Long Term Care Covid-19 Commission Mtg.

Ontario Pharmacists Association
on Friday, December 4, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 4th day of December, 2020, 1:00 p.m. to 1:53 p.m.

BEFORE:

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

PRESENTERS:
Justin Bates, CEO Ontario Pharmacists Association
Jeff May, COO CareRx Corporation
Parnian Ghafari, Manager, Client Care Services, Medical Pharmacies Group Ltd.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Dawn PalinRokosh, Director, Operations, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Adriana Diaz, Senior Policy, Long-Term Care Commission Secretariat

Jessica Franklin, Policy Lead, Counsel, Long-Term Care Commission Secretariat

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: 43

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.

COMMISSIONER FRANK MARROCCO (CHAIR): Just let us know when everyone's here on your side. As I was -- I was saying to Mr. May, I am Frank Marrocco; there's Commissioner Dr. Jack Kitts; Commissioner Angela Coke. We are the Commission, so we're here, just a matter of when you're ready to go, and we're early, so...

JUSTIN BATES: We are. We're 1 o'clock now right on time, and everyone's here, so maybe on our end, we'll just do some quick introduction starting with Jeff, and then we'll share the screen and walk you through our presentation, and I'm hoping to pause at every point to allow for some questions as well.

COMMISSIONER FRANK MARROCCO (CHAIR): We tend to ask questions as we go along, so that's just fine. And I introduced Janet who's the court reporter who will create a transcript, which we post the transcripts just so that people who are interested can follow along with what we're doing.

JUSTIN BATES: Sounds great.

COMMISSIONER FRANK MARROCCO (CHAIR): So go ahead.

JEFF MAY: All right. Well, good

afternoon, to all of you. My name is Jeff May. I'm Chief Operating Officer of CareRx Corporation. We are a dedicated supplier of pharmacy services to senior care homes which is inclusive of long-term care homes, retirement homes, assisted living facilities. We also support group home, addiction recovery centres, et cetera, in a specialized non-retail pharmacy model, and we operate in Ontario, Saskatchewan, Alberta, and British Columbia.

Justin.

JUSTIN BATES: Excellent.

Parnian.

PARNIAN GHAFARI: Hi everyone. Very nice to meet you virtually. My name is a Parnian Ghafari. I'm a clinical pharmacist by background. I have 11 years of experience working in the pharmacy industry, and I'm a manager of the Clinical Innovations and Quality Improvement Department of Medical Pharmacies, where I lead a team of pharmacists for transitional care services, and I'm responsible for innovative clinical initiatives and clinical research in senior care.

JUSTIN BATES: Great. Tough act to follow, but I'm Justin Bates, and I'm the Chief

Executive Officer of the Ontario Pharmacists Association, and it's really a pleasure to be able to talk to you today about long-term care pharmacy operators and the work that's been done during the pandemic.

And what I'll do at this point is I'm going to share my screen, and hopefully, it will work out, the technology willing. We do have a brief deck here to walk you through, and I just want to make sure you can see.

COMMISSIONER FRANK MARROCCO (CHAIR): I think we can all see it.

JUSTIN BATES: Okay. Perfect.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, we're all -- we're all good.

JUSTIN BATES: Excellent. That's always the first step is getting the technology correct. So we wanted to provide today an overview of what long-term care in pharmacy is and, certainly, the role, important role we play in resident care and also provide you with some thoughts around recommendations of how we can invest directly in the care but also how to alleviate some of the burdens with the homes which we know was one of the challenges during the first

wave and certainly something that we think we can help contribute to address some of those challenges, certainly, looking at specifically the medication management system, different investments that have been made by the sector during the pandemic, and some of those specific solutions that we think will go a long way into helping improve the conditions for residents.

So this is basically a 30,000-foot perspective of the Ontario Pharmacy landscape, and you'll see here that about 16% of pharmacists practice in either a hospital setting or long-term care.

And in a totality, if you look at the entire pharmacy profession of which we represent as a not-for-profit professional association, there's about 20,000 pharmacy professionals across the Province, and they do operate in many different settings. We represent pharmacists, pharmacy technicians, as well as pharmacy students, who operate in community pharmacies, hospitals, long-term, and family health teams across the Province.

Specifically to long-term care pharmacies where there's a specialized care model,

pharmacists serve a hundred thousand seniors every year, and there's approximately, out of that 20,000, about 500 pharmacists that support long-term care homes and about 16% of the entire pie of 20,000 that represents.

So if we look at some of our shared objectives for achieving a safe and effective medication management system for long-term care homes, we think it's really important that the health and safety of vulnerable seniors in care is protected. And that's really paramount to everything that we do in a very specific model of care and delivery and also with respect to the underpinning of our recommendations. That's the first and foremost priority, and in looking at ensuring that it's an efficient system, and it does leverage the expertise of the pharmacist and taps into opportunities to continue building on the successful model.

