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

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

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

PRESENTERS:

Allan O'Dette, Chief Executive Officer

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

Dr. Samantha Hill, OMA President, OMA Board Director

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

Dara Laxer, Executive Director, Economics, Policy Research

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

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

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

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

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Lynn Mahoney, Gowling LLP

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So we welcome the work that you're doing.

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

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

Dr. Boyd.

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

Care and Care of the Elderly.

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

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

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

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

It's important to clarify the OMA's

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

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

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

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

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

personal protective equipment in long-term care facilities?

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

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

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

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

Allan may have some better insight --

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

HUGH BOYD: So we discovered that at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Kitts, you wanted to ask a question?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JIM WRIGHT: Can I add -- sorry --

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Excuse me --

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

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

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

and to promote those kinds of conversations about future planning.

COMMISSIONER JACK KITTS: Thank you.

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

Number 7 -- oh.

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

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

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

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

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

long-term care facility or even the hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

by a collective like that?

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

COURT REPORTER: Thank you.

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

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

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

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

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

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

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

Number 10 --

Yes, Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in those emergencies or crises.

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay.

HUGH BOYD: Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: So, sorry.

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

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

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

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

find it incredibly helpful to provide quality care.

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

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

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

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

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

medicine.

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

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

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

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

COMMISSIONER JACK KITTS: It sounds

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

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

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

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

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

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

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

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

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

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

making it a legislative requirement makes me nervous.

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

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

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

You've already heard from two major

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> "Legislative requirements of the attending physician include: Every long-term care home shall ensure that either a physician or a registered nurse in the extended class -- "

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

> "-- can fulfill the duties and the requirements of the legislation as attending physician."

Is -- did I read that right?

HUGH BOYD: I believe so.

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

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

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

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

COMMISSIONER JACK KITTS: So the --

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

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

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

Sorry. Go ahead, Dr. Wright.

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

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

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

education that one could substitute for the other.

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

COMMISSIONER JACK KITTS: Thank you.

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

Thank you, Dr. Boyd.

And thank you, Mr. O'Dette.

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

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

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

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

their families. It's all about teams.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HUGH BOYD: We have already been --

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Bye-bye.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

SAMANTHA HILL: Thank you. Be safe.

-- Adjourned at 2:00 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 19th day of November, 2020.

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NEESONS, A VERITEXT COMPANY
PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Page Lines Change

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

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

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

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

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

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

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

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

decision making remove because) I understand it, a decision was made that there wasn't enough N95. (Add As) It needed to (remove be protected) or

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

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

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

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

WORD INDEX