

Long Term Care Covid-19 Commission Mtg.

Shirlee Sharkey SE Health
on Monday, December 21, 2020



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom, with all participants attending
15	remotely, on the 21st day of December, 2020,
16	11:00 a.m. to 12:00 p.m.
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1 BEFORE :

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8 Shirlee Sharkey, President & CEO SE Health

9 Justine Giosa, Manager, Research Operations SE

10 Research Centre, SE Health

11 Madonna Gallo, Head of Public Affairs SE Health

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13 PARTICIPANTS:

14

15 Alison Drummond, Assistant Deputy Minister

16 Long-Term Care Commission Secretariat

17

18 Ida Bianchi, Counsel Long-Term Care Commission

19 Secretariat

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21 Kate McGrann, Counsel Long-Term Care Commission

22 Secretariat

23

24 John, Callaghan, Counsel Long-Term Care Commission

25 Secretariat

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Lynn Mahoney, Counsel Long-Term Care Commission
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Derek Lett, Policy Director Long-Term Care
Commission Secretariat

Dawn Palin Rokosh, Director, Operations Long-Term
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Jessica Franklin, Policy Lead Long-Term Care
Commission Secretariat

Adriana Diaz Choconta, Senior Policy Analyst
Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

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I N D E X

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

INDEX OF UNDERTAKINGS

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

INDEX OF ADVISEMENTS

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

INDEX OF REFUSALS

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

1 -- Upon commencing at 11:00 a.m.
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 I'm Frank Marrocco. This is Commissioner
4 Angela Coke; and Dr. Jack Kitts, Ms. Sharkey, you
5 obviously know. We're essentially ready to go. We
6 have a court reporter here. We will publish a
7 transcript of what we've talked about so that
8 people can follow along. We'll ask questions as we
9 go along, if we might, and we're ready to go.

10 SHIRLEE SHARKEY: Great. Wonderful.
11 Thanks so much. And I really appreciate the
12 opportunity to meet with everyone. I'll be talking
13 about my presentation drawing on, well, quite
14 frankly, my experience in the healthcare system as
15 early on, believe it or not, actually a nurse and a
16 nurse working in the community, a visiting nurse
17 and then a health executive in the acute care, and
18 then also in the community and home care area, but
19 probably most importantly, too, as a family
20 caregiver, I can bring, hopefully, that
21 perspective.

22 Additionally, in 2008, I had the
23 privilege to work and participate on a report, a
24 2008 staffing report for long-term care that I'll
25 talk a little bit about, and then lastly, my role

1 as CEO of Saint Elizabeth Health Care, SE Health,
2 which I've been there for well now over 28 years,
3 and probably the best way to describe SE Health as
4 a non-profit social enterprise is that well now for
5 over 110 years, our key interest has been to really
6 impact how people live and age at home. That's
7 really been the overall focus.

8 I have with me today, Dr. Justine
9 Giosa, a research scientist at SE Health and co --
10 principal investigator of our Long-Term Care At
11 Home Study, and that's in partnership with the
12 University of Waterloo and interRAI Canada, and I
13 think Justine will help us work through some of the
14 opportunities and the findings that we have for
15 people both in long-term care homes and in the
16 community.

17 And also Madonna Gallo is with us, and
18 she is the Head of our Public Affairs at SE Health.

19 So to start, in February 2020, and I
20 guess you could put up just for your own enjoyment,
21 I actually wrote an article that compared the
22 ongoing transformation of our healthcare system to
23 the movie the Groundhog Day. I hope you've all
24 seen it, and this is with Bill Murray, and he plays
25 a TV weatherman who is, in fact, stuck in a time

1 loop, and among other things, he keeps stepping off
2 the sidewalk in the same icy puddle over and over
3 again.

4 And I wrote the article largely about
5 the lack of focus and investment in home care, but
6 I certainly could have written it about long-term
7 care because the same things that I'm sure you have
8 heard, the repetitive cycle in underfunding, how
9 there have been many studies and many reports, all
10 very similar themes.

11 And I think to date, although there's
12 been some very good work done, I would say that we
13 have not reorientated the system for an aging
14 population, and this, as we know, has been very
15 apparent during the pandemic.

16 But before we get into the pandemic, I
17 just thought I'd present a context that I think can
18 help describe what's been going on with seniors
19 well before the pandemic. And looking at the
20 latest statistics with C.D. Howe, and that was June
21 2020, generally, Canada has underinvested in
22 services for seniors; 90% of what is spent on
23 senior care goes, in fact, primarily to
24 institutions, hospitals, and long-term care
25 facilities, and only 10% actually goes into the

1 community.

2 Compared to other OECD countries, they
3 spend about 35% in the home and community care
4 side. So we have two problems: The pie that
5 exists for senior care services is certainly or
6 would appear that we are under-investing as a
7 country, and the proportion that goes into the home
8 and community care piece, the 10%, what that really
9 does is eliminates many options for seniors to be
10 able to live in their home longer. It also
11 eliminates options of where they go, and that's why
12 we have the acute care and the long-term care, to
13 some extent, manifesting itself with its
14 challenges.

15 Then additionally, from research
16 insights, you know, what we've known for a long
17 time is that older adults need an interconnected --
18 I didn't say integrated -- interconnected care and
19 services across a continuum. So when we look at
20 where we're going to invest and what we're going to
21 do, you have to look at this and kind of widen the
22 lens.

23 Secondly, most seniors want to stay and
24 age in their home, so this is an opportunity for us
25 to actually get very good response with the changes

1 that we could be putting in place.

2 And thirdly, unsurprisingly, because of
3 the way our funding has been positioned, we have a
4 high proportion of older people living in
5 residential care facilities that, in fact, could
6 have been cared for in their home environment if
7 we, in fact, expanded and looked at the program in
8 a very different way.

9 So what I hope today to talk about is
10 actually hope for seniors and, in fact, how to move
11 forward versus I know sometimes all we do is talk
12 about the negative things and, you know, never move
13 to, so what should we do about it, so this is, I
14 think, a good way to at least begin.

15 If I leave you with one message that's
16 important in this whole conversation is that if
17 we're really trying to change the system with
18 investments, we have to think about the long-term
19 care problem as a system problem, not a sector
20 problem, and we have to actually think about that
21 system as an integrated community-based care for
22 seniors.

