's 50:17 son 4:19 soon 52:9 sorry 31:8 sort 39:7 42:24 47:18 49:15 53:6 63:24 sources 61:16 space 23:14 60:13 62:23 spaces 59:3 60:7, 24 61:2 speak 4:14 28:12, 14, 15 33:6 49:5 50:21 60:25 speaking 60:17 61:1, 5 specialized 36:19 37:10 specialties 44:5 specific 30:21 31:11 42:9 45:6 spent 6:17 sponsored 29:17 spread 24:7 25:13 27:24 28:7 35:23 45:14 59:8, 19 spreading 25:25 stable 18:14 46:24 staff 5:3 14:24 18:13, 14 19:4, 17 20:5 23:10, 11 24:11, 22 29:3 38:22 41:8 45:18, 21 46:9, 21 55:10 56:18, 20 58:9 staffing 18:11, 24 19:14, 16</p>
---	--	--	--	---

<p>23:8 38:6 51:17 55:14 stakeholder 32:9 stakeholders 32:15, 24 33:5 34:3 58:21 stand 46:6, 7 stark 17:24 start 54:5, 13, 18 started 7:7 state 49:2 statement 12:9 states 16:6 status 50:7 stay 18:3 23:11 31:8 47:5 stems 48:7 Stenographer/Tra nscriptionist 3:7 stenographically 66:11 strategies 24:5, 14 37:17 59:21 strategy 60:1 strengthen 46:22 strong 4:20 48:2 stronger 22:17 48:17 studied 41:18 studies 9:13 stuff 27:3 submission 11:1 45:5 subsidies 62:11 subsidized 62:8 sub-transfer 42:16 sufficient 38:12 45:24 suites 60:23 61:4 Sunnybrook 6:10 Sunnyside 5:19 supervision 63:17 supply 45:24 56:19 support 30:23 34:9 37:5 38:9 39:2 46:10, 19</p>	<p>51:7, 20 53:7 63:18 supported 52:17 supporting 29:4 supports 62:19, 21 surge 18:15 19:13 23:22 55:4 surgeon 44:23 Surgeons 6:3 25:2 survey 35:1 surveys 39:24 suspect 62:12 suspending 58:3 swab 64:10 symptom 20:3 symptomatic 24:12 symptoms 24:20 27:4 29:2 system 32:13 45:2 51:24 52:7 59:17, 20 systemic 23:6 systems 50:23 < T > Table 8:25 9:1, 3 40:20 57:19 tables 8:23 talk 12:7 talked 53:20 talking 49:20 task-oriented 38:14 taste 24:23 team 9:7 12:12 40:6 49:6 52:25 teams 15:2 technology 52:12 Telemedicine 42:8 term 5:11 17:12 terms 64:9, 14 test 50:11, 14 52:17 64:11 tested 24:11, 13 45:22 testing 31:20 32:5 43:21</p>	<p>45:19, 20 52:11, 15 tests 43:20 50:12 64:10 Thanks 27:19 thing 7:9 things 13:24 24:21, 23, 24 36:11, 12 37:11 40:7, 14 41:24 43:16 54:24 57:9 58:23 thinking 44:2 49:13 65:9 third 15:5 thoughts 63:7 three-day 13:18 three-quarters 18:18 time 7:6 10:5 12:22 18:5, 14 19:9, 10 21:3 28:11 33:14 35:4 38:12 50:1 52:6, 7 55:24 60:5 64:3 65:13 66:7, 10 time-consuming 55:22 timely 30:21 31:10 51:25 52:14, 19 53:22 times 25:12 today 11:12 34:13 topic 30:10 topics 14:7 Toronto 6:25 8:24 64:15 town 28:4 29:17, 23 tradition 17:6 traffic 28:25 trained 41:8 training 5:15 16:11 34:8 38:20 39:2, 3 45:9 46:1, 19, 20 48:13, 22 51:13 transcribed 66:12 transcribing 10:6</p>	<p>transcript 10:8 66:15 transcripts 10:10 transfer 31:22 43:9 50:11 transferred 44:11 58:12, 13 transfers 24:1 27:14, 15, 16 31:19 43:3 44:25 transitioning 50:25 transpires 32:8 treatment 31:21 trends 26:15 triad 34:19 39:17 true 31:25 47:12 66:14 Typically 9:19 47:9 < U > U/T 10:16 ultrasound 43:23 unacceptable 64:13 unaware 24:6 understand 11:13 14:5 23:19 46:12 47:20 55:4 59:13 understanding 31:13 32:2, 8, 22, 25 36:14 37:10, 22 43:17 understood 46:15 unit 36:3, 4 44:18 62:5 units 23:19 32:3, 6 49:20 57:22 60:20 universal 24:8, 14 University 7:12 unnecessary 31:19 unstable 22:24 31:9</p>	<p>unusual 9:10 54:12 update 39:10 upgrading 51:11 urban 25:18 urgent 26:5 useful 27:12 utilizing 26:3 < V > valuable 33:17 value 12:9 valued 51:22 variable 32:6 various 51:4 vary 60:21 VERITEXT 66:23 Veterans 6:10 7:16 Vice 2:11 7:2 videoconferencin g 42:11 view 9:22 viewing 11:10 virtual 17:9, 10 25:5, 24 26:3, 25 28:10, 13, 17 29:17 40:9 41:17 42:4, 5, 12, 22 43:10 44:16, 25 45:3 49:7 virtually 17:2 virus 23:12 25:24 30:18 61:10 vision 11:22 12:4 19:23 46:4 51:24 52:13 53:7 54:8 visiting 10:14 22:8 visits 7:11 21:4, 21 26:2, 4 28:22 44:23 49:7 voluntary 26:20 volunteers 19:7 < W > waiting 64:11 wake 30:7 wander 23:18 wandering 19:18</p>
---	--	--	--	--

<p>wanted 10:20 38:6 wants 10:14 water 49:25 Waterloo 5:20 wave 11:19, 20 30:7, 8, 12, 13 32:17 40:24 45:16 54:24 55:1, 3 57:13 58:24 64:9 waves 50:2 ways 27:1 43:4 webinar 30:4 website 10:10, 11, 13, 14 week 50:13 weeks 57:1 well-trained 38:8 wide 20:25 Williams 2:10 4:6 6:6, 7 11:6 13:25 14:1 15:25 21:23 29:6, 9 34:16 35:15 55:2 56:9, 15 64:7, 8 win 53:6 words 9:8 work 5:21 17:23 19:19 21:10, 11, 17, 19, 21 35:6 48:5 57:4, 8, 21 62:5 65:9, 14 worked 5:14 26:1 27:24 28:8 40:23 57:10 workers 46:19 48:3, 7, 25 working 15:1 19:8 40:6, 8 workshop 14:12 workshops 19:25 worsen 18:22 worsened 35:24 worsening 47:14 written 11:1</p> <p>< X > x-rays 43:23 50:12</p>	<p>< Y > Yeah 11:7, 11 20:14 21:15 26:9 28:1 32:21 34:17 35:13, 16 54:2 63:5 year 13:2 16:4, 5, 22, 24, 25 17:1, 10, 25 years 5:14, 17 6:9, 12, 17 8:15 9:21 12:17, 20 16:15 18:4, 5 39:10 51:11 yesterday 11:2</p> <p>< Z > Zoom 1:14</p>			
---	---	--	--	--