

# Long Term Care Covid 19 Commission Mtg.

Ontario Medical Association  
on Wednesday, November 18, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 18th day of November, 2020,  
1:00 p.m. to 2:00 p.m.

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

1 PRESENTERS:

2 Allan O'Dette, Chief Executive Officer

3 Dr. Hugh Boyd, Chair section Long-Term Care and  
4 Care of the Elderly

5 Dr. Samantha Hill, OMA President, OMA Board  
6 Director

7 Dr. James Wright, Chief, Economics, Policy &  
8 Research

9 Dara Laxer, Executive Director, Economics, Policy  
10 Research

11 Tim Lenartowych, Sr. Advisor, Economics, Policy &  
12 Research

13 Katherine Patterson, Sr. Advisor, Economics, Policy  
14 & Research

15 Jane Fahey-Walsh, Sr. Advisor, Economics, Policy &  
16 Research

17 Marla DiCandia, Sr. Advisor, Government Relations &  
18 Advocacy. Member Relations, Advocacy &  
19 Communications

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 Sanjay Bahal, Team Lead for Operations, LTCC

8 Derek Lett, Policy Director, Long-Term Care

9 Commission Secretariat

10 Lynn Mahoney, Gowling LLP

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12 ALSO PRESENT:

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14 Janet Belma, Stenographer/Transcriptionist

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I N D E X

\*\*The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose\*\*

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 53

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages:  
None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

1 -- Upon commencing at 1:00 p.m.

2 ALLAN O'DETTE: Well, I think in the  
3 spirit of your valuable time, whenever you're  
4 ready, you can -- you can let us know.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 All right. Well, let me -- let me say hello to  
7 everybody else. We were talking to Mr. O'Dette but  
8 didn't get a chance to say -- introduce ourselves  
9 to everyone else.

10 I'm Frank Marrocco, Commissioner  
11 Dr. Jack Kitts, and Commissioner Angela Coke. We  
12 are the three commissioners, as you undoubtedly  
13 appreciate, and the Court Reporter, Janet, is here.  
14 We do have a transcript of these, and we have  
15 tended to post them on the website. We do post  
16 them on the website.

17 We will follow the practice, if it's  
18 okay with you, of asking questions as we go along  
19 rather than waiting to the end and trying to go  
20 back. We have, as you probably know, put out a  
21 first interim report. We may put out a second one.  
22 We may not. We may just -- we have to decide that  
23 yet, but we're in the process of gathering  
24 information and look forward to your perspective on  
25 our terms of reference and what we're up to.

1                   So with that having been said, we're  
2 ready when you are.

3                   ALLAN O'DETTE: Okay. Terrific. Well,  
4 I would, again, just say good morning to  
5 Justice Marrocco, Dr. Kitts, and Ms. Coke. Thank  
6 you all for the work that you're doing on this  
7 long-term care commission.

8                   My name is Allan O'Dette. I'm the CEO  
9 of the Ontario Medical Association, and we  
10 represent some 32,000 practicing physicians across  
11 the Province, and I'll be joined this morning by --  
12 oh, there's Dr. Hill there, our elected president,  
13 along with Dr. Hugh Boyd, who is the Chair of the  
14 OMA's Long-Term Care and Care of the Elderly  
15 section.

16                   Also joining me is Dr. Jim Wright. I  
17 don't know whether we'll need to call on  
18 Dr. Wright, but Dr. Wright and his team. He's the  
19 Chief of Policy, Economics, and Research at the  
20 Ontario Medical Association. It's largely his team  
21 who have, along with some others, been responsible  
22 for writing our recommendations.

23                   I really want to thank you,  
24 Mr. Justice, for the opportunity to present this  
25 morning. I'm going to make just a few opening

1 comments, and then I'll turn it over to Dr. Boyd,  
2 and he'll take us through the recommendations, and  
3 we'll conclude with Dr. Hill.

4 As per your earlier comment, I  
5 recognize that you like to ask questions as these  
6 folks go long, so feel free to interrupt as you  
7 will.

8 As a representative of Ontario  
9 Physicians, the OMA, as you know, really, is -- its  
10 purpose is to advocate for the health of Ontarians  
11 and the well-being of all our members. And our  
12 physicians really continue to workday in, day out  
13 on the front lines during this pandemic. And I  
14 think you'll find that their insight and  
15 perspective is pretty important with regard to what  
16 they see in terms of the performance of the  
17 healthcare system.

18 I don't need to go through the data on  
19 the challenges and issues including deaths that  
20 we've seen in this sector. It's particularly  
21 important to all of us. These are our family  
22 members; they're our neighbours. They're among the  
23 most vulnerable people in our society, and we take  
24 that very seriously as our responsibility to those  
25 men and women who reside in long-term care homes.

1 So we welcome the work that you're doing.

2 I would like to comment, Mr. Justice,  
3 and other members of the Commission, that we really  
4 have no intent of blaming anyone. I think what's  
5 important about the work you're doing is that we  
6 figure out what has been working well and what do  
7 we need to do to be even more effective if, and as  
8 I described earlier, that is our collective  
9 responsibility. And as Dr. Boyd goes through his  
10 comments, I hope what you'll recognize is we are  
11 here to help, and that is the only thing that  
12 guides and motivates us.

13 So what I'd like to do is invite  
14 Dr. Boyd to make some comments. And, again,  
15 members of the Commission, feel free to just put  
16 your hand up, allow -- I'm sure the Chair has a  
17 system of doing that with each of you, so with  
18 that, I would invite Dr. Boyd to make his  
19 presentation.

20 Dr. Boyd.

21 HUGH BOYD: Thank you, Mr. O'Dette. My  
22 name is Dr. Hugh Boyd. I am currently a medical  
23 director of two long-term care homes, and as  
24 mentioned, I was elected as the Chair of the  
25 Ontario Medical Association Section on Long-Term

1 Care and Care of the Elderly.

2 We sent an advanced copy of the OMA's  
3 interim guidance to you, and my remarks draw from  
4 this document. We hope to generate dialogue with  
5 you and that our advice today will be followed in  
6 the weeks and months ahead with a separate set of  
7 system-level recommendations to improve long-term  
8 care delivery.

9 The initial wave of COVID-19 was a time  
10 of terrible uncertainty in long-term care homes.  
11 The risk to staff was not clear, and in some areas,  
12 the shortage of personal protective equipment  
13 heightened concerns. Often staff were confused  
14 about moving between long-term care homes and for  
15 physicians particularly, concerns about  
16 transmission to other vulnerable patients in their  
17 practice.

18 We are guided by hope for a path  
19 forward. I'd like to recognize the efforts that  
20 have been made to date by the Government to support  
21 long-term care homes.

22 We also recognize the heroic strength  
23 and resolution of long-term care home staff who  
24 continue to rise to the occasion each day.

