Long Term Care Covid-19 Commission Mtg.

Authors of LTC Study: Ontario and B.C. Experience
on Monday, December 21, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 21st day of December, 2020, 1:30 p.m. to 2:21 p.m.

BEFORE:

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

PRESENTERS:

Mr. Michael Liu, Graduate Student University of Oxford

Dr. Irfan Dhalla, Vice President, Physician Quality Unity Health Toronto

Dr. Colleen Maxwell, Professor, University Research Chair University of Waterloo

PARTICIPANTS:

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

Ida Bianchi, Counsel Long-Term Care Commission Secretariat

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Dawn Palin Rokosh, Director, Operations Long-Term Care Commission Secretariat

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

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: 17, 20, 47

INDEX OF ADVISEMENTS

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

INDEX OF REFUSALS

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

-- Upon commencing at 1:30 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, if you're all here, we're all here. For the -- we already introduced ourselves to Dr. Dhalla, but I'm Frank Marrocco. There's Commissioner Jack Kitts, Commissioner Angela Coke. We are the Commission.

Janet is our transcriptionist who will record the presentation, and, as you know, we will publish a transcript of it on our website.

So we have the paper, and you can assume we have some familiarity with it. We're at your disposal. We're ready to proceed when you are.

IRFAN DHALLA: Thanks, Commissioner. I'm happy to start. I'll introduce the team, say a few words, and then turn it over to Michael to take us through most of the presentation, which I think will probably only take about 15 or 20 minutes, and then we'll be at your disposal for any questions or feedback that you would have for us.

So with me today is Michael Liu, an entering medical student at Harvard Medical School. Michael led the bulk of the work, and Colleen Maxwell, an epidemiologist and professor

university research chair at the University of Waterloo.

Since you already -- do you have the slides as well?

COMMISSIONER FRANK MARROCCO (CHAIR): I think so, yes.

IRFAN DHALLA: Yes, okay. So I think Michael will probably be able to share his screen and put them up so we can go through them together.

But maybe if I might say a few words about why we did this work, I think in about May or June, it became clear that outcomes in long-term care homes in some provinces in Canada were much worse than outcomes in other provinces.

And Michael and I had a couple of conversations about this, and we put together, you know, in my view, an exceptional research team with leaders in geriatrics and long-term care from both British Columbia and Ontario to see if we could try to discern why it was that outcomes in Ontario had been so much worse than in British Columbia.

And through the summer, we did this work, and our paper appeared in the Canadian Medical Association Journal, I think, in September. I can't remember the exact date, but you would have

it.

And so what Michael's going to do is take us through some of the key findings in that paper, and then we can offer some speculative thoughts about why outcomes in long-term care have not been very good in both provinces in Wave 2, and so, you know, that information isn't in the paper itself because the paper was published before Wave 2. But we're happy to share some speculation on those points informed by what we understand is happening in both B.C. and Ontario, and then we can have a discussion with you all. Does that work okay for you?

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. Sometimes we will ask -- we've been in the habit of asking questions as things come up. We're amenable to doing it either way.

IRFAN DHALLA: I think that's fine with us. We read some of the transcripts, so we know that that's your style, and we're happy to do that so --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

IRFAN DHALLA: -- please interrupt us any time or interrupt Michael any time.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

IRFAN DHALLA: Okay. Over to you, Michael.

MICHAEL LIU: All right. Thank you Irfan.

And thank you, Commissioners. Sorry. I'm just going to share my screen. Is that working?

COMMISSIONER FRANK MARROCCO (CHAIR): It's working for me. Yeah, I think it's working for all of us.

MICHAEL LIU: Can you see the slides?

COMMISSIONER FRANK MARROCCO (CHAIR): I can. We all can, I think.

MICHAEL LIU: Oh, you can? Okay. Great. Sorry. Okay. Perfect. So I'm just getting new to this whole two-screen arrangement, but, great. So thanks. Thanks Irfan.

And thank you again for inviting us to speak today.

So I was hoping to just take the next little bit to take us through the main findings of our work, provide some further elaborations on points, and discuss how our findings from Wave 1

might be contextualized to what is happening now in Wave 2.

So as Irfan mentioned, our work was inspired by some informal discussions in the spring and observations that B.C. was doing considerably better than Ontario in controlling COVID, particularly in the long-term care sector.

So to investigate this, we performed a case study. We scanned through the gray literature, discussed with some experts just to sort of uncover some factors that might have contributed to these observed differences. And just to reiterate again, our analysis was focused primarily on the first wave in both provinces.

And the key points that came out of our analyses was that there was a much higher infection and mortality rate among long-term care residents in Ontario compared to B.C. We found that prior to the pandemic, the long-term care system in B.C. exhibited a number of strengths related to pandemic preparedness, and when COVID hit, we also found that B.C. was faster than Ontario in implementing key policy responses regarding Public Health support, staffing, and infection prevention control.

