

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

1 PRESENTERS:

2 Justin Bates, CEO Ontario Pharmacists Association

3 Jeff May, COO CareRx Corporation

4 Parnian Ghafari, Manager, Client Care Services,
5 Medical Pharmacies Group Ltd.

6
7 PARTICIPANTS:

8
9 Alison Drummond, Assistant Deputy Minister,
10 Long-Term Care Commission Secretariat

11 Ida Bianchi, Counsel, Long-Term Care Commission
12 Secretariat

13 Dawn PalinRokosh, Director, Operations, Long-Term
14 Care Commission Secretariat

15 Sanjay Bahal, Team Lead for Operations, LTCC

16 Derek Lett, Policy Director, Long-Term Care
17 Commission Secretariat

18 Kate McGrann, Counsel, Long-Term Care Commission
19 Secretariat

20 John Callaghan, Counsel, Long-Term Care Commission
21 Secretariat

22 Lynn Mahoney, Counsel, Long-Term Care Commission
23 Secretariat

24 Adriana Diaz, Senior Policy, Long-Term Care
25 Commission Secretariat

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

3 ALSO PRESENT:

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5 Janet Belma, Stenographer/Transcriptionist

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I N D E X

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

INDEX OF UNDERTAKINGS

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

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Just let us know when everyone's here on your side.

4 As I was -- I was saying to Mr. May, I am

5 Frank Marrocco; there's Commissioner Dr. Jack

6 Kitts; Commissioner Angela Coke. We are the

7 Commission, so we're here, just a matter of when

8 you're ready to go, and we're early, so...

9 JUSTIN BATES: We are. We're 1 o'clock

10 now right on time, and everyone's here, so maybe on

11 our end, we'll just do some quick introduction

12 starting with Jeff, and then we'll share the screen

13 and walk you through our presentation, and I'm

14 hoping to pause at every point to allow for some

15 questions as well.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 We tend to ask questions as we go along, so that's

18 just fine. And I introduced Janet who's the court

19 reporter who will create a transcript, which we

20 post the transcripts just so that people who are

21 interested can follow along with what we're doing.

22 JUSTIN BATES: Sounds great.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 So go ahead.

25 JEFF MAY: All right. Well, good

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

11 Justin.

12 JUSTIN BATES: Excellent.

13 Parnian.

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

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

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

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

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

13 JUSTIN BATES: Okay. Perfect.

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

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

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

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

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

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

1 pharmacists serve a hundred thousand seniors every
2 year, and there's approximately, out of that
3 20,000, about 500 pharmacists that support
4 long-term care homes and about 16% of the entire
5 pie of 20,000 that represents.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 et cetera.

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

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

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

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

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

15 The first was medication shortages and
16 supply-chain pressures driven through our wholesale
17 system and also the Government pharmacy. At the
18 outbreak of the pandemic, there was an
19 unprecedented demand for stockpiling of medications
20 particularly in the community, and that created
21 pressure on wholesale and Government -- or
22 wholesale stocks, and the system adapted by moving
23 to a 30-day medication supply instead of a 60 or a
24 90-extended-day medication supply. That helped to
25 stabilize the system, but in the early days of the

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

6 COMMISSIONER FRANK MARROCCO (CHAIR)

7 Mr. May, let me interrupt you for a minute.

8 JEFF MAY: Sure.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 How did you bring about a change in inventory to 30
11 days? You obviously -- did you do that -- did you
12 do that after there was a -- the -- who said there
13 was a pandemic? Or did you do it before? And how
14 did you do it?

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

19 Justin.

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

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

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

11 JUSTIN BATES: Yeah, so it was put in
12 place at the end of March. I think it was March
13 25th, in that area, and it was lifted in July.

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

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

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

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

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

1 continue to monitor.

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

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

15 COMMISSIONER JACK KITTS: Great. Thank
16 you.

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

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

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

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

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

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

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

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

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

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

25 So procuring PPE, we -- pharmacies have

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

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

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

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

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

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

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

24 Next slide. So I'll stop there.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Excuse me.

2 JEFF MAY: Any questions on that?

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 I did. There are outbreaks. You alluded to it
5 right at the end of your remarks. There are
6 outbreaks. They aren't pandemics, but they're
7 outbreaks. And were -- did you employ -- was it
8 basically the same approach to the pandemic, or did
9 the previous outbreak protocol or procedure not
10 really apply?

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

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

1 accordingly.

2 Parnian, do you have any additional
3 comments?

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

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

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

24 JEFF MAY: Go ahead, Parnian.

25 PARNIAN GHAFARI: Yes, so we worked

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

10 Dr. Kitts.

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

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

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

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

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

14 JEFF MAY: Okay. Yeah.

15 COMMISSIONER JACK KITTS: My apologies.

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

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

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

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

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

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

25 JEFF MAY: Okay. Justin.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 it in the first place?

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

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

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

21 Jeff, do you have anything to add to
22 that?

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

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

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

21 COMMISSIONER JACK KITTS: So does
22 that --

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

25 Go ahead, Commissioner.

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

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

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

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

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

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

18 JEFF MAY: I see.

19 Justin?

20 COMMISSIONER ANGELA COKE: That's
21 right.

22 JEFF MAY: Yeah.

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

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Okay.

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Okay.

17 JEFF MAY: Thank you.

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

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

25 So clinician and nurses and allied

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

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

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

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

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

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

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

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

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

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

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

25 We talked a little bit about the

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

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

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

18 I look to my colleagues, I think --

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

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

1 measured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And lastly, I wanted to say a recently

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

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

9 PARNIAN GHAFARI: Correct.

10 COMMISSIONER JACK KITTS: Is that
11 correct?

12 PARNIAN GHAFARI: Yes.

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

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

22 PARNIAN GHAFARI: Yes.

23 COMMISSIONER JACK KITTS: Okay. Thank
24 you.

25 PARNIAN GHAFARI: No problem. And

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

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

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

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

25 COMMISSIONER JACK KITTS: Okay. Thank

1 you.

2 PARNIAN GHAFARI: No problem.

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

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

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

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

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

25 JEFF MAY: I think you've covered it.

1 JUSTIN BATES: Any questions on that?

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 I don't think so.

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

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

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

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

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

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

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

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

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

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

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

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

1 that you may have.

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

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

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

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 They --

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

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

13 JUSTIN BATES: Yes, thank you.

14 COMMISSIONER JACK KITTS: Thank you.

15 JUSTIN BATES: Thanks, everyone.

16 COMMISSIONER ANGELA COKE: Thank you.

17 JEFF MAY: Thank you so much.

18 -- Adjourned at 1:53 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:

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

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

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

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18 Dated this 7th day of December, 2020.

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