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.

BEFORE:

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

PRESENTERS:
Dr. Fred Mather, President of OLTCC;
Dr. Evelyn Williams, Past President of OLTCC;
Dr. Benoit Robert, Vice President of OLTCC;
Dr. Rhonda Collins, OLTCC Director.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Ida Bianchi, Counsel, Long-Term Care Commission

Secretariat;

Kate McGrann, Counsel, Long-Term Care Commission Secretariat.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 4:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, good afternoon, everybody.

DR. RHONDA COLLINS: Good afternoon.

DR. EVELYN WILLIAMS: Hi.

DR. FRED MATHER: Good afternoon.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm Frank Marrocco. This is Commissioner Kitts and Commissioner Coke, and together we make up the -- our Commission of Inquiry.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): We'll certainly do that. I saw a great deal of your son during the Collingwood inquiry, and there's a strong resemblance.

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

COMMISSIONER FRANK MARROCCO (CHAIR): It is. It is. He's doing a great job.

DR. FRED MATHER: Good. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

Ben, you're on mute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. EVELYN WILLIAMS: Oh, here we are.

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

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

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

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

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

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

The OLTCC's value statement is:

> "We believe a dedicated, collaborative, interprofessional team with physician leadership provides the highest quality, comprehensive, evidence-based medical care for long-term care residents."

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

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

and education.

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

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

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

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

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

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

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

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

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

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

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

And the next slide.

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

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

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

Thank you.

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

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

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

Recommendation for the inquiry states that:

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

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

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

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

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

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

THE REPORTER: Doctor, you're muted.

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

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

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

admission, and this reflects really how frail they are.

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

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

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

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

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

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

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

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

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

Thank you.

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

DR. RHONDA COLLINS: So --

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

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

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

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

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

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

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

COMMISSIONER KITTS: They are.

DR. BENOIT ROBERT: Yeah.

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

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

COMMISSIONER KITTS: Okay. So it's --

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

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

COMMISSIONER KITTS: Okay. Okay. Thank you.

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

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

COMMISSIONER KITTS: Okay. Thank you.

DR. FRED MATHER: Okay. Dr. Collins?

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

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

DR. FRED MATHER: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

they worked in more than one location.

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

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

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

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

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

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

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

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

Okay. Rhonda?

DR. RHONDA COLLINS: Thanks. So --

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

DR. EVELYN WILLIAMS: Oh, we lost Rhonda.

DR. FRED MATHER: We lost you, Rhonda.

DR. EVELYN WILLIAMS: Oh...

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

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

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

DR. RHONDA COLLINS: I --

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

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

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

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

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

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

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

But we felt --

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

DR. EVELYN WILLIAMS: The facility.

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

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

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

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

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

COMMISSIONER KITTS: So they're --

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

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

COMMISSIONER KITTS: Thank you.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. RHONDA COLLINS: For an outbreak plan?

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

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

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

It's meant to be a home where they are

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Dr. Mather?

DR. FRED MATHER: Yes.

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

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

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

even without a crisis?

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

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

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

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

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

departments and hospitals carrying on? Yes, I do.

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

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

COMMISSIONER KITTS: Thank you.

DR. RHONDA COLLINS: Can I add to that?

DR. FRED MATHER: Yes, please.

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

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

And so being able to communicate with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

psychogeriatric.

DR. BENOIT ROBERT: Yeah.

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

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

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

COMMISSIONER KITTS: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

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

second wave?

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

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

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

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

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

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

(BRIEF INTERRUPTION)

I'll get rid of that phone.

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

DR. EVELYN WILLIAMS: Right.

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

How do you see that happening, or do you?

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

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

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

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

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

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

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

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

The ones that overlook are being used

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

full capacity, as a potential strategy.

COMMISSIONER FRANK MARROCCO (CHAIR): So in -- and, you know, the reason -- I mean, I appreciate you could construct something, but assuming you don't have time to do that, so would be the retirement residencies where a person might look to find additional spaces?

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

COMMISSIONER FRANK MARROCCO (CHAIR): And you have the -- and I'm not -- I'm asking.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm. Okay.

COMMISSIONER KITTS: Dr. Mather?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

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

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

DR. FRED MATHER: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye, everybody.

-- Adjourned at 5:20 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 30th day of September, 2020.

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