And we want to decrease the burden on home operators and nurses. We know that this has been a very challenging time across the board, and we think we can step up and do more, okay?

Just to give you a little bit of background, and I think it's important just as a

baseline of context to understand that the way that long-term care pharmacy operates is very different than the community pharmacy model. It is a separate regulatory framework, and this sector, over the last several years, has undergone significant changes, changes to the funding model, changes to what's included and not included; and we're going to walk you through some of those services that are included and what we offer, but not necessarily part of the funding model.

We also want to underscore that this model is designed to really serve the needs of seniors who can't visit a pharmacy themselves, and we offer a lot of different services that are unique to long-term care and to ensure that we're safely administering, monitoring all of their health conditions and potential reactions that come from medication use.

Pharmacy operators dispense; they deliver, and they monitor the residents' medications as well as destroying any unused surplus meds, which is equally important. We operate in an integrated model. It's 24/7 medication administration process in the home with an average of about eight to twelve prescriptions

per person. And we're going to talk a little bit more as we walk through the presentation on some of the initiatives around deprescribing as well to optimise medication use in the homes.

And I think it's important, also, to emphasize that there's a lot of changes that go on with residents. Doctors adjust in order to appropriately prescribe dosages, changes, and so forth to deteriorating health conditions of the -- of the resident population, and a lot of that happens typically in the last 18 months of their life.

Virtually, the entire business of long-term care is from the public plan, the Ontario Drug Benefit and its fulfillment and the free Government supply. There isn't the cross-subsidization that you see in community pharmacy where they're selling other products and services. This is a very focused care model.

So with that, I wanted to transition over to Jeff to cover some of the interdependencies between the homes and the pharmacies.

JEFF MAY: So as just an indicator, we do operate in a very interdependent model, and the Ontario Long-Term Act identifies the basic

requirements for a medication management program in a licensed long-term care home, and the relationship between pharmacies who specializes in this area at the home are driven by requests for proposal and contractual agreements that exist between the two parties. And those agreements include requirements for ensuring delivery of legislated services by pharmacists and the pharmacy services, any additional services to support medication management technologies and also financial supports.

And we work together with the nursing team and the care providers and the home physicians, obviously, to ensure optimal health outcomes for medication therapy, provide a safe and secure supply of medications, drive continuous quality improvement in the system, work to minimize or make more efficient nursing time spent to manage and administer medications to residents; and we also play a significant role in educating home staff and residents and their families on medication use, outcomes, and safety-related issues or any emerging issues that come to bear related to changes in medication therapy and changes or new approaches to accepted clinical protocols,

et cetera.

Next slide, please. And we -- just to give you a sense, I won't go through all of these, but just to give you a sense of the scope, the breadth and scope of the services that we provide, we have pharmacists who visit homes. As Justin said, it's 24/7. We have pharmacists who are on call. We do medication monitoring and reporting of drug utilization statistics that are quite broad in partnership with our homes. Some of those are regulatory requirements. Some of those are just definitely requirements or -- or we use for clinical and quality improvement, technologies, electronic medication administration record systems, and much more. We provide equipment. We provide other technologies in order to create that full medication management system within the long-term care home.

And these specific services aren't funded by Government directly. There is a Capitation Model for funding that is intended to cover some of -- some of this, not necessarily all of it, but it's a very integrated, broad system. You can almost think of a medication administration system in a hospital. It's that's sophisticated

and there's a layer of medication distribution and the deliver logistics. There's a layer of clinical support from pharmacists and nurses that support the medication administration in the homes and education of the staff, and then there's these additional services to support system and quality that are really part of our overall relationship.

Next slide, please. So if -- shift from our overall service model, the -- I'd just like to go through some of the impacts that we saw in the first wave of the pandemic.

The first -- and none of these -- this -- these aren't in order of importance. They're all important.

The first was medication shortages and supply-chain pressures driven through our wholesale system and also the Government pharmacy. At the outbreak of the pandemic, there was an unprecedented demand for stockpiling of medications particularly in the community, and that created pressure on wholesale and Government -- or wholesale stocks, and the system adapted by moving to a 30-day medication supply instead of a 60 or a 90-extended-day medication supply. That helped to stabilize the system, but in the early days of the

pandemic, our pharmacies collectively spent a significant amount of time ensuring that our allocations of medications were appropriate so that we wouldn't run short of any one med and a resident would not be without a medication. We --

COMMISSIONER FRANK MARROCCO (CHAIR) Mr. May, let me interrupt you for a minute.

JEFF MAY: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): How did you bring about a change in inventory to 30 days? You obviously -- did you do that -- did you do that after there was a -- the -- who said there was a pandemic? Or did you do it before? And how did you do it?

JEFF MAY: Yeah, I think Justin was working at the Association level and with the Canadian Pharmacists Association and his colleagues.

Justin.