25 It's important to clarify the OMA's

1 role in a pandemic which has been to disseminate  
2 information, field inquiries from doctors, support  
3 implementation, and advocate for improved policy.  
4 Consistent with this later aim, our interim  
5 guidance includes the following 14 recommendations:

6 First, strengthen the roll-out of a  
7 comprehensive seasonal influenza plan that  
8 compliments COVID-related activities. This will  
9 require strong collaboration between public health  
10 units and long-term care homes and should maximize  
11 the influence of a vaccine, and we've seen  
12 significant improvements here.

13 Second, continue to prioritise COVID-19  
14 testing for long-term care homes. It is imperative  
15 that homes and public health have timely data  
16 needed to prevent and/or manage outbreaks.

17 Third, ensure the availability of  
18 personal protective equipment. Physicians and  
19 other healthcare providers need to be safe at work.  
20 Proper PPE must be readily available at all times  
21 along with training on proper selection and use of  
22 PPE.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 Can I just stop you there for a second, Doctor? Do  
25 you have any sense of why there was a shortage of

1 personal protective equipment in long-term care  
2 facilities?

3 And when I ask that question, I  
4 recognize that once the world started demanding  
5 personal protective equipment, that this would  
6 interrupt the supply chain, but my question really  
7 refers to the time period leading up to that.

8 Why wasn't there an adequate supply in  
9 your view, or do you have a view?

10 HUGH BOYD: I will say that I may not  
11 be the best person to ask this; however, I do note  
12 that when the supply was found to be short, a lot  
13 of us long-term care physicians cried out to groups  
14 like the OMA to try to find us more.

15 So all I know is that a lot of groups,  
16 including the OMA, fight, scraped, scrounged, did  
17 whatever they could to get more PPE, and  
18 eventually, there was some success there.

19 Allan may have some better insight --

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 But as a medical director, wouldn't the medical  
22 director know that there's a -- that they don't --  
23 that there's not -- that there's none or there's  
24 very little?

25 HUGH BOYD: So we discovered that at

1 similar rates to many of the public discovering  
2 that as well. All homes have a certain level of  
3 personal protective equipment based on our past  
4 use. And we tried, all of us tried to estimate  
5 what our future use would be with the new pandemic  
6 occurring, and all of us tried to acquire more PPE  
7 because we all suddenly needed more than we  
8 typically use.

9 So the demand far outweighed the  
10 supply, and that was the problem that every medical  
11 director saw.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Dr. Hill, I think you wanted to say something?

14 SAMANTHA HILL: Yes. Thank you. So  
15 with full respect, I think you're underestimating  
16 the change in amount required pre- and post-COVID,  
17 and so what the staff would have on site and have  
18 available for normal use would be, let's call it,  
19 Tier 1; and that would require occasional use for  
20 occasional patients.

21 They went from that to needing full use  
22 on every patient, and that's an exponential growth  
23 in need. And that happened at a world place  
24 (phonetic) where the rest of the world was  
25 already -- or much of the world was already

1 acquiring some of that supply. And so there was an  
2 exponential increase in need at the same time as  
3 there just wasn't that supply out there.

4 I'll turn it over to Allan if he has  
5 anything else to add to that.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Wasn't -- didn't this come up in the SARS Inquiry?  
8 I mean, wasn't there -- weren't there -- wasn't  
9 this discussed at that time, though, about the need  
10 to have sufficient supply of PPE on site?

11 ALLAN O'DETTE: Dr. Wright, do you  
12 remember that period?

13 JIM WRIGHT: Yeah, I think you've hit  
14 upon a key point, which is -- to the SARS  
15 Commission, I believe the recommendation was not  
16 for individual institutions, but, Federal and  
17 Provincial organizations to be able to meet this  
18 acute and immediate need.

19 And we certainly know that there was a  
20 very large stockpile. We were uncertain how much  
21 of that stockpile supply was available. It was  
22 rumoured to be as much as, for example, 6 million  
23 masks. We heard later that maybe it had expired  
24 and not renewed. I'm in no position to say how it  
25 fell by the wayside, but I think there was a hope

1 that at the Provincial and National level, there  
2 would be some maintenance of a stockpile to deal  
3 with these threats.

4 I don't think anyone anticipated COVID,  
5 but there's been a belief there would be a major  
6 genetic shift in always such as the flu virus that  
7 might be similar in severity to COVID even if it  
8 wasn't another SARS, there was certainly an  
9 expectation of pandemic.

10 COMMISSIONER FRANK MARROCCO (CHAIR):  
11 I didn't mean to imply by the question that the OMA  
12 was -- or that you were responsible. I was just  
13 asking the question.

14 Dr. Kitts, you wanted to ask a  
15 question?

16 COMMISSIONER JACK KITTS: Yeah, I was  
17 just -- we've heard that the Registered Nurses  
18 Association of Ontario were very vocal in  
19 advocating for N95 masks, and thinking back to the  
20 SARS report, it was recommended that the  
21 precautionary principle be applied when there's any  
22 uncertainty.

23 Where was the OMA and the physicians in  
24 long-term care -- where did you stand on that  
25 aspect of the PPE?

1                   JIM WRIGHT: Hugh, you go, but I'm  
2 prepared to answer as well.

3                   HUGH BOYD: Certainly. So long-term  
4 care physicians did receive in the Ministry  
5 Directives specific instructions, along with other  
6 long-term care staff, about performing a  
7 point-of-care risk assessment with each patient  
8 encounter, and at that time, making the  
9 determination themselves about what the most  
10 appropriate PPE use would be. And so that has been  
11 a message I have reinforced.

12                   And in the end, personally, I do  
13 support the science that has continued to learn  
14 more and more about this terrible virus and at the  
15 beginning, felt that droplet and contact  
16 precautions were adequate.

17                   And to this day, I even continue to  
18 support that, and as we learn more about  
19 circumstances that may have had aerosol spread or  
20 may have been accelerated droplet spread, we  
21 continue to learn but support the science  
22 recommending contact and droplet precautions with  
23 the exceptions of aerosol generating medical  
24 procedures.

25                   JIM WRIGHT: Yeah, and I think that's a

1 key point. And I believe it was actually the ONA  
2 that came out very strongly when Directive 5 first  
3 came out. The RNAO and the OMA were both aligned  
4 with Public Health Ontario which emphasized about  
5 droplet transmission which seemed to be based on  
6 the early evidence, the predominant form of  
7 transmission.

8           And other than the circumstances that  
9 Hugh has described where there might be an  
10 identified individual risk, the routine risk of  
11 increased surgical -- the routine use of surgical  
12 masks was consistent with the PHO. And we  
13 supported that based on the best evidence; I think  
14 you would find the RNAO had a similar view  
15 initially.

16           In terms of the precautionary  
17 principle, you could argue that N95, in the absence  
18 of definitive information, may have been a better  
19 source of precaution, I believe was the ONA and --  
20 CUPE and the other unions who advocated very  
21 strongly for changes to Directive 5.