And finally, we found that overall leadership in B.C. was much more decisive and consistent in their communication responses.

And so just to review the raw numbers, just prior to the pandemic -- and sorry. I'm sorry. Just prior to the beginning of Wave 2, around September 10th, the infection and mortality rates among long-term care residents were much higher in Ontario compared to B.C. at 7.6% of residents being infected and 2.3% ultimately succumbing in Ontario. These were compared to figures of 1.7% and .6% in B.C.

It's important to note that the case fatality rate or percent of people that succumbed once diagnosed with COVID-19 was comparable in both provinces. So crudely, this seems to suggest that it was primarily a difference in COVID-19 entering and spreading in long-term care homes that drove the primary differences during the first wave.

It's been several months now, and we've since learned quite a bit about COVID-19 in long-term care. But just to take us back to March and April, actually, quite a bit at that point, earlier reports in February from -- oh, sorry -- early --

COMMISSIONER FRANK MARROCCO (CHAIR): Michael, if I can just interrupt for a second?

MICHAEL LIU: Of course.

COMMISSIONER FRANK MARROCCO (CHAIR): Could you just explain to me, again, why -- the point you made about the mortality rates when some -- with people who were diagnosed earlier and later -- you said it was -- it was comparable.

You said the mortality rate was higher in Ontario, which I understood, but then you said something was comparable, and I don't think I caught that quite.

MICHAEL LIU: Oh, apologies. So just to clarify, I was talking about the case fatality rate which was what happens when someone does get COVID, be the rate or percent of them succumbing and ultimately dying. And, you know, we can't make any conclusive interpretations, but what we do think is that what we can draw from this is the quality of care that might not have been provided or the risk factors for a resident to ultimately succumb was similar.

And so the observed higher rates of infection and mortality were due to the fact that more people were getting COVID -- or more residents

were getting COVID in the --

COMMISSIONER FRANK MARROCCO (CHAIR): I see. I see. So it's sort of a way of ruling out the treatment? It's a way of ruling out the hypothesis that the poorer outcome was due to poorer treatment.

MICHAEL LIU: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So -- all right. All right. I understand now. Thank you.

MICHAEL LIU: Of course.

COMMISSIONER JACK KITTS: Michael, can I ask a question as well? We've learned that the highest risk factor for entering the home and having outbreaks is the community spread rate. Did you measure that in this analysis?

MICHAEL LIU: No. We did not account for that, and that's something that we will discuss and also come back to. I believe you've already heard from Dr. Stall, and so some of that work is -- and exactly as you mentioned that what we are starting to understand now is that the -- one of the biggest risk factors for COVID entering homes is due to the transmission around the home and community.

COMMISSIONER JACK KITTS: Okay. Thank you.

MICHAEL LIU: Great. Sorry. So I just wanted to quickly contextualize what we knew back in March. And so there were kind of -- there were reports in February from China that had uncovered the death rate from COVID-19 increased significantly with age, and furthermore, early reporting of outbreaks in the U.S. in Washington State had cautioned about transmission between long-term care facilities and very high case fatality rates, so about 30% similar to what we're observing now in homes.

And of course, we've dealt with many infectious and respiratory disease outbreaks before, and the unique vulnerability of long-term care facilities to these pathogens has been extensively documented in the past.

So in this table, we just briefly summarize the temporal differences of first wave responses in the two provinces. You can appreciate that in almost all cases, despite COVID-19 coming into the two provinces at roughly the same time at the end of January, B.C. was faster, sometimes several weeks ahead of Ontario in responding to

COVID-19 in long-term care homes.

So some of these examples include implementing single-site work restrictions and universal masking policies. And although a few weeks may seem like a short time period when there's an exponentially spreading disease, even a few days of delay can contribute to considerably worse outcomes. And so what --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I ask, Michael --

MICHAEL LIU: Of course.

COMMISSIONER FRANK MARROCCO (CHAIR): -- we've been told that the lack of personal protective equipment is driving some of these decisions. Did B.C. have a similar -- can you say whether B.C. had a similar problem to Ontario as far as PPE was concerned?

MICHAEL LIU: Yeah, it's -- and I don't know if Irfan would like to jump in here, but essentially, there were no -- I think there's not much rigorous data or reliable data on the levels of PPE in both provinces early on in the pandemic. There were reports from, you know, investigators that had called on, kind of, a shortage of PPE in both provinces. There were early movements in B.C.

with the B.C. care providers and some organizations that had made it their principal goal to procure PPE and prioritise long-term care homes.