JUSTIN BATES: Yeah, that's a great question, and we worked collaboratively with the Ministry of Health, and it was their policy that we supported to try to mitigate any future drug shortages with the early trends that we were seeing globally as well as domestically from the

wholesales -- wholesalers and the manufacturer, so it was a preventative policy to limit to 30 days. And, of course, pharmacists maintained their professional judgment. There were circumstances where patients would qualify for supply beyond 30 days, but it was in place for approximately three months, and I do think it helped mitigate a much worse situation from presenting itself.

COMMISSIONER FRANK MARROCCO (CHAIR): And when did that happen about?

JUSTIN BATES: Yeah, so it was put in place at the end of March. I think it was March 25th, in that area, and it was lifted in July.

JEFF MAY: And since then, we have -- we have seen a stabilization of medication supply. I think it's important to note that pharmacy and the health system have been dealing with medication shortages in Canada for a long time. There's a significant impact on a day-to-day basis notwithstanding the pandemic on drug shortages in Canada, and it does take up a significant amount of pharmacy's time whether you're in a long-term care pharmacy or in the community-based pharmacy. It does affect our day-to-day work because shortages come and go, and it's just something that we

live -- lived with, and we had an exacerbation during the early wave of COVID and particularly with some of the meds, specifically, even where we had to look at medication changes: Hydromorphone, morphine, salbutamol being three key products that went in short supply, and we had to work with the care team and the physicians to look -- in some cases, look at therapeutic changes.

JUSTIN BATES: And, Jeff, you mentioned about drug shortages. It's interesting from a Canadian perspective, there's been, since the pandemic started in March, over 1,300 drugs in shortage for an average of about five months.

So if you look at that -- and that, you know, exasperated (sic), as Jeff mentioned, around the pandemic, but drug shortages have been around for some time, and they will continue to be here. And pharmacists spend roughly about 24% of their time managing drug shortages, so it's a -- it's a growing concern, and it doesn't just relate to domestic supply-chain challenges.

It also has to do with global international challenges, sourcing active product ingredients and things of that nature, so it's a -- it's a very complex challenge and one we need to

continue to monitor.

COMMISSIONER JACK KITTS: And were you able to mitigate the effects of these shortages fully, or were there some adverse effects noted?

JEFF MAY: Yeah, we polled our -- we did poll our colleague -- colleagues who support long-term care homes, and we had no reports where there were adverse effects that worked its way down to residents as a result. We were able to work with our wholesalers and other pharmacies to get supplies required, or we had to make therapeutic substitutions working with the care team and the physicians to ensure that the clinical effect or the clinical outcome wasn't interrupted.

COMMISSIONER JACK KITTS: Great. Thank you.

JEFF MAY: So moving on to the next points, because of the pressures on the nursing staff, shortages in staff, et cetera, there was an immediate need to implement changes in med pass times and the number of medications per resident, so for every -- almost every home, and particularly when they were in outbreak, the pharmacists worked with the home and, in some cases, the families to reduce the number of medications, so look at

nonurgent medications whether it's vitamins and OTC medications that may not be -- may not be necessary for -- for health maintenance.

In some cases, those were put on hold for a period of time, but we also looked at med pass compression where if a resident was getting -- and the nurses were making four Med Passes a day, we looked at restructuring their medication therapy so we could reduce that to two or one Med Passes -- Med Passes per day so that we reduced the burden on staff and nursing administration time.

Next slide. There was also an increase called for in palliative care medications at the homes because of so many end-of-life situations, so we responded and worked with our wholesalers as well to ensure that we could -- and given the early shortages, to ensure that there were access to palliative care medications whether it was the pharmacy carrying additional inventory or providing additional quantities to be on hand at the home through the emergency box.

We also had to ensure that the contact points that the pharmacy has with the long-term care home, primarily our medication delivery services, individuals or services, plus the

clinical pharmacists who visit the -- their homes, were trained in infection prevention and control procedures. That meant some change in process, change in equipment, but pharmacies responded very quickly in that.

And another very important therapeutic issue that we dealt with was switching nebulized medications to metered-dose inhalers to reduce the risk of aerosol transmission within the home.

So those were the key initiatives that were the key impacts that we saw in the first wave, and as we're going through COVID right now, I think the -- you know, the palliative -- you know, we -- I think we've -- we've solved the distribution and prevention and control measures.

We do -- we are seeing calls for relooking at med pass times, also relooking at medication holds as homes go in and out of outbreak.

Next slide, please. Back one. There we go. I'd also like to highlight just some -- as pharmacy, some of the operational changes that we made in support of our own staff and also in support of staff at the homes.

So procuring PPE, we -- pharmacies have

access to supply chains and manufacturers and suppliers, so in some cases, our pharmacy providers were able to provide PPE to staff at the homes. We also had to go through the process to acquire them for our pharmacies, so many of our pharmacies are closed-door, not open to the public.