22           I would tell you that I think there  
23 could have been greater transparency in decision  
24 making, I understand it, a decision was made that  
25 there wasn't enough N95 as it needed to or

1 preserved for aerosol generating procedures, and  
2 that's why the precautionary principle had to be  
3 forsaken. I don't believe that was ever  
4 transmitted broadly to anyone.

5           And I'm only guessing what was going  
6 on. I think that may have interfered with the  
7 ability to use the precautionary principle because  
8 there was insufficient N95 to be used generally,  
9 and it was being saved for what was afraid to be an  
10 overwhelming of ICUs.

11           ALLAN O'DETTE: Well, I'll just add one  
12 comment to all of that. And frankly, it was all  
13 about planning. We called this out in January,  
14 February, March, April, and there -- we just were  
15 unable to get coordinated.

16           We saw the problem. I couldn't tell  
17 you how many nights and weekends I was on the phone  
18 with Government folks, and we were unable to help  
19 them get coordinated. Again, I'm not blaming  
20 anyone.

21           We took a decision on our own to go  
22 procure, and I can tell you that I tracked down no  
23 fewer than 20 different suppliers, and it was  
24 absolute chaos. The OMA made a purchase through  
25 our own funds. We ran drives and collected

1 millions of pieces of PPE and delivered those to  
2 communities. I can tell you I personally got in my  
3 car and drove PPE around this province.

4 But the summary answer was around  
5 planning, and, you know, I appreciate Dr. Kitts  
6 raising the point about nurses because in January  
7 and February, Dr. Wright and his team were  
8 literally on the phone every day with various  
9 stakeholders, so it was a planning issue.

10 COMMISSIONER FRANK MARROCCO (CHAIR):  
11 Can you just -- can you help me with, do you have a  
12 sense of why it was so difficult to be heard?

13 ALLAN O'DETTE: Yes. In my view --  
14 this is a personal view about how they were running  
15 crisis and prioritising matters. The Government  
16 typically procures through a process that they  
17 have, and they were just unable to procure and make  
18 decisions quickly enough.

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 But, you know, most procurement policies originate  
21 around trade agreements where procurement has been  
22 negotiated, but almost all of them have an escape  
23 hatch in the event of an emergency.

24 And I understand procurement policies  
25 can take a while by the time you have a request for

1 proposals and you put out, and you receive bids,  
2 and you evaluate the bids and so on. But in an --  
3 as I say, in an emergency, there's usually an  
4 escape hatch for that.

5 Were you -- did anybody ever -- was  
6 that a surmise of yours, or did -- was that what  
7 you were told?

8 ALLAN O'DETTE: I was told they were  
9 working on it, and they just were unable to get at  
10 it, and I could tell you, I spent hours and hours  
11 and days even through the procurement process  
12 myself tracking people down here in Ontario, in  
13 Canada, and overseas and ultimately took delivery  
14 of supplies and hired a truck and distributed it.

15 It was -- it was just coordination and  
16 an inability to procure quickly and make decision  
17 quickly.

18 JIM WRIGHT: Can I add -- sorry --

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 Sure. Go ahead.

21 JIM WRIGHT: -- to your question. I  
22 think where I feel that, in retrospect, the  
23 Government was under enormous pressure from every  
24 stakeholder for more PPE. I think they had  
25 insufficient stockpiling. They couldn't procure it

1 quickly enough. There was enormous flood of  
2 counterfeit PPE, and they clearly had to trade off  
3 procurement while assuring whether -- the quality.

4 Where I think the Government perhaps  
5 fell down is being transparent and candid with both  
6 the providers and the public. There was, you know,  
7 pictures of the Premier in a warehouse with all  
8 sorts of PPE, and we said, oh, thank goodness. And  
9 then it never came.

10 So I think that they were under  
11 enormous public pressure, and I think if they'd  
12 been more candid with the population, we don't have  
13 it yet; we're doing our best, that would have gone  
14 a long way because the implication was there was a  
15 stockpile of 6 million, albeit out of date, that  
16 they could release, that there was stuff on the  
17 way. I'm not sure they were as transparent as they  
18 could have been.

19 People just want to know what the real  
20 situation is -- that's my view -- and then they'll  
21 cope. But if people feel that they don't get the  
22 full information, that's where the insecurity and  
23 the anxiety -- and Allan pulled out huge chunks of  
24 hair just because we couldn't get a straight  
25 answer.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2   Okay. Well, I think I -- we interrupted somewhere,  
3   so I don't think we have any further questions on  
4   that for now. Carry on.

5                   HUGH BOYD: If I may make one  
6   recommendation. At my organizations, we found it  
7   far more helpful to share with staff and the  
8   leadership team about PPE supply in terms of number  
9   of days as opposed to number of masks or number of  
10   gowns or number of other things.

11                   Number of days allows you to consider  
12   the burn rate, how frequently you're going through  
13   things, and can help give staff and leadership a  
14   better sense as to how much time we have until we  
15   hit that critical nature. And I certainly  
16   encourage other homes to do the same.

17                   Next on our action plan was Number 4:  
18   Proactively undertake advanced care planning,  
19   education, and conversations. Many homes are doing  
20   this, and we encourage them to continue to do so.

21                   Number 5: Review indications for  
22   transfers to hospital. Avoid blanket policy that  
23   would prevent the transfer of long-term care  
24   residents to hospital when resources became  
25   strained -- become strained. Instead, these

1 decisions should be influenced by the identified  
2 goals of care and input from healthcare providers.

3 Number 6: Continue to group and  
4 isolate residents with COVID-19.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Excuse me --

7 COMMISSIONER JACK KITTS: Can I just go  
8 back to the one, undertake advanced care planning,  
9 education, and conversations? I gather, then, that  
10 not every resident in long-term care homes has had  
11 that conversation; is that correct?

12 HUGH BOYD: So we hear different things  
13 based on what people define as advanced care  
14 planning. My understanding is every resident who  
15 enters a long-term care facility has at least a  
16 rudimentary conversation particularly around what  
17 we call code status: When the heart or lungs were  
18 to stop, what would we want them to do? And this  
19 has been, kind of, advanced care planning that has  
20 been taking place for decades.

21 So every resident should, at the least,  
22 be having that conversation. What we're  
23 encouraging is a bit more robust conversation, the  
24 what ifs, the, I'm worried something might happen;  
25 I wish you'll continue to be helpful -- healthy,

1 and to promote those kinds of conversations about  
2 future planning.

3 COMMISSIONER JACK KITTS: Thank you.

4 COURT REPORTER: Sir, if you could  
5 speak up a bit when you're talking. And that would  
6 be for Mr. O'Dette [sic]. Sorry.

7 COMMISSIONER JACK KITTS: Thank you.

8 COMMISSIONER FRANK MARROCCO (CHAIR):  
9 Go ahead, Doctor.

10 HUGH BOYD: Yes, so regarding  
11 cohorting, to the greatest extent possible,  
12 long-term care homes with the available  
13 configuration should be supported to isolate and  
14 group infected residents, and all efforts should be  
15 made to assign dedicated staff to care for these  
16 residents.