And -- but it is -- it is difficult. You know, there's no kind of hard core -- hard numbers out there for us to quantify whether or not there was a relative shortage.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, certainly, we've been told that by virtually everybody. You know, that's been what people have told us at the beginning.

MICHAEL LIU: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): There was a shortage. What nobody has told us is why there was a shortage. The -- everybody's strangely silent about exactly why Ontario found itself in this predicament.

But anyway, I just was curious whether the situation was similar, and it sounds like B.C. may have been in a little better position or in a better position than Ontario.

Yes, Dr. Dhalla, please.

IRFAN DHALLA: Yeah, I don't think I can answer that question with certainty, but there were rumours at the beginning of the pandemic that

there was some stockpile of PPE that had expired. Somebody has probably told you that.

COMMISSIONER FRANK MARROCCO (CHAIR): The Auditor General.

IRFAN DHALLA: The Auditor General mentioned that? And I think there was also some news at the beginning of the pandemic how Alberta, in particular, had a much larger supply of PPE due to some decisions that had been made, if I recall correctly, in December or January, just at the very beginning of the period when it started to be perceived that this new coronavirus might make its way into Canada.

And again, I don't know how accurate that is. I personally haven't seen any data comparing PPE stockpiles in British Columbia and Ontario or any other provinces.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

IRFAN DHALLA: I think the other thing that happened at the beginning of the pandemic in Ontario -- and I know you've heard this from others -- is that the entire system in Ontario geared up to support hospitals, and so there was a sense that even on issues like PPE, hospitals were

sort of the first priority. And, you know, whether that was just a sense or whether that was actually a reflection of policy and practice, I don't know.

But as somebody who was practicing on the ward in the spring, you know, we were worried about our levels of -- about our PPE supplies in an acute care hospital. You know, I can only imagine how worried they would have been at long-term care homes who didn't have the support of an acute care hospital behind them.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Yes, Doctor, Dr. Maxwell.

U/T COLLEEN MAXWELL: I was just going to say, I think in both B.C. and Ontario, there were some early media reports where an individual director of care at one site took the initiative in January and started to prepare, and those sites did particularly well early on. So I'm fairly sure we have media reports of that.

And so it does -- it does show within a province as well that there was variability in the response, so we could find those for you as well.

COMMISSIONER FRANK MARROCCO (CHAIR): It isn't a case where there's, like, a provincial purchaser. Each individual director can go out in

the marketplace and purchase? Have I -- is that -- have I got that right?

COLLEEN MAXWELL: That was my understanding early on.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, mine too.

COLLEEN MAXWELL: That was -- came, you know, to the fore, things might have been more systematic.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. So sorry. We keep --

MICHAEL LIU: No. No worries. Please keep the questions coming. So we just wanted to focus on two responses that we thought were particularly important. So the first were the single-site work restrictions, and we know you've probably already heard about these quite a bit, but B.C. implemented this policy on March 26, whereas Ontario did so a few weeks later on April 14th.

We knew, given a variety of factors related to a lack of economic and employment security, that many long-term care staff were working at multiple homes prior and early in the pandemic which is not optimal given our understanding now of the high rates of asymptomatic

infection. And much evidence now shows that staff are the main vectors of COVID-19 into long-term care homes. I know you've heard from Dr. Fisman, but his study in [indecipherable] work open was one of the first to show quantitatively that staff infections preceded resident infection and death.

And similarly, Dr. Stall's work, whom I'm -- also believe you've heard from, demonstrated that these single-site work policies were indeed effective, that they reduced the number of connections or movement of staff between long-term care facilities in Ontario.

And so the second is universal masking policies within long-term care homes. So B.C. recommended universal masking on March 25th. For context, at this time, recommendations around masks in the general population were really mixed, and we were still trying to understand the mode of transmission of the virus.

But in its recommendation, B.C. cited several -- a clinical guideline from Australia and New Zealand about masking among healthcare workers given droplet precautions which is relatively standard for respiratory infectious diseases.

And in Ontario, an order for universal

masking didn't come until April 8th despite ongoing calls and urges from Public Health experts as already outlined by the Auditor General. And we --

COMMISSIONER FRANK MARROCCO (CHAIR): Michael, can I just stop you for one second?

MICHAEL LIU: Oh, sure.

COMMISSIONER FRANK MARROCCO (CHAIR): By April 8, were -- did you do any work to see how bad it was in terms of infections by April 8th? In other words, you know, B.C. acts -- incorporates universal masking March 25th. Ontario, for some reason, doesn't do anything in that vein until April 8th.

How -- were you able to try to determine how many of the people who died were -- got sick between -- I mean, I'm using -- I'm using language that I would use rather than what a doctor would, but got sick between March 25th and April 8th?