23 In other words, if long-term care is
24 not just about buildings -- long-term care needs to
25 be not just about buildings and beds. It needs to

1 be about people, their home, and the communities.
2 And we need to, as we look at the problems, in the
3 bed, long-term beds, we have to at the same time
4 look at investments in the other areas that are
5 critical.

6 So speaking of beds and buildings, I
7 thought I'd share a little bit about the 2008
8 report that, quite frankly, everybody has
9 interpreted it in 50 different ways other than
10 really what I said, so it's always interesting to
11 write a report and then see it manifest itself in
12 an interesting way of what your recommendations
13 really are.

14 But the key focus was to look at staff
15 capacity for better care and how this related to
16 quality of care and accountability. Those are the
17 two things that actually the independent review was
18 to be considering and contemplating.

19 There was a real focus on minimum
20 standards, and I had difficulty with that
21 terminology from the get-go because I thought it
22 speaks to the persistent undervaluing of older
23 adults when we talk about minimum standards. It
24 just seemed bizarre, and I always had this, sort
25 of, analogy when you get your brakes done, you

1 don't walk in and go, you know, could you give me
2 the minimum intervention to fix my brakes? You
3 know, you usually would go in and say, you know,
4 what's the premium kind of service? So it -- I
5 always had trouble with the terminology, but above
6 and beyond that, when there was real pressure to
7 come up with provincial standards, I did not
8 recommend the four hours of provincial standards.

9 What I did recommended was that there
10 was more staffing and funding that was definitely
11 needed and recommended provincial guidelines and
12 that they be designed to achieve up to four hours
13 of care back in 2008 because I realized that the
14 four-hour standard was too simplistic with all of
15 the variability in homes, that the design of the
16 homes, the case mix, the leadership, so many of
17 those things had huge variability. And I had
18 actually determined that clients had everything
19 from one to six hours of care that they required
20 and needed.

21 And when I looked at those guidelines,
22 there were two important pieces that I said needed
23 to take place. One, there had to be local
24 planning, so it speaks to the issue of customizing
25 and making some sense of this. If not, it's only

1 going to be a numbers game. We've got the four
2 hours, check. But local planning to enable all of
3 the stakeholders, the residents, the staff, the
4 operators, and the owners to come up with, in fact,
5 how best to allocate the resources, how best to use
6 those hours of care. And we actually created a
7 really very good staffing playbook for homes to
8 use. That was never implemented.

9 Additionally, it was critical that
10 there be annual evaluations, and rather than such a
11 fixation on all of the compliance and regs, but to
12 really push annual evaluations with a good
13 scorecard that would validate that the funding was
14 actually addressing the resident care needs and to
15 inform decision making and staff enhancements.

16 So there was a fine difference between
17 minimum standards and guidelines but a very
18 specific process that I wanted to recommend to
19 suggest this thing constantly needed to be
20 examined. And it wasn't a simplistic, sort of,
21 pathway, these are the hours and this is what you
22 do.

23 So the good news is 12 years later,
24 we've come up with the same suggestions, but I am
25 fearful we'll go back to, sort of, more focus on

1 the numbers and hours of care and not enough focus
2 on are we meeting the needs, are the residents
3 getting the outcomes, and is everyone satisfied
4 with the care that we're providing.

5 So let me now move into the pandemic
6 and, sort of, from both the home care and the ALC
7 point of view, some observations. As we all know
8 in March 2020, with the lockdown and as we
9 continue, and rightfully so, real concern about
10 hospital capabilities, ICUs and vents, critically
11 important.

12 But I think that there was some
13 shortsightedness not only in looking at how it was
14 necessary to have a community-system approach to
15 what we did but also to build on what we know from
16 the research and the evidence. And I'm going to
17 talk about the ALC, and I'm going to talk about the
18 home care to expand a little bit.

19 From an ALC point of view, we know that
20 from March to early May, roughly 2,200 ALC patients
21 were discharged to long-term care homes or
22 retirement homes. And we know that these settings
23 quickly became the epicentre of the crisis in
24 Ontario. Also troubling, I think families
25 certainly felt pressure that they didn't have a

1 choice. They had to move people into the long-term
2 care facilities.

3 Now, remember the thesis was absolutely
4 right. You had to get capacity in the hospital,
5 and you had to get these ALCs out of that system.
6 Where I think it was flawed, to my knowledge, none
7 of these patients were discharged home. Could they
8 have been? Research suggests absolutely, yes. Not
9 all of them, but many of them could have been
10 discharged home.

11 Why do I say that? Well, before the
12 pandemic, with CIHI data, one in five seniors
13 admitted to residential care have actually similar
14 needs as individuals being supported in the
15 community. Also, a very high percent, probably
16 well over 30% of ALC patients waiting for long-term
17 care could be cared for at home, certainly not with
18 our current home care program and the design of it,
19 but, in fact, if we changed some of the home care
20 that exists.

21 Actually, this is another very
22 interesting finding: The biggest factor
23 influencing whether patients are assessed to go to
24 long-term care facilities, which I find that's
25 really that surprising when you understand it --

1 it's not related to the cognitive impairment nor
2 living alone nor the wandering behaviour.

3 What seemed to be the key switch that
4 had everyone assessed they needed long-term care
5 facilities was actually being assessed in the
6 hospital setting by hospital personnel, and that
7 was, again, CIHI data.

8 So now, let's talk about what happened
9 in home care which is, sort of, I know more about
10 home care than I ever wanted to know is one of
11 those things. But just to, again, present the
12 context for home care, very, very similar to
13 long-term care. It's been underfunded over the
14 years, not well understood. The model of care has
15 been challenged. It's a task-oriented, almost
16 fee-for-service model in particular in Ontario, and
17 there have been many reports talking about the need
18 for change, modernisation, new funding. So that's
19 the backdrop of what was happening.

20 Okay. Put that with, for some reason,
21 the thesis, again, was that need capacity in
22 hospitals, going to discharge everyone to long-term
23 care, going to actually shut down home care, and
24 then we'll have freed up capacity for the home care
25 staff to actually get into the long-term care homes

1 even though research from other countries was
2 saying that was very problematic. Primary care and
3 home care when that was, sort of, compromised
4 created even more of a bottleneck into the system.