We don't typically work in retail settings, so we had to ensure that, you know, we had our internal incident management plan and implement policies and procedures within our pharmacies, getting guidance from medical staff and public health. And many pharmacies went to split shifts to protect groups of employees because, as an essential service, we cannot have our pharmacies go non-operational.

So we extended operating hours and dealt with that and increased our cleaning frequency at our operation sites. We trained our staff and implemented COVID testing as per Provincial requirements particularly for our pharmacists who had started to go back into the homes.

And in some cases, we also worked with after-hours pharmacy where needed to for continuity of care particularly for controlled substances

where -- if staffing was short within the pharmacy or otherwise.

And on the next slide, some of the impacts that -- and changes that we made to our direct resident care clinical services, in the early phases, we suspended visits and nonessential clinical services at the request of homes and especially now even while in outbreak. We've created more scheduled rather than ad hoc visits from our clinical pharmacists visiting only one home per day for -- it's as per protocol.

Drug destruction which pharmacists or nurses in our employ typically do was done virtually, and we set up virtual ways to connect with the homes virtually whether it's meetings, education training sessions, which was a significant demand particularly for new staff, and doing medication reviews and consultations as required virtually, and the medication compression, med pass optimisation and focus on deprescribing, that is an ongoing activity, and -- but it does escalate at times where there are outbreaks in the homes.

Next slide. So I'll stop there.

COMMISSIONER FRANK MARROCCO (CHAIR):

Excuse me.

JEFF MAY: Any questions on that?

COMMISSIONER FRANK MARROCCO (CHAIR): I did. There are outbreaks. You alluded to it right at the end of your remarks. There are outbreaks. They aren't pandemics, but they're outbreaks. And were -- did you employ -- was it basically the same approach to the pandemic, or did the previous outbreak protocol or procedure not really apply?

JEFF MAY: I'll start, and maybe Parnian as well if you have thoughts on that.

I think the work that happened after the first wave, I think, the pharmacy partners in their homes, I think, were comfortable with the -- with the processes that we have in place generally for the pandemic, and when a home goes on outbreak, you know, there's -- typically, there's policies or a playbook that gets put in place around suspending visits. You know, we deal with -- as an example, we've always dealt with in -- pharmacy's a key partner in managing influenza, influenza protocols, and assisting in managing influenza outbreaks with Tamiflu, so, you know, we're familiar with what an outbreak protocol looks like, and so we've adapted

accordingly.

Parnian, do you have any additional comments?

PARNIAN GHAFARI: I second your thoughts, Jeff, that we temporarily cease all non-essential activities in accordance to the directives including minimizing the number of healthcare providers working on site, decreasing any unnecessary reliance on the utilization of personal protective equipment in long-term care.

But we modified that strategy when, obviously, [indecipherable] was just an outbreak, and it's a dynamic process because depending on the virus, depending on the outbreak, we have to modify our strategy.

COMMISSIONER FRANK MARROCCO (CHAIR): And did the long-term care homes that you were dealing with, did they have outbreak strategies, not necessarily for a pandemic, but did they have outbreak strategies that you would, in effect, each kind of, be working towards your -- carrying out your own protocol to deal with it, or how did that work?

JEFF MAY: Go ahead, Parnian.

PARNIAN GHAFARI: Yes, so we worked

with our partners and nursing homes to develop policy and procedures. So depending on the homes, and that's variable. I can't say that it's a standard across all homes, but most homes, they do have a policy and procedures in place in -- for dealing with emergencies and pandemic and outbreaks.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

Dr. Kitts.

COMMISSIONER JACK KITTS: Yeah, I just -- if you could go back two slides, I just want to follow up on Commissioner Marrocco's question. Yeah.

So increased -- development of an internal COVID-19 Incident management plan, and so is that in addition to the -- to the plan that would be existing for, let's say, the flu outbreak? Or not sure what this -- that bullet meant.

JEFF MAY: Yeah, I think that that's focused on the internal operations of the pharmacy. So, you know, when -- and outside the homes, so within our -- within our pharmacies and to protect our staff, we implemented all of the -- our colleagues' competitors implemented protocols

within their pharmacies to ensure that, one, we -- our staff and our teams were following all the Public Health guidelines so that we kept ourselves safe, and we could ensure that there's uninterrupted supply of medications and services from the pharmacies and creating our own policies and procedures and protocols for utilization of PPE in the pharmacy, social distancing, infection prevention and control procedures within the pharmacy itself as it pertains to the Public Health recommendations for managing COVID.

COMMISSIONER JACK KITTS: I'm sorry. I thought it was in the long-term care homes.

JEFF MAY: Okay. Yeah.

COMMISSIONER JACK KITTS: My apologies.