U/T MICHAEL LIU: No. That's a really good question. I don't have the numbers in front of me, but I can get them for you, and -- but I do believe that by that point, there were already quite a few homes in outbreaks, and there were already quite a few resident deaths and infection.

And I think the key parts of this is that, you know, there were already a lot of urges and reports that masking would be quite effective in reducing spread.

COMMISSIONER FRANK MARROCCO (CHAIR): So if that were the case, then, by April 8th, it's just too late. Like, if that's right, then the problem has started, and the outcome is going to be the death of a certain percentage of those people who got the disease in that period. And the decision on April 8th, in that case, is just going to be too little too late.

MICHAEL LIU: Yes, exactly.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. I'll try to stop -- I'll try to stop asking questions every ten seconds.

MICHAEL LIU: No. Please keep going. I just wanted to also say that there are several studies now, although they're not perfect, that have found really strong associations between universal masking and lower transmission at both local and community levels, and just so you had those studies there.

So in this next table, we outlined some of the factors that were in place prior to COVID-19

related to pandemic preparedness that might have rendered B.C. more prepared to minimize viral entry and spread. The first is that there were significantly more shared rooms in Ontario than B.C. If you look at the data, it's 63% of residents were living in shared rooms in Ontario versus 24%. And there is evidence now, but it should have been -- it should be pretty clear, even without the evidence, that residents sharing rooms would facilitate more spread of virus within that particular room and home.

Secondly, a greater proportion of homes were for-profit in Ontario, and we know from past studies that for-profit status is associated with worse process and outcome measures on average.

In the context of COVID, I know you've also heard from Dr. Stall's team that profit status is complicated; it's not associated with the risk of outbreak, but the extent of an outbreak is, and the relationship is complicated. It's confounded by factors like design standards and chain ownership as well.

Third, we note that inspection policies in Ontario were reactive in recent years with the shift away from the comprehensive RQIs which really

precludes assurance that homes are well prepared from an IPAC perspective to prevent and control outbreaks.

And finally, we note that the overall health system was less integrated and more in flux in Ontario compared to B.C.

We wanted to call particular attention to this last point since we believe it hasn't really been touched upon in detail in past presentations to the Commission. More specifically, B.C., like several other provinces in Canada, has a regionalized health system.

In this system, five regional health authorities directly oversee acute care in Public Health and indirectly oversee long-term care. So this integration allows for much more coordination and better mobilisation of support, particularly IPAC support for long-term care homes. And we saw this from very focused interventions from so-called swat teams early on to help quell long-term care outbreaks in B.C.

Conversely, in Ontario, Public Health is overseen by 34 Public Health units which govern -- while the governance of long-term care and acute care is more separated.

At the same time, we know -- we know from past experience like the 2003 SARS outbreak that poor coordination between Public Health and the rest of Ontario's health system was one of the contributing reasons to poor outcomes.

And at the same time, Ontario's health system was also undergoing a lot of flux. The entire health system -- the 14 Local Health Integration Networks were being amalgamated into five Ontario health regions.

And also, finally, to add to that in Ontario, there was quite a large exodus of senior leaders from provincial and regional health organizations such as Public Health Ontario and Health Quality Ontario, and due to provincial direction, the budgets for many of these organizations were also being reduced.

So all of this is to say that B.C. was better prepared organizationally to respond to COVID-19 in long-term care homes even before the pandemic began.

So in this final section, we wanted to just take a quick look at what is happening now given that both provinces are currently in the midst of a second wave. So as you can see from

these graphs, the left-hand side represent rates of total cases per 100,000 people, and the right-hand side represent the rate of total deaths per a hundred thousand people.

So you can see that B.C. had controlled COVID-19 generally much better than Ontario during the first wave, but both provinces are doing comparatively poorly for the second wave.

And this table here shows the raw data for both the overall population in long-term care. I apologize. This is quite a busy table, so I'll takes us through it.

So the first two columns are data from the beginning of the pandemic to the end of Wave 1 or September 10th. The next two columns are data from the beginning of the pandemic to relatively recently into Wave 2 or December 5th. And the last two columns show what's happened in just Wave 2 with the difference between September 10th and December 5th.

So as you can see in the first few rows, the rate of infections in the entire population was much lower in B.C. than Ontario for Wave 1 at .4% and .3% of the population respectively.

By Wave 2, or December 5th, B.C. and Ontario have similar rates at .59% and .56%.

And furthermore, when you look at the last two rows in long-term care, which focuses specifically on long-term care, resident infection mortality were much lower in B.C. during Wave 1, but by Wave 2, B.C. has now done relatively worse than Ontario with infection and mortality rates of 4.8% and .9% versus 3.7 and .7% in Ontario.