17 I've actually been involved with a  
18 COVID-19 outbreak in my facility on the wandering  
19 unit. The nightmare has finally come to us, and  
20 this was a critical part of our success.

21 Number 7 -- oh.

22 COMMISSIONER ANGELA COKE: Can I ask a  
23 question? Just your general thoughts about  
24 decanting and getting people out of the facility,  
25 if needs be, to alternative, sort of, settings.

1                   HUGH BOYD: I've been involved with  
2 some pretty thorough discussions with Ministry  
3 representatives, with the Chief of Staff at  
4 Sunnybrook on this exact topic and have spoken to  
5 Lisa Levin at AdvantAge Ontario.

6                   The decision about decanting can  
7 generally be split into two. One is to decant for  
8 medical reasons; for example, residents are not  
9 getting their care needs met, and there's imminent  
10 risk of harm.

11                   The second version is decanting for  
12 nonmedical reasons where the staffing is not  
13 sufficient enough, or there's problems at the home  
14 such that, while some may need some urgent medical  
15 attention, a -- groups of large numbers of  
16 residents are being transferred, many for not  
17 medical reasons, but just because there isn't the  
18 correct and safe environment around there.

19                   So with regarding to, of course,  
20 decanting for acute medical care needs, this is, of  
21 course, supported by myself and I think everyone we  
22 speak to. If the resident care needs exceed the  
23 location where they are, then we, as physicians and  
24 nurses, need to advocate for better care. And this  
25 happens whether we're in the community or in

1 long-term care facility or even the hospital.

2 Decanting for nonmedical needs is more  
3 challenging, and I say this because I've always  
4 tried to view care in long-term care homes with a  
5 person-centred view, is that we want to advise what  
6 the best medical decision is, but we also want to  
7 make sure we're incorporating resident and family  
8 values, wishes, and their active decision making.

9 Sometimes that decision to decant large  
10 groups of people doesn't consider the family or  
11 resident beliefs or values. Sometimes there isn't  
12 time to.

13 So while there may be opportunities to  
14 provide that on a case-by-case basis where  
15 particular facilities that have significant risk  
16 factors for worsened outcomes, there may be an  
17 argument that there could be some benefit to that.  
18 Deciding which homes that is, which situation, and  
19 when that trigger and threshold should be reached  
20 is something I haven't heard anyone across the  
21 country has been able to figure out.

22 There's been lots of conversations on  
23 both sides, and clearly, at this time, a lot of  
24 concerns that we don't have the resources to  
25 effectively offer that intervention fairly and

1 equitably across the board and discussions about  
2 who to offer this to have been very difficult.

3 Decanting may be one of the tools that  
4 could be helpful, but so far, no one's quite  
5 figured out how or with whom.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Well, who makes that -- who should make that  
8 decision?

9 HUGH BOYD: So that is a question  
10 probably best for legal counsel. I know in the  
11 Hamilton area where I'm involved, who makes that  
12 decision is going to be disputed in the courts as  
13 one of the homes felt that it was made improperly.  
14 So there is some risk around this, we're learning.  
15 Who should make that decision --

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 No. No. But I wasn't asking the question from  
18 that perspective. I was asking it from the -- from  
19 your perspective as a medical director.

20 Naturally, legal challenges can affect  
21 the answer, but looked at from the medical  
22 director's perspective, who should decide whether  
23 you remove people who are infected or people who  
24 are not? In fact, I mean, who should make that  
25 decision?

1                   HUGH BOYD: So thankfully now we have  
2 these congregate care setting groups set up across  
3 the province which involves hospital infection  
4 prevention and control experts from Public Health  
5 Ontario and some long-term care experts.

6                   That decision should be made as a team  
7 with those experts including the long-term care  
8 facility's administrator, director of care, and  
9 medical director.

10                   So those three, the triad, are critical  
11 in understanding what is best for that particular  
12 facility. The others on the congregate care  
13 settings can provide answers about whether or not  
14 there are even beds or safe places to decant these  
15 individuals to, and that decision should be made  
16 together.

17                   COMMISSIONER FRANK MARROCCO (CHAIR):  
18 It -- one of the -- one of the things that concerns  
19 me is that you're in the middle of a pandemic, or  
20 you go back to Wave 1, people -- the disease  
21 spreads quickly.

22                   I'm wondering about the speed with  
23 which there can be that kind of collaborative  
24 decision making in an emergency and who should  
25 decide. Can those decisions be made that quickly

1 by a collective like that?

2 HUGH BOYD: I believe they can or with  
3 strong relationships, pre-existing relationships,  
4 collaboration before the outbreak happens, having a  
5 network of hospitals and long-term care facilities  
6 who know each other.

7 And in our region, we have seen that  
8 decision made, which I felt was responsible, made  
9 within about 48 hours, I believe, from when the  
10 hospital was heavily involved with support to when  
11 the decision to decant was made.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Thank you.

14 COURT REPORTER: And, sir, it was Mr.  
15 Boyd, if you could just speak up a little bit. At  
16 times, you're kind of trailing off.

17 HUGH BOYD: Of course, ma'am. Thank  
18 you.

19 COURT REPORTER: Thank you.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 So carry on, Doctor.

22 HUGH BOYD: Next on our plan, Number 7:  
23 Ensure sufficient staffing is available.  
24 Facilities should be supported for additional  
25 staffing needs associated with COVID-19. We know

1 that there are persistent staffing challenges in  
2 the sector, and the pandemic is making the  
3 situation more complex.

4 Any non-essential movement of staff  
5 between long-term care homes should continue to be  
6 avoided. Clarity is needed regarding the  
7 application of certain directives to ensure that  
8 physicians are aware of their duties and are  
9 supported to meet their professional  
10 responsibilities which may include delivering  
11 medical care across multiple sites.

12 Number 8: Ensure residents of  
13 long-term care homes have access to essential  
14 visitors, caregivers, and other social supports in  
15 a safe manner. The impact of social isolation and  
16 lack of access to central visitors during Wave 1  
17 was particularly devastating. Clear guidance and  
18 consistent implementation of the Ontario  
19 Government's updated visitor's policy is essential  
20 to help reduce social isolation, ensure care needs  
21 are met, and reduce the spread of infection.

22 Number 9: Expand virtual care capacity  
23 and mobile outreach as needed for the on-ground --  
24 on-the-ground support within the long-term care  
25 sector. This will improve the ability to care for

1 residents in their home while decreasing viral  
2 transmission. We're living in a new era in  
3 healthcare. Healthcare is often appropriate and  
4 should be encouraged virtually to minimize the  
5 transmission of COVID-19 and other respiratory  
6 viruses.