5 Well, 70% of the first assessments --
6 you have to be assessed to get onto home care in
7 Ontario -- there was a decrease of 70% of those
8 assessments, so people were not able to get onto
9 the new home care or old -- old home care program,
10 and the visit volumes decreased by 27%. And this
11 is probably in a span of, like, two to three weeks.

12 And I think people generally initially
13 were fearful even though -- it's funny -- the whole
14 world was saying stay at home, one would have
15 thought, healthcare we should have had the same
16 kind of thinking. But I think people initially --
17 and our staff were a little nervous to begin with,
18 but then when we saw what was going on in the
19 congregate settings, many people wanted to make
20 sure or look at the option for their loved one to
21 remain at home.

22 So while this, though, was happening,
23 we did have a lot of people who have chronic
24 illnesses certainly having some challenges, and we
25 did have a lot of people with end of life who would

1 have preferred to die at home with their loved one.
2 It wouldn't have fallen into the same situation
3 that it did in the long-term care homes.

4 Interestingly enough, though, and this,
5 again, hasn't been, kind of, well-publicized or
6 understood, that surprisingly, the community and
7 the home-care program actually responded quite
8 positively with the pandemic. We saw nothing of
9 the same infection spread or rates of death in the
10 home environment.

11 And, you know, I've thought about that
12 a lot to say, well, what was different? And I
13 think -- and this is just my own experience years
14 ago as a visiting nurse, I think there's a natural
15 orientation toward IPAC in the community just by
16 virtue of visiting homes, et cetera. I think there
17 was also a real spunkiness in home care, like,
18 resourcefulness where many of us pulled out all
19 stops to get our own PPE. So we didn't get to
20 this, we don't have PPE. I know that for a couple
21 of weeks, all of us were calling around and were
22 able, actually, to get our own PPE supplies.

23 We moved to universal masking and
24 eyewear very early on, actually, ahead of the
25 guidelines. And so as a result, our infection

1 rates were remarkably low. Public Health doesn't
2 actually provide this data in a sector-specific
3 way, but for large home-care providers, we looked
4 at our data to see the infection spread amongst our
5 staff, incredibly low, well less than 1%.

6 So, I mean, that's an interesting
7 component to look at, could we have saved some of
8 these people if they had been discharged home?

9 Now, when we look at the implications
10 for these volume changes with the home-care
11 providers, as you can well appreciate, as with any
12 other part of industries where their volumes
13 decreased to that extent, surprisingly, rather than
14 have all this capacity build up, because the
15 business model was different, when there was no
16 revenue coming in and a 50 to 70% drop, all of the
17 frontline employees, thousands, thousands, went off
18 on a leave of absence. SE Health alone, we had
19 2,500 go off on leave of absence. And, of course,
20 this was exacerbated by the CERB support that our
21 staff had.

22 So it created significant
23 destabilization early on, and only now, we're
24 actually beginning to get back to pre-COVID, but
25 it's challenging because there were also pressures

1 to support the long-term care homes, and so we had
2 both things happening. We had all the
3 destabilization in the home-care space, and there
4 was great difficulty redeploying our staff to the
5 long-term care facilities because they simply were
6 not there. There was not the capacity, and
7 actually where there was, which was helpful, is
8 that's where the hospitals were still funded in the
9 whole way and with less, sort of, reduction in
10 their patient care, they were able to move over to
11 long-term care.

12 What other provinces actually did in
13 home care is they actually funded the agencies as a
14 whole, and that did create -- you were able to keep
15 people employed, and it did create the capacity for
16 both home-care services and to help with the
17 long-term care sector.

18 So it was a significant lesson for all
19 of us to learn, with this pandemic, what not to do
20 in this particular sort of area. As we --

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Can I just ask you a question? This keeps coming
23 up, of course, you know, the number of staff that
24 stopped reporting for work. And as you've been --
25 described, your situation, it wasn't so much safety

1 or the lack of personal protective equipment as it
2 was the CERB, so you can get that money and stay
3 home.

4 SHIRLEE SHARKEY: Absolutely.
5 Absolutely.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 So I got that that was -- you have a similar
8 perception.

9 SHIRLEE SHARKEY: Absolutely. If we
10 had been funded differently, we would have been
11 able to keep these people employed, and they would
12 have continued working.

13 The CERB really affected, I would say,
14 our personal support workers because pretty much
15 what they could get on unemployment is what they
16 could get if they were working certain hours.
17 Nursing was a little bit different, and a lot of
18 the nurses left because there simply wasn't the
19 work. And with our business model where you're not
20 funded collectively as a whole, it's like any
21 business, the revenue goes down 50%; you have to
22 adjust for your costs.

23 And so not only do we have frontline
24 that we had layoff, we actually had, within our
25 whole leadership team, all kinds of adjustments

1 that had to be put in place for two to three months
2 'til we got on the other side, so really
3 destabilized the sector. And I don't know if there
4 was actually logical thinking to say, well, we're
5 going to shut this down, and we're going to do this
6 and do that. It just sort of happened, which is, I
7 think, an interesting reflection to think about
8 because while this was happening, I remember
9 reading in New York and in Spain where there was a
10 lot of discussion that you can't possibly get over
11 this unless you continue to keep the community
12 supports functioning and in particular home care
13 and primary care.

14 And I remember while this was
15 happening, I was very vocal to look at what's
16 happening in other countries right now because
17 we're going to create a big problem. And exactly
18 what happened in other countries happened here, a
19 real problem in the congregate settings and in the
20 hospital capacity.

21 And, I mean, a lot of reasons why
22 people were safer in their home is they didn't have
23 the same environment for the infection spread. And
24 I also think if we had leveraged the home
25 environment in a different way by supporting it and

1 funding it and basically keeping the doors open, it
2 might very well have helped with fewer deaths.

3 COMMISSIONER JACK KITTS: Shirlee, can
4 I just ask a question about the process, then, for
5 the CERB because none of these workers were laid
6 off, and all of them are declared essential
7 services. Does that allow them to qualify for the
8 CERB?

9 SHIRLEE SHARKEY: Well, they were --
10 because our volumes went down, we didn't have the
11 work. We did not have the work. Now, we had -- so
12 it's a good -- I think they went off on leave of
13 absence. We actually had some of our -- this was
14 our -- not our direct staff but our overhead staff,
15 they were actually laid off and qualified for
16 unemployment insurance.