And so we haven't done --

IRFAN DHALLA: Maybe, Michael --

MICHAEL LIU: Yeah.

IRFAN DHALLA: -- is it worth just asking the Commissioners if they have any questions about this slide because there's quite a bit of data on it.

MICHAEL LIU: Yeah. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): The only -- the only question, I guess, is by the Wave 2, would you say both provinces have comparable policies when Wave 2 starts?

MICHAEL LIU: So, I mean, we were going -- we were going to get to this, and in many ways, I think that Ontario had made some meaningful steps, and some of that is coming out of, I

believe, from the recommendations that the Commission has made and a lot of other steps that were taken --

COMMISSIONER FRANK MARROCCO (CHAIR): That was not the reason I asked the question.

MICHAEL LIU: No. No. No. But you're correct in that, you know, Ontario was not doing nothing in the months before the first and second waves and that there was progress being made. And so -- and we'll get to this a little bit more as well. But you're right that many productive or more productive policies were being implemented in Ontario prior to the wait.

COMMISSIONER FRANK MARROCCO (CHAIR): So does that suggest that the infections are now occurring in a way that no one understands? I mean, if both -- if both -- if both -- and I'm really asking this as a layperson, but if both parties are engaged in similar practices, how does one account for the difference between B.C. and Ontario now, I guess is --

IRFAN DHALLA: It's probably a good --

COMMISSIONER FRANK MARROCCO (CHAIR): -- better way of saying it.

MICHAEL LIU: Yeah.

IRFAN DHALLA: It's probably a good segue to your next slide, Michael, and then I think -- but I wouldn't say that we have no idea. So I'll let Michael go through the first three points, and then I might add a little bit of colour commentary, if I might.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

MICHAEL LIU: Sure. And that's a great question, Commissioner, and I think this is where we're trying to get a little bit at -- at a bit of this. We haven't done a thorough analysis, and so we can't, kind of, explain all the potential factors. But we can think of, kind of, three main categories. And so the first, as we said, was that Ontario has taken some quite meaningful steps to improve and emulate B.C. before and during the second wave such as enlisting more IPAC support, starting to reduce the number of residents sharing rooms.

And furthermore, one key strength that's also been identified in Ontario is that they -- we've taken quite an active testing and screening strategy for staff, residents, and visitors, which allows us to -- and I believe it's

that most staff need to be tested every 14 days in some regions and seven days in more severely hit regions. And that actually allows us to capture more symptomatic and asymptomatic cases before they can enter homes.

And the third is that there is, as you've also pointed to, a relatively higher community transmission in B.C. now, and we know from Dr. Stall's work that this is a major risk factor for long-term care infection and death.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

MICHAEL LIU: And speaking to some of our partners in B.C., Dr. Schwandt also mentioned -- who's -- who sends his regrets and is a medical health officer in B.C. has said that much of this community transmission has overwhelmed the highly engaged hands-on Public Health approach that B.C. took quite early on. And so it's sort of reached this critical mass where Public Health staff are finding it difficult to focus as much as they did on single homes and provide the high-level support that they did in Wave 1.

IRFAN DHALLA: I think it's more that than it would probably be just an unknown, so I

think it's not quite accurate to say we have no idea how COVID is getting into long-term care homes. It's probably more accurate to say that staff continue to be the portal of entry, if you will, but that long-term care homes and the system as a whole is struggling from a resource perspective to do the things that we know need to be done to prevent transmission.

So, for example, I was speaking with a colleague over the weekend about why test turnaround time in Ontario appears to be increasing, not just in long-term care but across the system as a whole. And her response to me was that a lot of it has to do with long-term care homes sending screening specimens all on the same day of the week instead of sending them in on the day they're collected, long-term care homes not sending specimens in at the time of collection even for diagnosis as opposed to screening, but rather than sending them in, you know, in batches.

So this was all focused on test turnaround time, but I think what it made clear is that we haven't provided long-term care home staff with the support they need to be able to reduce risks as much as we know they can be reduced. And

when -- you know, we know Public Health units in the hardest hit regions like Toronto and Peel are so overwhelmed that they can't keep up with contact tracing, so it probably indicates that they are also so overwhelmed that they can't manage outbreaks as closely as they would like to be able to manage outbreaks. And we've heard that firsthand from our colleague Michael Schwandt in B.C., where he has basically told us -- I think -- you know, I spoke with him earlier this morning, and he said that, you know, they like to talk about an at-the-elbow approach, so the long-term care home staff would be obviously doing the direct work, but the Public Health unit staff would be at their elbow providing them with support, guidance, answering questions, et cetera. But as the number of outbreaks has increased, they haven't been able to provide that "at-the-elbow support."