JUSTIN BATES: Actually, that care model and the distribution and all the things that go into it, it's quite sophisticated in long-term care pharmacy providers, and it's done in an industrial setting, and there's a lot of technology that's used, and the medications are done through these pouches. And you might want to talk a little bit about that. Just it's a very different model on how it's delivered to the homes.

JEFF MAY: Yeah, you can't think of our

pharmacies as a -- as a retail operation. We -- the process starts when a resident is admitted to a home. We work with the staff in the home, and they -- and the physician to decipher all the medications that the resident is on in their home, create an order set within the long-term -- within the long-term care home. Those orders are created, transmitted to the pharmacy. We use specialized equipment, robotics to pouch package unit-dose time-based pouches, and we work on weekly batch systems and daily order change systems.

We support technologies through our own internal clinical software, plus we work with -- in partnership with the homes to populate the data in the eMAR system, Electronic Medication Administration Record System, and we deal with the ongoing management of safety and security of the medications in the homes, and then we have a return process for unused medications that's -- it's a -- it's a full-on supply chain logistic system.

JUSTIN BATES: Do you have any other questions about the previous slides?

COMMISSIONER FRANK MARROCCO (CHAIR): No, I don't -- I don't think so.

JEFF MAY: Okay. Justin.

JUSTIN BATES: Great. So wanted to build off of the Honourable Eileen Gillese's, Commissioner of the Long-Term Care Public Inquiry Report and Recommendations back in July of 2019, I think when you look at some of what was uncovered in terms of how it relates to long-term care pharmacy from that report, and, sort of, the three areas that we -- emphasizing as part of our recommendations, you'll see shortly, which is significant investments and benefits around more on-site clinical pharmacist support.

And where that helps in the correlation to the home is that helps alleviate some of the burden on the nurses and others like PSWs that are doing some of the support work, and I think having that physical presence makes a big difference, and there's ways with technology to implement that as well.

Education and medication management system for home staff was another area that was highlighted as well as investments in technologies for improving nursing staff efficiency and the medication security.

So building on those themes, we've got four recommendations. The first is to reinstate

the long-term care MedsCheck program. This is a program that was highly successful in terms of resident care outcomes, and when the model changed at the end of last year in 2019, this program was essentially rolled into the Capitation Model, and the Capitation Model didn't allow for a specific investment in clinical services and, sort of, was a catch basin for all of these things.

And we think pulling it back out as a specific program is a critical importance to ensuring that we increase the pharmacist-direct contributions for that ongoing assessment and decision making as well as driving active participation of the pharmacists in the home, and it's in partnership and collaboration with the entire care team.

Focusing on the med pass compression with the deprescribing is an element of an outcome from the long-term MedsCheck program as well as reducing some of the workload on nursing staff.

Now, there are elements to what happened previously around working with the care teams and providing clinical advice, and this would really be -- go a long way to alleviating some of the burdens.

I don't know if, Jeff, or, Parnian, you have any other comments on that?

JEFF MAY: Yeah, and I also think there's an element of accountability in this with the previous MedsCheck program, there was -- there was a process for reporting and building to the Ministry so that the Ministry of Health had visibility to the number of med reviews that were happening in the home, and that has -- that's no longer a requirement within the system.

And in addition to what Justin mentioned about the impact and how it drives more direct participation, we think there is -- there's a significant benefit there, but the reporting is one key aspect of it.

And, Parnian, as a clinician, I think you can speak to the type of interaction that you have with the care team and the outcomes that come as a result.

PARNIAN GHAFARI: Sure. Sorry. Do you -- should I take the question before we move on? Would you like to ask a question?

COMMISSIONER ANGELA COKE: Yeah. I just wanted to clarify. You're saying reinstate this program. What was the rationale for stopping

it in the first place?

JUSTIN BATES: I think it was a fundamental shift in the way that they were approaching how they fund long-term care pharmacy operators with a move from a fee-for-service model into the Capitation Model, and that has impacted quite significantly in the way that the programs are designed and implemented in the homes, and that was actually just introduced months before the first wave in the pandemic, so timing-wise, it created some challenges.

COMMISSIONER ANGELA COKE: Okay. So I'm just trying to figure out, is this in terms of a way to save money?

JUSTIN BATES: I don't think it's necessarily about the economics of it. It's more or less to make sure that we have a program that continues to be provided from a resident care perspective and is designed to help alleviate some of those burdens within the home.

Jeff, do you have anything to add to that?

JEFF MAY: Yeah, I think there was working groups between pharmacy and the Ministry of Health on looking at ways to readjust the

medication management system and move from the fee-for-service model into a Capitation Model, and there was a Provincial Auditor Report that references why -- or requested that The Ministry of Health look at those -- look at a change. And through that, the process around establishing the Capitation Model, a decision was made to remove or the Ministry made the decision to remove funding for the MedsCheck specifically. And so the program just disappeared, and there was -- there was accountability within the Ontario Long-Term Homes Act -- or Long-Term Care Act for quarterly and annual medication reviews to occur.