17 Front line, were on -- it's a good
18 question whether they were on a leave of absence or
19 we -- or laid off. I'm not sure how we -- I think
20 most went on a leave and then applied for the CERB,
21 our frontline because there simply wasn't the work.

22 COMMISSIONER JACK KITTS: But very
23 shortly there was when the -- when the long-term
24 care homes needed PSWs, and I understood there was
25 a shortage also in home and community care, so

1 there's --

2 SHIRLEE SHARKEY: Yes. And two things
3 were happening at the same time. I think we've
4 almost had everyone come back, but it did come back
5 in stages. There was certainly the school program
6 where workers had children at home, so there was
7 that component that played a role, and I think you
8 have to keep in mind the context that I presented
9 at the first was home care had previously a PSW
10 problem and has had -- well, let's call it labour
11 problems as relates to the funding and the
12 resourcing, and it's been constantly, probably for
13 the last 20 years, a real challenge to retain and
14 recruit and keep, so you had that happening all at
15 the same time.

16 COMMISSIONER JACK KITTS: Okay. Thank
17 you.

18 SHIRLEE SHARKEY: But I think you're
19 right. Most of us as providers started to look at,
20 okay, what can we do? You know, how can we -- how
21 can we help with this? And actually, just looking
22 back, Jack, your question's right. We didn't --
23 there was no frontline layoffs. You're absolutely
24 right. They were all leave of absence, and then
25 within that, they were able to qualify for the

1 CERB.

2 COMMISSIONER JACK KITTS: Right.

3 SHIRLEE SHARKEY: But we did have
4 layoffs, as I say, at the clinical level,
5 management level in order to get our costs adjusted
6 with those volume reductions.

7 But what was happening during this
8 time, we said we've got to help out here. What can
9 we do? And, you know, is there a way we could
10 build capacity knowing that the long-term care
11 system and beds, you couldn't -- wouldn't be able
12 build these beds overnight -- and started to think
13 about, you know, we've been looking at alternatives
14 in the community for people to stay home for a
15 number of years. And this is where Justine comes
16 in because we started to look at, is there -- could
17 we be pushing this whole long-term care at home or
18 other options for people even while we're going
19 through this so that at least, while we're in this
20 crisis and the beds are not available, we have some
21 alternatives, because we were concerned the
22 hospitals were going to fall into the same problem
23 with the ALC, and we've got the vicious circle all
24 over again with Wave 2.

25 So I am going to turn it over to

1 Justine and to talk about a lot of the work that
2 we've been doing to really understand the need to
3 have more options for people. Certainly, the
4 pandemic is one thing, but we've got this
5 opportunity to get on the other side, and if all we
6 do is look at the long-term care bed situation,
7 it's going to create the same problem that we've
8 had for 30 years.

9 So, Justine, over to you.

10 JUSTINE GIOSA: Right. So going back
11 to Shirlee's earlier comments, the starting point
12 for our research on the long-term care of older
13 adults is to think about long-term care, again, as
14 a system and not a single sector, so extending our
15 thinking beyond buildings and institutional beds to
16 prioritising people's needs in their homes and in
17 their communities and bearing in mind these two
18 very well-established points that Shirlee's already
19 made: Number 1, people want to be at home; and
20 Number 2, there are unmet needs and capacity issues
21 in both home care and long-term care.

22 So our goal with the research is to
23 develop and help to operationalize a new model of
24 needs-based home care for older adults who are at
25 risk of going into a long-term care home at some

1 point in their lives. And our aim is to strengthen
2 our home-care offerings to give older adults more
3 options to where to live and receive care as they
4 age. We want to build a whole continuum of
5 services to meet their whole-life needs and make
6 home the default trajectory.

7 So this work is funded and led by SE
8 Health, as Shirlee mentioned, in partnership with
9 experts at the University of Waterloo and interRAI
10 Canada. And, essentially, we're using a
11 data-driven approach to accomplish three main
12 things: The first is to really understand the
13 needs of people receiving home care. The second is
14 to compare these needs of people at home to people
15 in residential long-term care; and the third is to
16 really develop and operationalize life-care
17 packages so that the home care sector can better
18 meet those needs.

19 So I'm going to start with the first
20 which is understanding the needs of people at home.
21 We completed an historical analysis of over 205,000
22 Ontario home-care assessments using standardized,
23 routinely collected interRAI home-care data, and we
24 did a market segmentation of this population into
25 six categories of individuals at risk of long-term

1 care admission. And we found that about 80% of
2 long-stay home-care clients, so that's some 160,000
3 people, are considered at risk of long-term care
4 placement based on known medical, functional, and
5 psychosocial predictors. So these are things like
6 social frailty, caregiver distress, chronic
7 disease, cognition, behaviours, and medical
8 complexity. And we also did further descriptive
9 analysis on these categories which revealed that
10 about 35% of the Ontario home-care population has
11 mental health, medical, and functional needs
12 combined.

13 So this means that we need more than
14 just medical care. We need what we call full-life
15 care which considers health not just as absence of
16 disease, but living well as possible under any
17 circumstances. So, yes, we need medical care, but
18 we also need mental well-being, societal
19 participation, and daily functioning.

20 A one-size-fits-all approach does not
21 work to address the breadth and diversity of the
22 needs of the older population, and an understanding
23 of this is really required to break that Groundhog
24 Day loop that Shirlee was mentioning earlier. We
25 need different services in home care, not just more

1 of the same.

2 The second thing we did was to compare
3 the needs of the people at home and home care to
4 the people currently living in residential
5 long-term care. And so we did an historical
6 analysis of over a hundred thousand Ontario
7 long-term care assessments using that same
8 routinely collected standardized CIHI data.

9 And we mapped the six categories of the
10 home-care population considered at risk of
11 long-term care admission to our current long-term
12 care population. And what we found was around 93%
13 of the long-term care population in Ontario mapped
14 to five of the six categories that we used to
15 describe the home-care population.

16 So what's most notable about this was
17 that 38% of the long-term care population actually
18 falls into the category that we most serve in the
19 home-care sector. So this means there's
20 significant overlap between the needs of the
21 individuals who are receiving care in long-term
22 care and those receiving care at home.