COLLEEN MAXWELL: I was just going to add, Irfan, that the tipping point is there in both provinces. I mean, both provinces are doing poorly now. And it's just -- it's similar to the tipping point you see with ICU bed care.

At some point, the community outbreak is such that it doesn't matter how prepared or how

timely or how responsive Public Health has been in the past. It's just overwhelming the system, and the shortages of staff are overwhelming the system, the low morale, et cetera.

So, you know, Ontario has possibly improved in many ways given our article, but both provinces are not doing great right now.

COMMISSIONER FRANK MARROCCO (CHAIR): I don't know if you've looked at this, but --

Well, Dr. Kitts, you had a question?

COMMISSIONER JACK KITTS: Yeah, I was just going to ask whether you have data that might be able to show, like you said, that the belief is that the vectors into the home are staff. But you'll recall that for some time, visitors and caregivers were allowed in. Then they weren't, and then they were again.

And I'm just wondering if you have any data to suggest whether the visitors, caregivers were a -- also a factor in bringing it into the homes or contrary.

IRFAN DHALLA: I don't think we have data on that point.

Do we, Michael?

MICHAEL LIU: Oh, I think Colleen was

going to say something.

COLLEEN MAXWELL: No. No, I don't believe we do. I mean, there's data from Europe showing that letting visitors in did not cause additional spread, but I don't believe we do. And I don't know the difference in testing with family caregivers in Ontario versus B.C.

So if there was more testing in Ontario, that might have played a role when both provinces had, you know, open doors to visitors.

MICHAEL LIU: And I also believe that the Ontario policy now does apply also to essential -- to the visitors that --

COLLEEN MAXWELL: M-hm.

MICHAEL LIU: -- that it's a 14-day -- a report of a 14 -- a negative test within 14 days is needed for visitors as well. And so a lot of these -- a lot of the benefits that have come from these general active screening strategies has also been applied quite broadly.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just return to this delay in ordering universal masking? And the reason I do that is I'm -- I remember now having seen a photograph of

two children being sent to school during the 1918 flu, Spanish flu, and they had masks on.

And so I -- I'm wondering in terms of the decision to order universal masking how big a mystery it was on March the 25th that masking was a good idea. I mean, how well-known -- how obvious -- is it -- would that have been obvious on -- at that time? Or is this some revelation?

MICHAEL LIU: I don't think it's a revelation, and, you know, applying the precautionary principle, as you've heard again and again that masks are -- you know, even in the absence of evidence to show that it was effective at the time, for SARS-CoV-2, with our past experiences with respiratory pathogens that -- and it was generally agreed upon at the time that it was -- that there was at least droplet precautions, that masks should have been a good idea.

I think there were -- there was a lot of rhetoric at the time whether or not masks were needed in the general population, and I think that was mainly a cause of concern because there was a lack of shortage for healthcare workers, for high-risk settings, but I believe long-term care homes applied very much under that umbrella. And

so I think that rhetoric at the time should not have confused or led to hesitancy within the context of long-term care homes.

COMMISSIONER FRANK MARROCCO (CHAIR): So if I understood you correctly, even a perceived or real shortage -- let's say real shortage of personal protective equipment should not have affected ordering universal masking with respect to long-term care facilities, not enough masks to, you know -- if you're -- if you don't have enough -- if through some sort of error, you do not have enough masks, then -- and why you don't want to tell the entire population that they should wear a mask, it -- you can't because you don't have the masks.

But that -- if I understood you, Michael, that same dynamic is not working with respect to long-term care facilities.

MICHAEL LIU: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): That's a concern.

MICHAEL LIU: Right. I believe, and, you know, I believe that shortages are definitely practical limitations, but I think that the idea of prioritising or at least trying to prioritise more supply of PPE to long-term care homes and requiring

to whatever extent possible or practically possible should have been made.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. Yeah.

IRFAN DHALLA: I think it may -- I mean, we -- I don't -- I don't think we are capable of answering this question, but it may be interesting to better understand whether the shortages were similar across the country or whether they were more severe in Ontario, and if they were more severe in Ontario, why that was the case.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, yes, that -- the last question is definitely of interest. Actually, the whole thing is because that's why I was asking about B.C. and Ontario earlier on. I was trying to get a sense of whether that portion of it was the same in both provinces, and I recall what was said. Anyway, thank you. Carry on.

MICHAEL LIU: Great, sorry. I just have one more slide. Apologies for dragging along. But so in light of everything we've talked about, I think our team just had a few more recommendations which we think would supplement the really

incredible recommendations that have already been made by the Commission, many of which we believe have already contributed to the better outcomes observed in Ontario.

So further, we believe that there needs to be more economic security and support to staff within long-term care homes particularly for care aides and personal support workers.

Second, we think the Province should also look at formalizing structures and processes to ensure the integration between Public Health, long-term care, and acute care in Ontario.