But it wasn't necessarily -- previously, it was more formalized under the MedsCheck program. Now it's a -- it's a -- it just goes back to that core regulatory requirement that medications have to be reviewed on an ongoing basis, but it's not as formal as a program as MedsCheck.

COMMISSIONER JACK KITTS: So does that --

COMMISSIONER FRANK MARROCCO (CHAIR): If I -- sorry.

Go ahead, Commissioner.

COMMISSIONER JACK KITTS: I was just going to ask: So if it was successful previously, has it shown to be unsuccessful, or is there more concern about potential safety for residents?

JEFF MAY: Because we're so early -- early on, and I think with the impact of COVID, the -- you know, our pharmacists and the care teams are working very closely together on medication issues and resident safety.

The -- some of the changes that were made as a result of the Capitation Model across all pharmacies -- I can't speak to -- I can speak generally across pharmacies -- there was a reduction in the number of pharmacists -- or has been a reduction in the number of pharmacists supporting long-term care homes. And some services were downloaded to homes which increased burden on nursing staff.

And I think, you know, given where we're at today and understanding, you know, the need to increase direct care hours but also to reduce the burden of the medication management system, having pharmacists more active and incentivized and, you know, being held, you know, through the -- through a MedsCheck-type program,

having the reporting and accountability underneath that program, I think, would definitely help to enhance the system as it is today. Now, we've adapted through virtual care models as I mentioned earlier, but, you know, we strongly believe that having this program in place will be a benefit not just to the overall system in terms of medication safety and dealing with potential adverse events, but also assist the nursing staff significantly in the homes.

COMMISSIONER FRANK MARROCCO (CHAIR): I took Commissioner Coke's question to be whether the rationale advanced by the Ministry of Health to you for the switch was because they wanted to -- because they were convinced this was a money saving thing or whether they gave some other reason for this which had nothing to do with money?

JEFF MAY: I see.

Justin?

COMMISSIONER ANGELA COKE: That's right.

JEFF MAY: Yeah.

JUSTIN BATES: I think it's fair to say that they were looking for some savings from the sector as part of the overall shift to a

Capitation Model and this, I think, is one of the, I would say, disadvantages of doing that is that you saw some of the downloading of the services and some of the net negative impacts to that care model that we've highlighted.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

PARNIAN GHAFARI: And if I may add, this program is -- it does exist in a retail setting, so I think it speaks to Justin's point that it was purely more driven by -- as a cost-reduction strategy than not having the positive outcomes to continue with MedsCheck program in long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

JEFF MAY: Thank you.

JUSTIN BATES: Parnian, was there anything else you wanted to add before --

PARNIAN GHAFARI: Yes. If I -- I figured maybe I can very briefly to go over the MedsCheck process itself. I think it provides an overview of how it actually provides a value to the residents of nursing homes.

So clinician and nurses and allied

health professionals in long-term rely on clinical pharmacists to catch drug-related problems and monitor residents for therapeutic outcomes. This work is done on site and remotely to maximize and providing the right place at the right time approach.

So clinical pharmacists, they actually play a critical role in resident medication safety by conducting medication reviews. The medication program itself is an indepth medication review intended for residents at long-term care homes with complex conditions. These residents are on the -- on multiple medications, require medications with therapeutic index or requiring therapeutic drug monitoring.

It -- I think I'd like to emphasize on this point that it actually serves as an important point of intervention to target specific medications such as antipsychotics.

The medication review could also have as information including medication selection, dosage, hours, and [indecipherable] administration, duration of therapy, treatments, allergies, drug and -- drug and drug-food interactions, and it will identify any potential drug-related problems that

may require in-depth and follow-up later on.

And lastly, I wanted to mention that the MedsCheck program, it's a collaborative opportunity for pharmacists to liaise with caregivers, nurses, prescribers to optimise each residents' pharmacotherapy plan, reduce nursing and prescriber burden, and promote evidence-based resident-centred care.

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

JUSTIN BATES: Parnian, thank you for that additional context.

Any other questions before we move on to our second recommendation?

COMMISSIONER FRANK MARROCCO (CHAIR): No. I think we're good.

JUSTIN BATES: Okay. So the second recommendation is about having pharmacist-led reconciliation, MedRec, for long-term care home admissions and transfers of care so there's a degree of fluidity between transitions of care from hospitals, from the community, and back and forth into long-term care homes. And that's where there can be gaps in care.

We talked a little bit about the

importance of ensuring that it's the right medication for the right person, right dose, et cetera, and this is a program that would greatly benefit from looking at medication histories, medication optimisation, also looking at driving efficiencies in the health system, savings from medication discontinuations.

There is a gap from technology and sharing of information between community and institutional care. It happens on discharge and admission. We see that causing a lot of challenges for residents as well as patients in the broader community.