23 So not everyone in long-term care
24 requires 24/7 PSW services, and not everyone in
25 home care just needs a bath. So we really do need

1 to get creative and have new thinking about how to
2 care for these people in new and creative ways and
3 prevent or delay their admission to long-term care
4 homes altogether.

5 So the third thing that we're doing,
6 and it's in progress, is that we're really
7 committed to taking this beyond a conceptual
8 concept, and our goal is to really support the
9 operationalization of this model, so we're working
10 in partnership with home-care leaders, clinicians,
11 point-of-care staff, patients, and families to
12 codesign new life-care packages for home care to
13 meet these needs.

14 And what we're finding so far is that
15 life care involves access to more than 65 types of
16 services and care in the community from a range of
17 interdisciplinary and multisector providers
18 anchored by home care. And so this is a stark
19 contrast to our existing models.

20 We're also working to compare our
21 existing model to existing models of care -- or
22 sorry -- our emerging model to existing models of
23 care. We're doing an in-depth review of historical
24 LHIN service utilization data to understand how our
25 emerging model compares to current LHIN offerings.

1 We're reviewing new high-intensity support programs
2 in home care, and we're also working to better
3 understand the fully loaded costs for current
4 residential long-term care beds which requires
5 thinking more than just about the per diem direct
6 care costs but also thinking about external factors
7 like caregiver support, social interaction, and
8 care coordination to name a few.

9 So overall, what we're learning is that
10 long-term care home admission risk goes beyond
11 thinking about the current waitlist or ALC
12 population. Social frailty, caregiver distress,
13 and mental health are hidden risk groups that are
14 often one hip fracture away from a crisis placement
15 to long-term care, and we can do better for them at
16 home. And a new model of home care to support
17 older adults at home and help them avoid long-term
18 care admission requires an optimisation approach,
19 not a substitution model. We can't just have more
20 of the same home care, and we simply can't just
21 repurpose the current per diem costs of residential
22 long-term care to the community and expect change.

23 So our research will help us understand
24 not only how to better support people in the
25 community but also what beds are needed for what

1 populations.

2 And so now, I'm just going to turn it
3 back over to Shirlee to wrap us up.

4 COMMISSIONER JACK KITTS: Can I just
5 ask a question before you turn it over?

6 JUSTINE GIOSA: Sure.

7 COMMISSIONER JACK KITTS: So in your
8 study, I want to see if I understood what you said.
9 So 80% of people in home care are at risk to move
10 into long-term care. They've got the risk factors
11 that would suggest that someone might look at them
12 and say you need long-term care. Is that --

13 JUSTINE GIOSA: Yeah.

14 COMMISSIONER JACK KITTS: Is that what
15 you -- the second thing you said you -- a hundred
16 thousand people -- residents in long-term care you
17 studied, and 93% of them, of that population,
18 matches in risk factors to people who are being
19 cared for at home --

20 JUSTINE GIOSA: Correct.

21 COMMISSIONER JACK KITTS: -- or five
22 out of six, I think you said --

23 JUSTINE GIOSA: Yeah.

24 COMMISSIONER JACK KITTS: -- of
25 factors. So I think if you studied the patients in

1 hospitals, in hallways, or ALCs, you'd probably
2 find a similar overlap.

3 SHIRLEE SHARKEY: Yeah.

4 COMMISSIONER JACK KITTS: And, Shirlee,
5 you'd agree. So my question is, you've got three
6 very similar populations of patients; it would be
7 hard for someone without a study to figure out
8 which one is long-term care, home and community
9 care, or subacute hospital care.

10 And so that's a -- that's a large
11 number of frail elders that we have, and you've
12 shown that the decision to where they go is very
13 narrow because they're all very similar.

14 So my question is, you know, in your
15 opinion, the goal is to get the right care in the
16 right place at the right time.

17 With such an overlap, how do you decide
18 which one of those three places is right? And even
19 if you do decide, just one -- you say one
20 fracture -- I'd say one cold away, they move to
21 another level of care and then back.

22 So you're right. This has to work as a
23 system, and it has to be seamless so they can go
24 back and forth, but I've never been able to really
25 figure out who is the decider as to where they go

1 and then where the resources are put? Who is that
2 decision maker?

3 SHIRLEE SHARKEY: I think it's a really
4 good question. And what is another piece that we
5 haven't added is the decider, ultimately, should be
6 the client and the family because, you know, a
7 lot -- especially when we talk about the life-care
8 needs which are broader than the medical-care
9 needs. You know, sometimes, medically, Jack, it's
10 a no-brainer. You need to go listen. You need to
11 be in the hospital. You need to have the right
12 diagnostics; here's the intervention.

13 But so many of these people with
14 chronic disease -- the only thing I would suggest
15 when you asked Justine the question, these people
16 need long-term care; I'm not sure I agree that they
17 need. We have identified that they have needs
18 similar to long-term care, but they may not need
19 that institution.

20 And you're right. It's an economic
21 issue to some extent. It's a caregiver and family
22 issue to some extent, and then it is a health
23 professional all, kind of, talking to figure out
24 where and what makes sense.

25 And the big challenge has been right

1 now, the choices are very limited for people, and
2 our first starting point is you need to go to a
3 long-term care facility. And I think that's
4 problem Number 1.

5 I think you're right, I don't think
6 we'll ever get it straight where who -- one, who is
7 making the decision? It typically is the family
8 members who are making the decision based on the
9 input.

10 But also, if we don't give them options
11 and look at, you know, where and what and how makes
12 sense and design those options, we will continue to
13 flood the hospitals, and we will not be able to
14 build enough long-term care beds with the
15 population.

16 I think that we're not addressing
17 actually what people want. People want to stay in
18 their home and age in their home, and the majority
19 want to die in their home. And we've not designed
20 the system to make sense of it, and so who,
21 ultimately, is making the decision most of the time
22 is actually the health providers influencing the
23 family to make the decision, and I think that's
24 flawed.

25 I think the health provider should be

1 figuring out how to design the systems. We have
2 all these options. Because your point's an
3 absolute correct point. They could be in a
4 hospital, in a long-term care facility, and in
5 their home and be thriving or surviving or dying,
6 one of those three. And it's much more complicated
7 to help people understand their choices and for us
8 to create and design the system that allows that to
9 happen, and I think that's where we -- that's the
10 biggest flaw right now.