Third, now that we've been talking about this idea of PPE, there should be more transparency, we believe, surrounding staffing levels, e-stock (phonetic), hours of direct care, and staffing mix in long-term care homes both to facilitate management and these research questions.

Fourth, there should be a phasing out of shared rooms in homes, particularly in homes with older designer standards.

And fifth, now that we know that community transmission is able to overwhelm or contribute quite highly to long-term care cases and overwhelm prevention and response efforts, reducing

community transmission is likely one of the best methods to protect our residents in long-term care from COVID-19.

And just finally, learnings in long-term care should be applied to other continuing care settings, and Colleen can speak to this more, such as supportive or assisted living facilities. We know that these are directly outside the purview of the Commission, but these facilities have also been hit incredibly by COVID, but they've received much less attention.

And also important to note that there are unique issues that are faced each in different settings, and those are important to take into account as well.

And so that's all the slides I have. Thank you for bearing with me, and we're happy to answer any other questions.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, Commissioner Coke.

COMMISSIONER ANGELA COKE: I'm just curious. Because B.C., you know, has a more, sort of, integrated structure, did they have -- do you know if they had, sort of, the issues with staff moving across different parts of the healthcare

system like PSWs? Or do they have some consistency in the way these staff are treated and paid that would mitigate against that happening?

IRFAN DHALLA: I think they have more consistency than we do here. Long-term care homes are not -- or before the pandemic at least, they were not formally part of the Regional Health Authority, so, you know, a staff member who worked at a long-term care home could quit their job at the long-term care home and go work for an acute care hospital.

But relatively early in the pandemic, and I don't know the details of how this worked exactly, but the Provincial medical officer of health there instituted an order that effectively gave her full control over staffing in long-term care homes, I think, throughout the Province. And so I don't know the details of exactly how that was implemented, but I know that, you know, obviously, that led to the single-site restrictions. It also led to a greater level of pay, and I think part of the reason for that was to avoid the problem that you've just alluded to.

MICHAEL LIU: And in addition to that, it also led to a greater centralization of ensuring

that staffing levels were appropriately high. I believe that same directive allowed the medical health officer to -- I'm sorry -- the Provincial health officer to monitor and directly, kind of, move staff around such that homes were appropriately staffed as well.

IRFAN DHALLA: Yeah. So, I mean, one of the things that's happened in Ontario that has been very interesting to see is some long-term care homes have received much greater levels of support than other long-term care homes.

You know, I work -- I'm on the executive team at Unity Health Toronto, and we have a long-term care home as part of our health system, and so we've been able to provide, I think, a much greater level of support to that long-term care home than has -- than -- you know, than other long-term care homes in Ontario have received.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask about a couple things that you didn't touch on but which we've heard about? And the first one is, you know, moving residents who test positive out -- offsite or to a field hospital, that sort of thing. We heard about the effects of it in Windsor, and it seemed to be very

positive, and Windsor wasn't the only example.

Did your research -- did you look at that strategy at all? Or are you able to comment on that?

MICHAEL LIU: I don't know if --

IRFAN DHALLA: No. We didn't look at that. I mean, I think that this -- I think -- I mean, at the risk of stating the obvious, a long-term care home is someone's home, and so transfers out of the home should be done carefully. And I don't -- you know, it probably can work well in some situations, but it can also probably go quite badly if the place that the resident is being transferred to doesn't offer the kind of care and support that that individual needs. So it was probably very context specific.

So, I mean, even if --

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, they were field hospitals --

IRFAN DHALLA: Yeah, so I --

COMMISSIONER FRANK MARROCCO (CHAIR): -- for all practical purposes.

IRFAN DHALLA: Yeah, that term does make me nervous because when I think of a field hospital, I tend to think of a place that is, you

know, temporary, doesn't provide a high degree of personal support; staff tend to have generic training rather than the training that is needed to take care of people with the kinds of behaviours that sometimes people living in long-term care homes have.

I'm not speaking about any specific example. It may be that we've had some really great examples of field hospitals being used to take good care of people in long-term care homes in Ontario, but that strategy does make me nervous.

COMMISSIONER FRANK MARROCCO (CHAIR): And the second question dealt with the rapid testing and whether any of your -- whether any of your research affected or looked at that. There's an article in The Globe this morning that, you know, a number of the major firms in downtown Toronto are now proposing really massive rapid testing so that their employees can go back to work in the office towers.

And I was wondering if there was any resort or anything you saw in relation to rapid testing in the work that you did because it does seem rather obvious that if you can test and get a result rapidly, that that would be a good idea.

IRFAN DHALLA: It does.