7 Number 10 --

8 Yes, Commissioner.

9 COMMISSIONER ANGELA COKE: I'll just  
10 ask a question about the virtual care. What do you  
11 see as any, sort of, barriers to effective virtual  
12 care, or what sort of limitations do people  
13 experience, if any?

14 HUGH BOYD: I've heard from members  
15 across the province that one of the biggest  
16 barriers is technology, whether or not they have a  
17 strong enough Internet connection either at their  
18 own location or at the long-term care facility as  
19 well.

20 For example, one of the physicians in  
21 my home, for some reason, cannot access OTN's  
22 Virtual Care Network from their office in Carlisle,  
23 just outside of Hamilton.

24 The other challenge, of course, is  
25 staffing as well, is making sure that there is

1 someone on the other end who can provide that  
2 virtual care whether it's through telephone or  
3 through virtual Tablet or video means as well.

4 And so having people comfortable and  
5 fluent with the technology and the ability to  
6 implement this quickly and move on is also key.

7 Virtual care seems like a stumbling  
8 block at first, but with practice, it becomes more  
9 comfortable and can be remarkably efficient for  
10 everyone involved. Thank you.

11 Next, Number 10: Highlight and  
12 maximize the role of the medical director in  
13 managing COVID-19 outbreaks. There is an increase  
14 in workload, and the attending physicians and  
15 medical director can collaborate by increasing  
16 communication, enabling virtual care, sharing  
17 resources, reorganizing the medical staff, and  
18 establishing or maintaining relationships with  
19 consultants in hospitals.

20 COMMISSIONER FRANK MARROCCO (CHAIR):  
21 Doctor, in a long-term care home, who decides that  
22 the Internet connection needs to be enhanced so  
23 that virtual care can be more readily provided?

24 HUGH BOYD: So that primary decision,  
25 as much of the decisions about how a home is run,

1 typically would come from the administrator, but  
2 they would take advice and guidance from the  
3 Director of Care or also known as the Chief of  
4 Nursing Staff or from the medical director themself  
5 [sic].

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 All right. Okay. Thank you.

8 COMMISSIONER JACK KITTS: Can I just  
9 ask about the -- is the medical -- maximize the  
10 role of the medical director? We've heard that  
11 some medical directors didn't go into the homes or  
12 were asked not to go into the homes or some fear of  
13 spreading the virus or getting the virus  
14 themselves.

15 Can you -- can you speak about the --  
16 maximizing the role in that context?

17 HUGH BOYD: Of course, Dr. Kitts. It's  
18 my genuine belief that leadership needs to be  
19 developed and not demanded. You've already heard  
20 about the incredible leadership that Colonel Scott  
21 Malcolm provided as a physician. You've heard that  
22 large corporations like Sienna and Exstandardcare  
23 [sic] have already quickly hired some of the best  
24 physicians in our area to be their Chief Medical  
25 Officers in their homes.

1                   You've heard the Ontario Long-Term Care  
2 Clinicians have a medical director course and  
3 attending physician course for long-term care  
4 physicians and NPs.

5                   Personally, I've done this training,  
6 and I also hold a certificate in infection  
7 prevention and control in post-acute and long-term  
8 care setting by the CDC.

9                   So last spring, the OMA and Ontario  
10 Long-Term Care Clinicians held several town halls  
11 to bring together experts in long-term care  
12 medicine, infectious disease, palliative care, and  
13 healthcare worker wellness, and we received a lot  
14 of very positive feedback.

15                   The OLTCC has held recently a  
16 conference with several sessions discussing  
17 COVID-19 and long-term care, but we need more  
18 events like these, and we need to be sure that  
19 every physician who needs this is able to benefit  
20 from it.

21                   I generally believe leadership can be  
22 developed and not just demanded, and I believe that  
23 all of us want to do this job well but need the  
24 correct skills, knowledge, and attitudes in order  
25 to do this job well.

1                   COMMISSIONER JACK KITTS: So I gather  
2 what you're saying, then, is, yes, we agree that,  
3 Scott -- Colonel Scott Malcolm and that -- that  
4 chain of command and -- worked very well in the  
5 homes that they went into.

6                   So I don't want to put words in your  
7 mouth, but you're suggesting that that chain of  
8 command where the physician -- the physician in  
9 charge in the military worked with a very strong  
10 nurse who was basically on the ground managing the  
11 staff; that works very well, and you're saying that  
12 that would be a model that long-term care homes  
13 should aspire to, but the training for the -- for  
14 the physicians as a commander would be -- would be  
15 required?

16                  HUGH BOYD: Forgive me. Thank you,  
17 Dr. Kitts, for clarifying. That was not my  
18 intention, and I appreciate the opportunity to  
19 clarify.

20                  I have phenomenal respect for the work  
21 that he did, and he performed those duties in an  
22 emergency and in a crisis. I am the last person to  
23 advise what is the best thing to do in emergency  
24 and a crisis, and I trust that the model that was  
25 developed and used should probably only be applied

1 in those emergencies or crises.

2           Outside of those truly terrible  
3 situations, I recommend that medical directors  
4 receive the knowledge, skills, and attitudes to do  
5 this job well whether that's through such training  
6 courses like the medical director curriculum by the  
7 Ontario Long-Term Care Clinicians, by other  
8 leadership courses that have been offered in  
9 healthcare systems to make sure that they are given  
10 the ability to do their job well.

11           In long-term care facilities, the  
12 administrators, the directors of care, they all  
13 receive advanced education on leadership in  
14 long-term care.

15           Usually, the medical director has the  
16 least leadership training when it comes to  
17 long-term care, and unfortunately, while there are  
18 organizations that are providing these amazing  
19 education opportunities, not enough of us have done  
20 it.

21           So medical director is an important  
22 position. It is. To maximize that role, let's  
23 give them the training to do so, and let's make  
24 sure their voices are being listened. So some  
25 medical directors have said they've been excluded

1 from discussions. I'm working with one in Hamilton  
2 who was not even involved with the outbreak call  
3 with Public Health. So both, let's maximize the  
4 medical director by giving him the skills, and  
5 let's make sure they continue to be an effective  
6 part of the team.

7 COMMISSIONER JACK KITTS: Okay.

8 HUGH BOYD: Commissioner.

9 COMMISSIONER ANGELA COKE: Just in --  
10 you're talking about working in a team, and I'm  
11 just curious about your views on the role of the  
12 nurse practitioners and how you work together where  
13 they exist. And I know they're not in every home,  
14 but just interested in that relationship and  
15 working together.

16 HUGH BOYD: Yes. I'm pleased to say I  
17 and every physician that I've talked to who works  
18 in long-term care has always spoken very highly of  
19 our relationships with nurse practitioners.

20 The medical director is responsible for  
21 creating a quality medical services program within  
22 a long-term care facility, and that includes  
23 attending physicians which the medical director is  
24 usually one, as well as nurse practitioners if  
25 they're available.