So this model could be designed and created very similar to the long-term care MedsCheck program. It would be more targeted towards those transitions.

I look to my colleagues, I think --

JEFF MAY: Yeah, so it's not consistent across all long-term care homes that pharmacists do the med reconciliation, and there have been models tested.

And, Parnian, you can speak to that where the impact of MedRec on nursing time and benefit to other healthcare costs has been

measured.

But you think of the process for a resident to be admissioned -- admitted into a long-term care home, going through the medication history, looking at their prescribed medications, their nonprescribed medications, what their taking, OTCs, any other vitamins. That med history does take a lot of time, and it's, you know, many, if not most cases, that's done by the nursing team at the home. We believe that there's a strong role to play for the pharmacists to do that.

Many of our home partners already are asking us to implement pharmacist-led MedRec, and -- because, one, of the expertise of the pharmacist; two, to reduce the burden of that process on the already stressed -- the team in the home.

So we think formalizing this as an initiative working with The Ministry of Health and the Ministry of Long-Term Care has significant benefits.

And, Parnian, you can speak to the work that your company has done.

PARNIAN GHAFARI: Sure. I can, and, maybe I can draw an example from COVID-19. So if

pharmacists were -- pharmacists leading the admission process for long-term care homes virtually, that actually ensure uninterrupted and timely care during these unprecedented times with social distance -- where social distancing is paramount to protect our most vulnerable citizens.

We -- the pharmacist-led medication reconciliation is conducted virtually, so the compilation of virtual medical and medication history decreases the clinician burden on transitions of care.

The process alleviates nursing time required for admission by average of three hours -- the time -- which the time can be dedicated to direct patient care which is of significant importance during the pandemic due to increased strain on nursing workload and staffing issues.

The comprehensive history also allows for informed discussions with prescribers to decrease physicians, nurse practitioners' burden, assists with the identification and the solution of actual and potential drug-related problems and influence prescribing behaviour to optimise patient care.

I'd like to say -- I'd like to add

additional virtual access to labs and diagnostic tests allow for minimizing unnecessary repeat ordering to realize cost savings to the healthcare.

During the pandemic, we have seen -- we have -- we have been finding that families and caregivers whom we speak with are not always informed in regards to their loved one's care if they're restricted from visiting in hospital, retirement home, or other care settings.

The pharmacist-led transitional care services has the potential to engage with families and caregivers of the patients by video call or a simple telephone call to enhance their experience, better understand their loved one's medications, and provide assurance and clarity by keeping families and caregivers connected.

And this is, I think, an effective way that long-term pharmacists can support long-term care homes in general and in their response to the COVID-19 pandemic by conducting medication reconciliation during transitions into the homes. The benefits of medication reconciliation are well-established, and when it's done right, it can achieve the four pillars of quadruple aim.

And lastly, I wanted to say a recently

published study demonstrated a pharmacist-driven medication reconciliation conducted virtually delivers substantial healthcare savings, enhances accuracy and patient outcomes.

COMMISSIONER JACK KITTS: Just see if I understand. So right now, most homes have a nurse doing the med reconciliation. Some have pharmacists?

PARNIAN GHAFARI: Correct.

COMMISSIONER JACK KITTS: Is that correct?

PARNIAN GHAFARI: Yes.

COMMISSIONER JACK KITTS: So if it's a pharmacist versus a nurse, you mention that it meets the four goals of the quadruple aim, one of which is it's safer, and the other is value for money.

So are you saying that if you have a pharmacist interchanged with a nurse, it will be -- it will enhance quality of care and safety as well as reduce costs; it's better value?

PARNIAN GHAFARI: Yes.

COMMISSIONER JACK KITTS: Okay. Thank you.

PARNIAN GHAFARI: No problem. And

maybe I can add to that is it's because of the changes that we made to the process, so it's a redesigned process. It's almost an enhanced medication reconciliation process, and I think pharmacists are well-position to provide high-quality care when they're in that position because nursing staff are -- although they're doing their best, but they're not -- they don't have the pharmacotherapy training of a pharmacist to be able to achieve the quadruple aim.

COMMISSIONER JACK KITTS: And in a -- in a -- let's just say -- I don't know -- an average size home of 120 residents, how many pharmacists or how many nurses would be required to deal with the med reconciliation on a daily basis?

PARNIAN GHAFARI: I think that's a great question. So on average, a pharmacist, in order to provide a quality medication and safe medication reconciliation, they should spend about one to two hours on a medication reconciliation.

U/T If maybe after the meeting, I can forward you the recently published paper which goes in through -- goes through the details of the economic analysis and shows the ROI as well.

COMMISSIONER JACK KITTS: Okay. Thank

you.

PARNIAN GHAFARI: No problem.

JUSTIN BATES: Great. Any other questions on Recommendation 2?

COMMISSIONER FRANK MARROCCO (CHAIR): I don't think so.