COMMISSIONER FRANK MARROCCO (CHAIR): Apart from me asking you that, did it come up in -- is there any -- did you notice anything or come up against anything like that or an observation about that?

IRFAN DHALLA: I think Michael's smiling because he and I are doing some work separately on rapid testing.

Rapid testing right now isn't used very widely in either B.C. or Ontario in the public system as far as I'm aware. I mean, I think the example that you're talking about is in the private sector. I think, you know, could we be using rapid testing more in long-term care homes in Ontario in December 2020? Probably.

In particular, the -- you know, the rapid tests are not as sensitive as the lab-based PCR tests, meaning that there is a higher number of false negative tests. But the tradeoff is you get the result immediately.

And so right now in Ontario, the turnaround time on lab-based PCR can be two days, can be three days, in some places can be even longer. And so you're trading off a more accurate

test that has a several-day turnaround time against a less accurate test that you have the result in 15 minutes. And the modeling study suggests that once the turnaround time on the lab-based PCR grows, you know, too long, you're better off using a rapid test even if it's less accurate and doing it every few days or every week.

In addition to that, you know, the usage of lab-based PCR tests in long-term care homes in Ontario particularly to screen visitors has, to some degree, gummed up the laboratory test processing system for the -- everyone else, right? Because -- and that is actually part of the reason why our test turnaround times are so long.

So if we were screening visitors with rapid tests, we would be getting faster results there, and we would also be getting faster results for people who have symptoms or who are close contacts and living in the community, essential workers, so on.

So, I mean, I think that's actually -- it's a really good question, and it's an example of where, if we were taking a holistic view of the whole pandemic response and using an improvement mindset, we might have switched to rapid tests

particularly for visitors to long-term care, you know, two or three months ago.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm. Well, the -- can I just pursue this a little bit further? The false negative, that means people think you don't have it, and you do.

IRFAN DHALLA: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that probably means you don't have any symptoms, in which case you would probably have slipped through the system anyway. You show up at the long-term care home, and somebody asks if you have a fever, and they take your temperature, and they ask if you've been outside the country for 14 days. You give all the appropriate answers, but you're asymptomatic, and you're -- well, the -- so you're going to get -- that type of person is going to slip through whether they falsely test negative on a rapid test or not.

IRFAN DHALLA: Yeah, I think you're generally correct.

COMMISSIONER FRANK MARROCCO (CHAIR): It's the -- but the other people, the people who test positive who are positive, they're not going to get in under the -- I --

IRFAN DHALLA: Yeah, and I think you're generally correct. There are multiple lines of defence, right? So for visitors going into long-term care homes, first of all, there's symptom screening. Then they're supposed to have a negative test, and they're also, of course, supposed to physically distance and wear a mask and wash their hands.

And so, you know, even if they have a false negative, if they have no symptoms and they physically distance and wear a mask, the risk of that individual transmitting COVID-19 into the long-term care home is going to be very low.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm. Okay. Thank you. Any other questions?

Oh, Commissioner Coke.

COMMISSIONER ANGELA COKE: I'm just wondering in terms of, sort of, broader context if you observed or had any observations about differences they may have had with respect to home care or community care for seniors, and did that have any impact on, you know, what might or may not have come into the long-term care homes in terms of more people being able to stay out.

IRFAN DHALLA: Colleen, do you want to

comment on that?

COLLEEN MAXWELL: I'm actually not sure of the data for B.C. I know in Alberta, for example, there has been a shift from long-term care to assisted living, and home care plays a very large role in assisted living. In some regions, they do view it as a substitute for long-term care.

In B.C., there has been quite a move to assisted living as well, but it's been private, so it's possible, but I don't know of the data for B.C. I know of Alberta.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think that's -- that exhausts our questions, I think. Thank you very much for taking the time to come. I think we found it very helpful in terms of what we're thinking about. And I really -- we really do appreciate it.

U/T If you should do any more work that gets to a publishable form before we're finished, please let us know. We'd be very eager to read it.

But anyway, thank you. Thank you for the presentation, and thank you for taking the time.

COMMISSIONER JACK KITTS: Yeah.

COMMISSIONER ANGELA COKE: Thank you.

IRFAN DHALLA: Thank you very much for having us. Thank you for having us, and thank you for everything you're doing.

COLLEEN MAXWELL: Yes. Yeah. Thank you very much.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Take care.

COLLEEN MAXWELL: Take care, everyone.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye.

COLLEEN MAXWELL: Happy holidays.

-- Adjourned at 2:21 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 22nd day of December, 2020.

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PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Clarification: One small typo found on page 10: The resident and mortality rates among long-term care residents were much higher in Ontario compared to B.C. at 7.6% of residents being infected and 2.3% ultimately succumbing in Ontario. The bolded word should read "infection".

WORD INDEX