1                   Access to nurse practitioners grants  
2 the medical director and their physicians an  
3 opportunity to provide a dynamic medical service  
4 where the right provider can provide the right care  
5 at the right time.

6                   So nurse practitioners and attending  
7 physicians fulfill very different roles within  
8 long-term care facilities both in terms of the  
9 skill set they have as well as the hours that they  
10 are available.

11                   And so we certainly encourage a  
12 collaborative model where the two work together to  
13 make sure that residents in long-term care receive  
14 the best medical care they can.

15                   COMMISSIONER FRANK MARROCCO (CHAIR):  
16 Could a registered nurse be a medical director if  
17 they took the -- this continuing education to which  
18 you refer, assuming it was available?

19                   HUGH BOYD: So legally, no. Currently,  
20 the medical director must be a physician, and I  
21 understand there are emergency orders either  
22 considered or was released -- forgive me -- about  
23 making sure that some nurse practitioners could be  
24 medical director in circumstances where they could  
25 not recruit a medical director.

1                   But a registered nurse is a very  
2 different role and someone who does not provide  
3 medical services. Forgive me about the  
4 differentiation. They're an incredibly important  
5 part of the team, absolutely, and thrilled that  
6 long-term care facilities have a requirement to  
7 have a registered nurse present at all times.

8                   But we're different parts of the team,  
9 and I don't think a registered nurse could be a  
10 medical director.

11                   COMMISSIONER JACK KITTS: I think,  
12 Frank -- I think he, Justice Marrocco, was meaning  
13 a nurse practitioner because we've heard that that  
14 order was issued during the crisis, that they could  
15 serve as a medical director in the absence of a  
16 medical director, so nurse practitioners were -- we  
17 were speaking to.

18                   HUGH BOYD: So I have heard that  
19 rumour, but unfortunately, I haven't been able to  
20 speak either with physicians or nurse practitioners  
21 on that. I've searched far and wide to try to find  
22 out where that happened, and while it sounds  
23 interesting and promising, it's something to watch  
24 very closely where it has been implemented.

25                   COMMISSIONER ANGELA COKE: So, sorry.

1 Just to follow on -- a little on that theme, are  
2 there any issues in getting doctors to take on this  
3 role? Do you have a supply issue, or no?

4 HUGH BOYD: Yes. So traditionally,  
5 certainly, my predecessors at both organizations I  
6 work at, both were, essentially, begged to do this  
7 job. Neither of them -- it was full-time. Neither  
8 of them, was it something that they planned to do  
9 when they left medical school, and quite across the  
10 province, we do hear about nursing homes having  
11 difficulty attracting physicians to be a medical  
12 director or attending physicians.

13 I do believe that's been changing these  
14 last ten years. There is a culture shift, and a  
15 lot of that has to do with funding. A lot of it  
16 has to do with attitudes towards caring for older  
17 adults.

18 Our society has a brutal prevalence of  
19 many prejudices including ageism, and certainly in  
20 our areas of Hamilton, there are far more  
21 physicians interested and willing to do this. We  
22 actually have a number of people who have completed  
23 the medical director course who aren't medical  
24 directors, who are maybe waiting for that  
25 opportunity to come up in their career or also just

1 find it incredibly helpful to provide quality care.

2 So I'm optimistic that it will improve  
3 in the future but only in certain areas. There are  
4 significant areas across the province where there  
5 is a shortage. And as we saw, certain  
6 circumstances where, even despite my efforts -- I  
7 tried to help out two of those organizations --  
8 physicians just didn't want to do it. So it is a  
9 challenge and one that we hope we can improve.

10 COMMISSIONER JACK KITTS: Dr. Boyd, are  
11 most of the, or all of the medical directors, do  
12 they come from the family practice group of  
13 physicians?

14 HUGH BOYD: Typically, probably with  
15 about 99.5% are family physicians.

16 COMMISSIONER JACK KITTS: And is there  
17 any course specific to long-term care homes like  
18 the medical director course that you speak to, is  
19 that in any part of the family practice residency  
20 or any other residency?

21 HUGH BOYD: Absolutely not. I can  
22 certainly speak for McMaster. I can't speak for  
23 the other organizations, but what I'm hearing from  
24 educators across the province is there's very --  
25 there's very poor education for long-term care

1 medicine.

2 I'm certainly proud to be with  
3 McMaster. We are the first university to require  
4 every single family medicine grad to do at least  
5 two longitudinal electives in long-term care. It's  
6 not elective. It's a required component, so they  
7 have to.

8 So McMasters' at least training docs  
9 who have guaranteed to have spent some time in  
10 long-term care, and that model has spread to  
11 Queens, I understand as well, but the training, the  
12 leadership training, appears to be felt to be  
13 beyond the scope of the residency program.

14 There is -- I should clarify: Family  
15 physicians can also be Care of the Elderly  
16 physicians, extended skills programs much like  
17 anaesthesia or emergency medicine. I hold a  
18 certificate in Care of the Elderly. Even there I  
19 became an expert in caring for older adults but not  
20 an expert in long-term care.

21 I had found it incredibly powerful and  
22 motivating and empowering to take the medical  
23 director course. It made me far more engaged with  
24 my team and far more effective.

25 COMMISSIONER JACK KITTS: It sounds

1 like you're going to be a very strong advocate for  
2 bringing the long-term care expertise into the  
3 training, so good luck with that.

4 HUGH BOYD: Thank you. We're trying  
5 very hard.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Is there any requirement for mandatory continuing  
8 education in -- within the profession generally, or  
9 obviously not in the long-term care -- as far as  
10 long-term care clinicians are concerned?

11 HUGH BOYD: So there is certainly  
12 continuing education requirements for all  
13 physicians. We have those, as you're probably  
14 aware. I'll clarify: So for me as a Care of the  
15 Elderly physician, I absolutely have to confirm  
16 competencies in the field of caring for older  
17 adults in order to keep my certification.

18 However, as most physicians providing  
19 care are not Care of the Elderly experts, the  
20 requirements do not get so specific.

21 Long-term care homes, the medical  
22 directors can provide education, and some do with  
23 our staff meetings. We have little education  
24 components as well as a staff meeting, but for the  
25 most part, it's completely voluntary.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2 Do you think it should be mandatory? In other  
3 words, if the College would require?

4                   HUGH BOYD: Difficult to say. I'll  
5 confess I'm nervous about that. On the one side, I  
6 love the idea of ensuring that every Ontarian in  
7 long-term care facility receives quality medical  
8 care and that we can somehow certify or guarantee  
9 that.

10                   However, it's hard enough to get  
11 physicians to provide care in long-term care  
12 facilities, and if there are too much bureaucratic  
13 requirements, could that turn some really excellent  
14 doctors who have provided care for decades -- would  
15 that make them consider retirement sooner? Would  
16 that consider -- make them consider a different  
17 area of practice? I'm nervous about requiring it.  
18 I truly am.