11 COMMISSIONER JACK KITTS: Well, can I
12 follow up, then, because your -- in your opening
13 comments, you said that what we need is a system,
14 but you made a point that it's an interconnected
15 and not an integrated system.

16 So when you've got three healthcare
17 organizations involved in almost an identical
18 patient and where they could go, I'm curious
19 because I think you mean interconnected is a
20 partnership model with separate governance and
21 separate funding, whereas integrated would be an
22 integrated model with integrated governance and
23 funding.

24 And so I'd like to -- I'd like to learn
25 more about how the -- at least the three key

1 players in this way could function and be
2 successful in an interconnected model.

3 SHIRLEE SHARKEY: Yeah, it's a good --
4 I'm not surprised you picked up the difference in
5 that terminology, Jack. You never let me get away
6 with anything. You just, sort of, slide it
7 through.

8 I think people -- we need to design the
9 system so that we are intersecting with people's
10 lives, not that their lives are intersecting with
11 our amazing integrated system. And that's why I
12 say, if we -- if our starting point is the -- is
13 the eyes and ears of the family and the individual,
14 the issue is that they, then, get to a system that
15 is connected for them. It may not necessarily be
16 that that system works best. It may work best for
17 us from an integrated point of view, but for a
18 family, it may be a very different model that's
19 required.

20 Sometimes an integrated system could
21 work. Sometimes, just as Justine talked about,
22 life needs may impact hundreds of agencies, small,
23 big, large, community, et cetera. And the issue
24 would be to design it so people can connect with
25 that, not that we connect all of these agencies in

1 one integrated way.

2 I think from a medical health point of
3 view, integration makes a lot of sense because it's
4 expensive; there's a need for exchange of
5 information. When we broaden this for the chronic
6 population and it's life care, that model needs to
7 look very different, and there needs to be
8 flexibility within that, and we need to figure out
9 a process that allows that to be flexible.

10 So, you know, one -- I just think we've
11 got the silver bullet thinking of everything will
12 be integrated -- like, we will be integrated, and
13 it will make everything okay. I think it needs to
14 change around to people will have all of these
15 things interconnected to meet their needs however
16 they're manifesting themselves.

17 And again, it's just a different
18 starting point with seniors, with the variability
19 that exists, and with life care which is much
20 broader than the disease process.

21 COMMISSIONER JACK KITTS: Okay. Thank
22 you.

23 SHIRLEE SHARKEY: Does that help
24 clarify that?

25 COMMISSIONER JACK KITTS: Yes, putting

1 it to the patient and family connection as opposed
2 to the caregivers, so.

3 JUSTINE GIOSA: In our research, we use
4 the definition of integrated or interconnected care
5 from the NHS which is the user-led definition of
6 integration which is, I can plan my care with
7 people who work together to understand me and my
8 care, or has put me in control, coordinate and
9 deliver services to achieve my best outcome. So it
10 really is putting them in the driver's seat.

11 COMMISSIONER JACK KITTS: That's
12 excellent. So one's a viewpoint from the
13 caregivers and the other from the patient or
14 client, so thank you.

15 SHIRLEE SHARKEY: And it doesn't mean
16 that one is right and the other is wrong. It,
17 again, is how we actually, then, design that to
18 work effectively because you're absolutely right
19 sometimes, Jack. It does make sense things be
20 integrated, and we get capacity, and we get
21 specialization.

22 But that doesn't mean that's how it
23 should be designed for the end user necessarily,
24 and I think especially with the seniors population,
25 our challenge of figuring out how to be customized,

1 personalized, and design it different, that is --
2 that is our biggest flaw, and because the rest of
3 our health system is trying to use pathways and
4 standards and continuity and linear thinking and,
5 you know, very, very specific things because the
6 environment is controlled, that changes up in this
7 other environment which creates havoc when you're
8 trying to have funding and policy and different
9 ways of looking at it. But if we get it all
10 organized and we don't get any better outcomes or
11 better value, what did we actually accomplish with
12 this?

13 So maybe to summarize -- I know I had
14 another thought when you asked me that question,
15 Jack, and I can't remember what it was, but anyway.

16 COMMISSIONER JACK KITTS: Okay.

17 SHIRLEE SHARKEY: So from, sort of, a
18 conclusion, I think what something we need to be
19 thinking about for our starting point is that
20 certainly, Canadians and certainly Ontarians are no
21 different -- overwhelmingly, they want to live and
22 age and die at home. This is a wonderful
23 opportunity for us to capitalize on, and there's
24 been all kinds of studies that talk about this.

25 But we haven't designed the system to

1 actually address what people want, and that does
2 baffle me sometimes. I go, well, it's an easy
3 thing to be looking at; this is what people want,
4 and how do we design? And that does not mean that
5 there's not a need for long-term care facilities,
6 nor does it mean that acute-care hospitals don't
7 play a role. They certainly do. It does mean it's
8 a different starting point.

9 What we also, I think, can conclude is
10 that home care is certainly one of the safest
11 settings for healthcare delivery during this
12 pandemic for the frail elderly. Certainly, with
13 the infection rates and with the home-care staff
14 and clients remaining exceptionally low, this is
15 something for us, I think, to certainly think about
16 as we go forward if there is, hopefully not,
17 another pandemic to make sure we keep community
18 services robust and thriving if even to help build
19 capacity to help other parts of the sector. That
20 would have been, in itself, extremely helpful in
21 this space.

22 If we had a different approach to
23 dealing with people in their homes -- and this is,
24 I think, the biggest takeaway for me -- the number
25 of beds we actually need for the future is unknown

1 right now. And I am convinced we would need fewer
2 beds, and I also am convinced we'd have happier
3 seniors because they want to remain in their home.
4 And so I think we have to do a little more work to
5 actually understand what capacity we need in what
6 areas and then how we need to change that up.

7 But I think what's probably fundamental
8 in any change is a new way of thinking, and you can
9 see from these conversations where just our
10 starting point is different. And then what changes
11 need to be put in place, talk about new ways of
12 thinking and working, and I think that's the only
13 way we're going to escape the loop.