JUSTIN BATES: Okay. Recommendation 3 is a request to pause the planned reduction of the current Capitation Model threshold to maintain funding at its current level of $1,500 per bed which will help ensure that the additional service reductions are not implemented and increase -- that will eventually increase, in our estimation, burdens on the long-term care home, operators and nurses at this critical time.

So when this was first introduced at the beginning of this year, it's a tiered model of capitation, so it starts at 1,500, and then every year it reduces to a floor of $1,200. And given that we're managing the pandemic and have increased these types of services, we think it would be an opportune time to pause that and do a reevaluation.

I don't know if my colleagues have anything to add to that?

JEFF MAY: I think you've covered it.

JUSTIN BATES: Any questions on that?

COMMISSIONER FRANK MARROCCO (CHAIR): I don't think so.

JUSTIN BATES: Okay. Our last recommendation is related to the Gillese Report when you look at technology and implementing technology to support enhancements to the safety and efficiency of the medication system. We've outlined three examples of that here in the recommendation on the slide.

One is online digital prescribing. I think Parnian just gave a great example of how some of these enhancements with the virtual components of doing a MedRec can reap some benefits for resident care and value for money, but that can also be expanded. And we're seeing that across the healthcare continuum where virtual visits and online platforms are creating a different care model.

Virtual capabilities for prescribing education and training and, certainly, enhanced medication storage cabinets, and maybe, Jeff, you want to just expand on what that means?

JEFF MAY: Sure. And just to go to the online -- or to prescribing, most prescribing in

long-term care homes happens through older technology. It certainly works. That digital pen which turns into a digital fax image to -- that goes to the pharmacy for the pharmacy to transcribe it, we know that there are eMAR providers that are -- that are developing and/or implementing online prescribing modules.

In community pharmacy, the National PrescribeIT®, PrescribeIT® platform is facilitating online digital prescriptions throughout the infrastructure, so that is something that we think is critically important going forward for efficiency, for the prescriber, improvements in safety, and also improvements in safety and efficiency at the pharmacy level.

Having virtual platforms for interaction, I think that is something that pharmacy typically has not done. The clinical model is the pharmacist has an allocated number of hours per week that they visit each of the long-term care homes, and they would do their work on site.

Given the pandemic, but also given the increasing acceptance of virtual interaction as we're doing today, having a common virtual platform

between pharmacies, prescribers, and the long-term care homes, is -- we can certainly leverage the success that we're seeing today.

And there are models that have -- care models that have been implemented, and more homes are looking at more hospital-style medication storage cabinets to enhance security of narcotics, improve the process on auditing of narcotics. And in more evolved technology models, these cabinets can be integrated into the pharmacy systems at home creating a fully integrated electronic system more like what you see in hospitals.

Prohibitively expensive at this point, there are -- there are a few models out there that different pharmacy providers are using, but it's something that, again, helps to deal with the efficiency of nurses in homes, reduce the amount of time they have to spend managing medications, and ensuring the security of medications in the homes. And there are some early benefits that could be leveraged, and that was called out in the Long-Term Care Homes Inquiry Report.

JUSTIN BATES: Any questions? This is the end of our slide deck, so we've left it open for any general questions or specific questions

that you may have.

COMMISSIONER FRANK MARROCCO (CHAIR): I suspect we asked them as we went along, but do either of the Commissioners have any questions, any further questions? No, I think we -- I think we all asked the questions as we went along.

This has been very helpful because this issue came up -- the cancellation of the program, the transition to a Capitation Model, it came up before, but this has been helpful in explaining the model to us and some of the benefits that were lost or arguably lost in the transition, and that's very, very helpful for us, and we will consider the recommendations.

You may have heard, we released a second interim report today, and it may not be our last, so we will certainly consider these recommendations going forward, and we want to thank you for taking the time to come and present to us.

JEFF MAY: Thank you, Mr. Chairman, and as you noted, the Ontario Long-Term Care Homes Association and AdvantAge Ontario have also identified some of their concerns --

COMMISSIONER FRANK MARROCCO (CHAIR): They --

JEFF MAY: -- with respect to the medication management system. And we do see that there's an important opportunity, and we're communicating with the Ministry of Health and the Ministry of Long-Term Care to have a -- have a table as -- a multi-stakeholder table to talk about many of these issues related to the medication management system and how we can create programs and solutions for the future, so we look forward to that collaboration.

And thank you so much for the opportunity to present to you today.

JUSTIN BATES: Yes, thank you.

COMMISSIONER JACK KITTS: Thank you.

JUSTIN BATES: Thanks, everyone.

COMMISSIONER ANGELA COKE: Thank you.

JEFF MAY: Thank you so much.

-- Adjourned at 1:53 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 7th day of December, 2020.

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

Pg-Correction

18-sourcing after-product 24 ingredients change to--sourcing active product ingredients.

WORD INDEX