19                   Incentivizing it, making it incredibly  
20 attractive both in terms of the improvements in  
21 your quality of life and your job satisfaction,  
22 certainly. In terms of making sure that the time  
23 is reserved and protected like family health teams  
24 are able to fund continuing education for their  
25 docs, why not long-term care facilities? But

1 making it a legislative requirement makes me  
2 nervous.

3 COMMISSIONER FRANK MARROCCO (CHAIR):  
4 Okay. All right. I don't think we have anymore  
5 questions right now.

6 HUGH BOYD: Thank you. I'll move on to  
7 Point Number 12 -- or sorry -- Point Number 11:  
8 Make appropriate funding decisions for the delivery  
9 of medical care during the pandemic. The OMA  
10 negotiates with the Minister of Health for the  
11 funding of physician services, and there are  
12 several enhancements that could be pursued  
13 immediately to ensure that physician remuneration  
14 reflects the demands on long-term care physicians.

15 Number 12: Consider establishing  
16 regional long-term care physician advisors for the  
17 five Ontario Health regions. Experienced long-term  
18 care physician leadership at the system level can  
19 engage medical directors in new ways and expand  
20 their education on infection prevention and  
21 improving the quality of resident care. These  
22 physicians can work with government and public  
23 representatives to enhance communication and better  
24 coordinate medical care.

25 You've already heard from two major

1 corporations who have hired -- recently hired chief  
2 medical officers which would be a very similar  
3 position providing leadership to their medical  
4 directors. This type of a position could help make  
5 sure that everyone gets that expertise.

6           Number 13: Support infection  
7 prevention control training for all long-term care  
8 staff and physicians. It's important that all  
9 providers in long-term care have a consistent  
10 understanding of infection prevention controls and  
11 best practices. Integration of Ontario-specific  
12 guidance will be an asset to success.

13           And lastly, Number 14, consider  
14 continuum of care and how long-term care homes  
15 interact with other areas of the system. We know  
16 long-term care homes do not exist in isolation, and  
17 they connect with and depend upon the interactions  
18 with other areas of the healthcare system.

19           While we recognize that the  
20 Commission's mandate is specific to long-term care  
21 homes, we encourage you to approach the issue  
22 systematically.

23           Ontario's doctors want to be a part of  
24 the solution, and we avail ourselves for further  
25 dialogue with the Commission and others on how to

1 improve the pandemic response. We look forward to  
2 sharing our advice early in the new year.

3 I'd now like to ask Dr. Hill to make  
4 some concluding remarks.

5 COMMISSIONER JACK KITTS: Could I just  
6 ask a question on that last point? You're aware of  
7 the Government's direction, strategic direction in  
8 the last couple of years in Ontario in creating  
9 Ontario Health Teams as primary care as a -- as the  
10 foundation of Ontario Health Teams, so a big  
11 component.

12 In terms of your last point, do you see  
13 that Ontario Health Teams would include long-term  
14 care and would satisfy that recommendation?

15 HUGH BOYD: Had you have asked me last  
16 year, I might have said -- been a lot more  
17 pessimistic. As I'd heard, many Ontario Health  
18 Teams had only considered long-term care when it  
19 came to reducing emergency department usage.

20 That has changed completely. We have  
21 phenomenal system support better than I've seen in  
22 the decade that I've been an independent  
23 practitioner. Hospitals, family health teams, and  
24 long-term care facilities are working better  
25 together than I could have imagined.

1                   So, yes, I think the model of Ontario  
2 Healthcare Teams could be truly wonderful. The  
3 idea of taking the power out of one particular silo  
4 and bringing this all together could be  
5 spectacular.

6                   COMMISSIONER JACK KITTS: Nice. I  
7 agree. I have one more question before we go to  
8 Dr. Hill. I'm sorry.

9                   I read through the appendix, and you've  
10 got three types of physicians' roles, the medical  
11 director, the attending physician, and the  
12 consultant physician; and they're clear.

13                   But in the attending physician, it  
14 says: (as read)

15                                 "Legislative requirements of  
16 the attending physician include:  
17 Every long-term care home shall  
18 ensure that either a physician or a  
19 registered nurse in the extended  
20 class -- "

21                   I believe that's a nurse  
22 practitioner -- (as read)

23                                 "-- can fulfill the duties and  
24 the requirements of the legislation  
25 as attending physician."

1                   Is -- did I read that right?

2                   HUGH BOYD: I believe so.

3                   COMMISSIONER JACK KITTS: Okay. So  
4 it's either nurse practitioner or -- so this will  
5 help with your shortage, or is the shortage of  
6 physicians really for the medical director role, or  
7 do you have trouble finding attending physicians as  
8 well?

9                   HUGH BOYD: So there's difficulty with  
10 attending physicians as well. And I'll be honest.  
11 One of the most difficult parts of this job is the  
12 on-call. I believe, you know, not to get too deep  
13 into remuneration, but it's pennies per patient, so  
14 about a quarter per patient per day. And these are  
15 incredibly complex and frail individuals.

16                   And I have yet to encounter a nurse  
17 practitioner who provides after-hours care or  
18 after-hours call service. They may exist. I just  
19 haven't met one yet, and I've met many.

20                   So the model -- the Medical Services  
21 Model has to be integrated and supportive, and we  
22 need to work together.

23                   COMMISSIONER JACK KITTS: So the --

24                   JIM WRIGHT: Do you mind if I add to  
25 that comment? I'm sorry I interrupted you there.

1                   COMMISSIONER JACK KITTS: No. Just the  
2 funding, then, just to be clear: So the attending  
3 physicians that are fee-for-service, they're not  
4 on -- not on some honorarium or something for --  
5 so, okay, so that -- I understand that.

6                   And the nurse practitioners, of course,  
7 don't bill fee-for-service. They would be on a  
8 salary. Okay.

9                   Sorry. Go ahead, Dr. Wright.

10                  JIM WRIGHT: I was just going to say, I  
11 think we're -- what the legislation says and what  
12 we think is ideal are slightly divergent. I think  
13 we would not support role substitution, that the  
14 two roles are interchangeable, albeit that's what  
15 the legislation is saying.

16                  I think physicians go to medical school  
17 and have a set of skills that give them special  
18 expertise, but I would also say the nurse  
19 practitioners -- the RNs extended class also have  
20 skills.

21                  So we don't see them -- and Hugh  
22 correct me if you feel I'm wrong -- but I don't  
23 think they're interchangeable. I think they both  
24 provide unique skills, and it would be a shame to  
25 believe that even with a little bit of extra

1 education that one could substitute for the other.

2 They both bring unique skills, and in  
3 an ideal world, they both would be part of the care  
4 team.

5 COMMISSIONER JACK KITTS: Thank you.

6 SAMANTHA HILL: Thanks for that,  
7 Dr. Wright. I think it was an excellent addition.

8 Thank you, Dr. Boyd.

9 And thank you, Mr. O'Dette.

10 And thank you to the Committee and the  
11 Commission for this dialogue today.

12 On behalf of Ontario's Physicians, I'll  
13 just share a few concluding observations because we  
14 are short on time, and I hope this has been useful  
15 for you.