14 My concern right now is with the
15 recommendations to improve the long-term care homes
16 is important, but once again, it's been discussed
17 in isolation. And once again, it will probably
18 create havoc to the home-care system, and you will
19 pull all of the resources that are already
20 stretched and with challenges to the long-term care
21 system. So we've done the full loop. There will
22 be less options for people to be in their home.

23 Go ahead, Jack.

24 COMMISSIONER JACK KITTS: I'm just --
25 is there -- is there any likelihood that the

1 leaders in the long-term care sector, hospital
2 sector, and home and community care sector get
3 together to figure out how we keep -- stop robbing
4 Peter to pay Paul and work as a system, an
5 interconnected system?

6 SHIRLEE SHARKEY: There certainly
7 should be, Jack. I think the problem is everyone
8 has a different starting point. The acute care has
9 a different starting point, and it's right. People
10 in their homes, I would suggest, that's the
11 paramount starting point when we look at seniors
12 demographics, what we're going doing; and the
13 long-term care facilities also have a different
14 starting point.

15 But you're absolutely right. We have
16 to come together and look at this as a system, but
17 I would -- I would even challenge; we actually have
18 to over-rotate on community-based support for
19 people. Why do I say that? When I go back to the
20 C.D. Howe statistics, we are underfunding services
21 for seniors, period. And the percentage that's
22 going into how they live their lives and where they
23 live their lives in their home is a small segment.

24 Now, I can just speak to home care.
25 Home care -- and I think in the 30 years I've been

1 in home care, it still is roughly 5% of the total
2 public expenditure within home care. Now, but
3 here's the kicker: Probably only a third of that
4 actually goes into direct care in that we've
5 structured it in an interesting way with lots of
6 layers and assessments that, you know, people are
7 actually not getting as much of that money in
8 direct care. And the other thing is -- we've
9 talked about, is we probably need a whole different
10 approach to the care. There can't be service
11 limits, and it can't be just, you know, do you need
12 wound care? Great. You get home care. It has to
13 be looked at in a much more life-care way to keep
14 them functioning in the community differently.

15 So you're right, Jack. The three --
16 the three groups need to come together, but the
17 three groups have to agree to what's the starting
18 point for all of us versus in each sector, what's
19 the starting point.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 How do you react to the assertion that we
22 constantly hear that the resident in a long-term
23 care facility is in their home? It seems to be a
24 rather institutionalised home.

25 And I'm curious whether you think the

1 terminology is causing part of the problem because
2 you want them -- you say they should be -- that
3 they want to be at home, and they're better served
4 at home. And the long-term care facility is
5 saying, this is their home. And it just -- you
6 know, it's a funny home where your loved ones can't
7 come to visit you. You can be confined to your
8 room for an extended period of time, et cetera,
9 et cetera.

10 And so I just wonder have -- what you
11 think, whether that has occurred to you, whether
12 you think that's, in a sense, part of the problem?

13 SHIRLEE SHARKEY: It is. I'm
14 wondering, Justine, some of your thinking with
15 that.

16 Because, I mean, I think you're
17 absolutely right. How we define one's home is an
18 interesting phenomena. But, I mean, most people,
19 when they say they want to remain at home, it
20 really is about their independence, control, and
21 management of their life which we all -- we all
22 have at every point in time.

23 I think the long-term care facility
24 and, you know, residential care, it becomes where
25 they happen to be living based on their condition

1 as I would see it. But, I mean, I think you're
2 right. Some -- in many ways, terminology we use,
3 especially within the senior's population, is a
4 challenge. And I would suggest, firstly, minimum
5 standards is terminology that I find difficult.

6 I would not want anyone to say to me,
7 here are the minimum standards of what I'm
8 providing to you. Just when you really think about
9 that language, it helps us ponder how we've moved
10 into that thinking.

11 But, Justine, you may have some other
12 thinking, so jump in.

13 JUSTINE GIOSA: Yeah, I think it goes
14 back to thinking about congregate living settings,
15 and I think prepandemic, you know, some of the
16 things I talked to about being predictors for
17 long-term care admission that are less-often talked
18 about are the social frailty piece, the mental
19 health piece, and the caregiver distress piece.
20 And I think those have been exacerbated in
21 long-term care for various reasons during the
22 pandemic because of lockdown and quarantine and all
23 those things you just mentioned. But pre-pandemic,
24 you know, being in a congregate environment, those
25 things you can't discount, you know, someone going

1 to a dining hall and having that social interaction
2 if they get it. So in some cases, that's good. So
3 it is home-like, and the intention is to be
4 home-like.

5 So I think when we think about what
6 life care looks like in the community, we can't
7 forget those things as being part of what being at
8 home requires and what people's needs are in terms
9 of their social interactions, in terms of caregiver
10 support, in terms of their mental health.

11 And so I think when we think about
12 home, it has to be not just about the medical
13 piece, but also about all those other factors. And
14 so in a congregate environment, some of those
15 things do happen under non-pandemic circumstances.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Well, I was just struck because Ms. Sharkey used
18 the phrase, facility. And when you call it a
19 long-term care facility, I think you're making a
20 distinction between that place and a person's home,
21 but the -- but the institutional terminology is
22 that it's the person's home.

23 SHIRLEE SHARKEY: Yeah.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 And I think that confuses -- I was just curious

1 whether you thought it confuses entirely the
2 discussion.

3 SHIRLEE SHARKEY: I think it sometimes
4 does, and, you know, I just go to the old adage, I
5 mean, there is no place like home. And I do think
6 some of these other options are home-like, but they
7 are not home. But I think you're absolutely
8 correct. It sometimes confuses, and I think some
9 of it is almost how to label it or brand it in a
10 more acceptable way for people.

11 I think the other thing we haven't
12 talked about with long-term care, which is another
13 thing to think about, is a lot of people who are
14 going into long-term care, there are the financial
15 issues. And that's typically why the decisions --
16 you know, Jack, when you talked about, when you
17 have people look a certain way in acute care and in
18 the community and in the long-term care, and they
19 all look the same from, sort of, a functional, a
20 medical, et cetera, many times the issue is, in
21 fact, the financial situation.