16 While known before, COVID-19 really  
17 demonstrated acutely four things: One was that  
18 long-term care homes are strongest when physicians  
19 are fully engaged on the team both for care and for  
20 policy decisions.

21 The second was that integrated teams of  
22 nurses, NPs, physicians from family practice,  
23 geriatric medicine, palliative care, geriatric  
24 psychiatry, and a variety of other specialties,  
25 actually, lead to better care for the residents and

1 their families. It's all about teams.

2 The third point is that education,  
3 support, and training around mental health in  
4 long-term care facilities are critical to enhance  
5 the psychological well-being of residents.

6 And the fourth is the item about  
7 health-human resources which was just most recently  
8 touched upon. It's vitally important to long-term  
9 care, and we need to encourage new graduates in  
10 medicine and other healthcare professions to work  
11 in this environment. We're changing that curve a  
12 little bit, but we're not there yet.

13 These points are more important now  
14 than ever as we move through this pandemic and  
15 beyond.

16 So in closing, I want to emphasize the  
17 OMA's commitment to supporting the work of the  
18 Commission, the work that you guys are doing to  
19 make improvements.

20 As Dr. Boyd mentioned, the interim  
21 guidance that we've talked about today will be  
22 followed by a separate set of system-level  
23 recommendations to improve long-term care delivery.

24 As part of this work, we'll consult  
25 with OMA members, physicians from many specialties

1 who provide care for long-term care residents. The  
2 consultation will include questions that you've  
3 posed, posed by the Committee and the Commission,  
4 and we look forward to sharing our findings with  
5 you.

6 But I also want to recognize the  
7 commitment to physicians who have and will continue  
8 to serve on the front lines of this pandemic.

9 As COVID-19 is surging again in our  
10 long-term care facilities, as Ontario's doctors are  
11 urging the Government, again, to do everything  
12 possible to make these residents safe both  
13 physically and mentally, we all have an obligation  
14 to protect and to care for these vulnerable  
15 patients and to prevent the virus from moving into  
16 their homes. And there's a role for all of us.

17 Doctors have an important role to play,  
18 and we have a unique insight. We really do urge  
19 you to include our input in your final  
20 recommendations.

21 Thank you again so much. If there's  
22 any further questions, we'd be happy to answer  
23 them.

24 U/T COMMISSIONER FRANK MARROCCO (CHAIR):  
25 Well, it doesn't look like there are any further

1 questions, and -- but I'm sure I speak for all of  
2 us when -- all three of us when I say that we would  
3 welcome your further input and more specific  
4 comments concerning recommendations. We'd be  
5 pleased to receive that, and it would be helpful to  
6 us.

7 SAMANTHA HILL: And we shall make sure  
8 you get it.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 All right. Thank you.

11 ALLAN O'DETTE: What's your deadline?  
12 Mr. Justice, what's your deadline just so we know  
13 the parameters of time?

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 Well, the deadline is a bit of a moving target.  
16 But our Executive Director, Alison Drummond is on  
17 the call, Mr. O'Dette, and I'll get her to contact  
18 you and work out a mutually convenient date for  
19 receiving the remarks.

20 ALLAN O'DETTE: Perfect. Yeah. We  
21 know Alison.

22 HUGH BOYD: We have already been --

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 We have -- we have -- without burdening you with  
25 our problems, we have certain ongoing document

1 issues with different groups or different -- and  
2 different entity, and that affects our timeline a  
3 bit.

4 ALLAN O'DETTE: Well, we'll try to make  
5 it as easy as possible for you.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 Well, thank you for that too. In any event, thanks  
8 very much for your time and for the thoughtfulness  
9 of the presentation.

10 ALLAN O'DETTE: Yeah. Thank you all  
11 for your service.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Bye-bye.

14  
15 COMMISSIONER JACK KITTS: Thank you.

16 COMMISSIONER ANGELA COKE: Thank you.

17 SAMANTHA HILL: Thank you. Be safe.

18 -- Adjourned at 2:00 p.m.

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REPORTER'S CERTIFICATE

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

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

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

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

Dated this 19th day of November, 2020.

*Janet Belma*

---

NEESONS, A VERITEXT COMPANY

PER: JANET BELMA, CSR

CHARTERED SHORTHAND REPORTER

1 Page Lines Change

2

3 14 14-18 which is - (remove and) (I change  
4 to the SARS Commission) believe (remove that) the  
5 recommendation was not for individual

6

7 Institutions, but, (remove therefore, you know),  
8 Federal and Provincial organizations (remove to) be  
9 able

10

11 14 21-25 very large (remove supply replace with  
12 stockpile). We were uncertain how much of that  
13 (remove just) stockpile(remove ed) supply was  
14 available. It was rumoured to be as much as, for  
15 example, 6 million masks. We heard later that maybe  
16 it had (remove been) expired and not renewed,  
17 (remove so I think that was a recommendation).  
18 (Remove And) I'm in no position to say how

19

20 15 7-10 genetic shift (add always) in (remove the)  
21 virus -(remove or replace with such as) the flu  
22 virus that might be similar in severity, (remove so  
23 add to COVID) even if it wasn't another SARS, there  
24 was certainly an expectation of (remove flu and add  
25 pandemic).

1  
2 17 2-10 (remove We're talking about non-identified  
3 aerosol generating procedures. We're talking about  
4 routine care.) And I believe it was actually the  
5 ONA that came out very strongly when Directive  
6 first came out (remove arguing) the RNAO and the  
7 OMA were both align(remove ing change to ed) with  
8 Public Health Ontario which (removed talked replace  
9 with emphasized) about droplet transmission which  
10 seemed to be based on the early evidence, the  
11 predominant form of transmission.

12  
13 17 14-17 (add increased) surgical -- the routine  
14 use of surgical masks was consistent with the PHO.  
15 And we supported that based on the best evidence,  
16 (remove and) I think you would find the RNAO  
17 (remove likewise and add had a similar view)  
18 initially.

19  
20 17 21-24 source of precaution,(remove and) I  
21 believe (remove that) was the ONA and (remove many  
22 of the other) -- CUPE and the other unions who  
23 advocated very strongly for changes to Directive 5

24  
25 18 1-3 could have been greater transparency (add in

1 decision making remove because) I understand it, a  
2 decision was made that there wasn't enough N95.

3 (Add As) It needed to (remove be protected) or  
4

5 18 9 (remove and) I think that may have interfered  
6 with the

7  
8 21 6 procurement (remove versus understanding  
9 replace with while assuring) whether -- the

10

11 21 8 Where I think (remove they and replace with  
12 the Government) perhaps fell down is

13

14 21 22 (remove and) I'm not sure they were as  
15 transparent as they could have been.

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