22 And that's where we also, in addition
23 to looking at this in a system, is looking at very
24 different alternatives for housing. Also, looking
25 as a system is what are some of the other tax

1 incentives for people to, you know, want to look at
2 other options to keep people at home. So it is a
3 complicated analysis that I can understand. It
4 makes people's heads hurt and go, could you just
5 make this simple for me and let me solve one little
6 part of this problem. But by solving one little
7 part of the problem creates the ongoing -- the
8 years and years of difficulty creating options for
9 people. And right now, with the growing
10 demographics, time is not on our side, and we do
11 have to change things up.

12 And I don't know, Jack, if we can do it
13 fast enough by bringing together the three sectors
14 and having conversations because that has been
15 happening now. I mean, I was -- I was just on a
16 panel and somebody was saying, Shirlee, for 25
17 years I've heard you talking about this. And I
18 thought, okay, so we clearly need to start doing
19 something different. And I think we do, and it
20 maybe is -- for example, we have an overhead that
21 we didn't bring up, is even rethinking long-term
22 care bed capacity.

23 And here's a thought: We have an
24 illustration that shows in a community with homes,
25 every home has a bed, so it actually is saying,

1 here is our long-term care capacity, and it shows
2 all of these additional beds above and beyond what
3 an actual facility would be, but we are creating
4 long-term care capacity in the community by doing
5 things entirely different.

6 So above and beyond the announcement of
7 actually new beds being built, why not allow --
8 announce a whole different approach and option.

9 Now, I understand there are all the
10 implications for where do we get the resources?
11 What does this look like? But if we don't begin to
12 get in front of this, it's unsustainable.

13 Economically, what we're proposing here
14 is unsustainable. Add to that, it's not what
15 people want anyway, so you begin to ask yourself
16 the question, what's the problem here to move
17 forward differently?

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Well, thanks very much. Oh, sorry.

20 COMMISSIONER JACK KITTS: Thank you.
21 Just one more question, and I don't know if it's a
22 question or a request, but I like the research and
23 your report on your findings in terms of
24 understanding the needs of people who are in
25 long -- in home care now and those in long-term

1 care.

2 My question is, are you planning to do
3 more follow-up research to learn where, of those
4 three places, the outcomes or the, I guess, the
5 experiences is best as given by the patient, and
6 it's more -- more asking for standards of -- I
7 don't know -- satisfaction or experience with the
8 three places given that they could be in any one of
9 three?

10 JUSTINE GIOSA: Yes, absolutely. So
11 this is a work in progress. We're part of the way
12 there, but we do plan to sort of operationalize
13 this model and then also seek further input beyond
14 the home-care sector in terms of referral patterns,
15 in terms of how those people might access services,
16 and how we might move forward in operationalising
17 this type of approach. So absolutely, we -- and we
18 will be publishing these findings. They're quite
19 preliminary, and so we will be putting those out
20 there so that we can share them more broadly.

21 COMMISSIONER JACK KITTS: Excellent.

22 SHIRLEE SHARKEY: I think you're asking
23 a really good question, what value are we creating?
24 So where can we get the best outcomes with the
25 clients' satisfaction, and client being client and

1 family satisfaction, of those outcomes over cost.
2 And that's where I think you're absolutely right.
3 We need to look at that and say, all right; how do
4 we design that that really accommodates the
5 greatest value for how we're funding services for
6 seniors?

7 The only thing I would suggest is, and
8 I know it drives me crazy when everyone goes, you
9 know, other countries are doing this. But other
10 countries are doing this, and they seem to have a
11 better handle on care for seniors. And, you know,
12 how do I gauge that? I simply say when I visit
13 them, boy, I would like to be aging here than in
14 Canada. And that's where I think -- that's the
15 real, I think, measure is, as Canadians, is this
16 where we want to age and where we feel the most
17 comfortable that we'll be able to age with the
18 dignity we're looking for.

19 And right now, it's not looking good,
20 and I'm the most positive person you could imagine,
21 but right now, I would say it's making me a little
22 nervous to how we'll get on the other side of this.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Well, thanks very much for, you know, helping to
25 develop this notion of more care at home than --

1 and slowing the transfer of people to a facility.
2 It's something that has come up in our discussions,
3 and this has fleshed that out a bit more for us and
4 considerably more for us. And so thank you for
5 that. And thank you for the presentation, and you
6 may hear from us again.

7 Oh, sorry, Commissioner Coke.

8 COMMISSIONER ANGELA COKE: No. No. I
9 just wanted to say that I do very much appreciate
10 your choice of words because that helps people
11 reframe their thinking about things. So even the
12 word life care means something very different than
13 just being narrowly focused on medical care.

14 SHIRLEE SHARKEY: Yeah.

15 COMMISSIONER ANGELA COKE: So I think,
16 like you say, if you want to reorient the way
17 people are looking and thinking about things, you
18 have to think of the different language that helps
19 people do that, so I found that very useful in
20 terms of how you're suggesting a way more holistic
21 approach. And I think the reason we don't have
22 that view, fundamentally, is because of the
23 devaluing of seniors. And I think if we had put a
24 different value on them, we're going to think
25 differently about the type of broad care that they

1 need. It was very helpful. Thank you.

2 SHIRLEE SHARKEY: Well, and thank you
3 all. I know it's a -- it's a complicated area, and
4 I can't tell you how much I appreciate the -- you
5 know, the depth and the work that you're doing in
6 this space because it is -- it is so critical, and
7 even though I do criticize a number of reviews and
8 expert panels and everything, I'm hoping that we
9 can -- all of these do eventually get to action
10 which is exactly what we need.

11 So, you know, I appreciate you're
12 commitment to keep the course with this, stay on
13 the course with this.

14 COMMISSIONER JACK KITTS: Yeah. Thank
15 you.

16 U/T SHIRLEE SHARKEY: We're happy to
17 provide any other information or any follow-up or
18 any more of our research work. We'd be honoured to
19 provide that to you.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Thanks very much.

22 COMMISSIONER JACK KITTS: Thank you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Bye-bye.

25 COMMISSIONER ANGELA COKE: Thank you.

1 SHIRLEE SHARKEY: Bye for now.
2 COMMISSIONER JACK KITTS: Bye.
3 -- Adjourned at 10:00 a.m.
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REPORTER'S CERTIFICATE

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

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

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

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

Dated this 22nd day of December, 2020.



NEESONS, A VERITEXT COMPANY

PER: JANET BELMA, CSR

CHARTERED SHORTHAND REPORTER

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