Long Term Care Covid-19 Commission Mtg.

Maria Elias (Belmont House)
on Tuesday, January 19, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 19th day of January, 2021, 9:00 a.m. to 10:10 a.m.

BEFORE:

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

PRESENTERS:

Maria Elias, Chief Executive Officer Belmont House, Belmont House Foundation

Dr. Brad Birmingham, Medical Director Belmont House

PARTICIPANTS:

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

Angeline Hawthorn, Senior Policy Analyst Long-Term Care Commission Secretariat

Angela Walwyn, Senior Policy Analyst Long-Term Care Commission Secretariat

John Callaghan, Co-Lead Commission Counsel Gowling WLG

Lynn Mahoney, Counsel Gowling WLG

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: 57

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 9:00 a.m.

MARIA ELIAS: Good morning.

BRAD BIRMINGHAM: Good morning.

LYNN MAHONEY: We're ready to go, Commissioner Marrocco.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, then go ahead.

LYNN MAHONEY: Okay. I think you've -- I think you've met Ms. Elias, and we also have Dr. Brad Birmingham, who's the Medical Director of Belmont House. And Ms. Elias and Dr. Birmingham are going to present to the three of you today on their experience with the vaccination rollout. They have a presentation which Janet has kindly agreed to share her screen and will go through, and to the extent I need to ask any questions, I will or -- in addition to whatever questions you may have.

So thanks, Ms. Elias.

COMMISSIONER FRANK MARROCCO (CHAIR): So welcome back, Ms. Elias.

Nice to meet you, Doctor.

BRAD BIRMINGHAM: Good morning to you.

MARIA ELIAS: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR):

Go ahead. We're ready. We're --

And you -- Commissioner Angela Coke and Dr. Jack Kitts, the three of us --

COMMISSIONER ANGELA COKE: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): -- comprise the Commission, so we're ready.

MARIA ELIAS: Good morning, everyone, and thanks for the honour of presenting a second time to the Commission. What we'd like to do this morning is just touch very briefly on Wave 2 before we get into our experience with the vaccination rollout. And so I'm not going to touch on every little thing in the PowerPoint presentation. It's there for your reference also at a later date.

Just, once again, to identify the Belmont House -- so this is on page 2 -- is a not-for-profit charitable long-term care home and retirement -- long-term care and retirement home located in central Toronto.

We have 140 long-term care beds and 81 retirement apartments, and we're located on one campus, and we go back as far as 1852.

LYNN MAHONEY: Can I just interject for one second.

Janet, I don't -- I --

Commissioners, can you see the screen --

COMMISSIONER FRANK MARROCCO (CHAIR): No.

LYNN MAHONEY: -- the presentation?

COMMISSIONER FRANK MARROCCO (CHAIR): No, I can't. There we go.

LYNN MAHONEY: Thank you very much, Janet.

MARIA ELIAS: Thank you. So we're on page 3 now. Perfect. Perfect. So Wave 2, we continue to experience suspect outbreaks where we have one employee or one essential caregiver that puts us into that outbreak situation which does continue to create a hardship for all of our employees with significant use of PPEs. And it's also a hardship for the residents and the family members also because the residents do need to be isolated for 14 days and remain in their -- in their rooms.

In terms of PPE, we generally have enough. We haven't run into a problem with PPEs, and we finally did get the commitment from the -- from the Government to provide us with eight weeks'

supply of those PPEs and the N95 masks.

We do continue to test all of our staff weekly now because we're in the gray lockdown zone, and so we also test our essential caregivers on site. So every Monday, we test our essential caregivers here at Belmont House, and we average about 150 to 170 essential caregivers being tested here on site every week for COVID.

That certainly has meant that we do need to add additional nursing staff to provide that benefit to our essential caregivers that we feel that that certainly is a needed and beneficial benefit to them. And we continue to have daily management debrief on COVID. We've been living this way for 24/7 now since last March, and we continue to focus on COVID and how everyone's managing through these difficult times.

So maybe, Dr. Birmingham, you might want to add a few things on how we've managed to get through it all.

BRAD BIRMINGHAM: If I could, and this is actually a bit of a drift from the primary subject of vaccines, but it's actually based on Ms. Mahoney asking when Maria and I spoke in advance about the fact that we've had some success.

So I don't know if you would like to let me indulge in this right now or at some other time, but I'd like to talk about -- a little bit about Belmont House and my other home, Chester Village, who have had good fortune and good success in the pandemic to this point. I think some good news and some reasons for success might be useful for the Commission.

COMMISSIONER FRANK MARROCCO (CHAIR): Why don't you do it now, Doctor, if this seems like a convenient time.

BRAD BIRMINGHAM: Okay. So Belmont House and Chester Village, I'm medical director for both. As Maria said, Belmont House has 140 long-term care residents, 81 retirement apartments. Chester Village has 203 long-term care residents. Both have had the good fortune and good success in the first two waves of the pandemic.

Both homes, like very many homes, have had several staff, students, or essential caregivers test positive resulting in suspect outbreaks, precautions, testing entire units or the entire home, but without any residents or tenants contracting COVID.

In Wave 1, Chester Village had one

resident develop COVID-19 and recover. In Wave 2, we had one resident with a suspected false positive who, again, did well. Belmont House have had no tenants or residents contract COVID-19.

I think the path to success for both homes has been slightly different, but there are many common strengths that you may wish to hear.

The biggest difference, quite frankly, has been Chester Village, from day 1, has had tremendous support from Michael Garron Hospital and the East Family Practice Network from day 1. In contrast, Belmont House have been doing much of this on their own.

Both homes have now given first doses of vaccine to over 90% of their residents, 100% of their tenants, nearing two-thirds to three-quarters of their staff, and 75% of essential caregivers.

I think there are many features that both organizations have that has helped in their success and in no particular order, but strong leadership from executive director, director of care, assistant directors of care, management teams, and medical staff.

In the first months of the pandemic, we all worked night and day, 18 hours plus per day

every day. For Belmont House, the director of care and director of retirement literally lived at Belmont House for weeks, literally lived here.

Both executive directors are extensively involved in the community beyond the homes itself representing long-term care. Maria is presenting to you for the second time today. Cynthia Marinelli, who's the ED at Chester Village, has been representing long-term care on several important committees such as the committee regarding the specialized care centre. Both homes have fostered a workplace culture that rewards staff and includes all staff as part of the Chester Village of Belmont family. Staff at both homes are working incredibly hard because they feel a part of the solution.

During outbreaks, they come to work knowing we're all working together to keep everyone safe and protect and provide best quality of life for our residents. Both homes have had a very proactive attitude moving quickly to respond during the pandemic. As a concrete example, both homes had masks on all their staff well before it was mandatory. They did it in different ways. Chester Village benefitted from the partnership with

Michael Garron Hospital who directly provided them with masks. Belmont House, we scrounged; we sourced; we paid crazy money, but we got the masks on our staff.

Both homes have been vigilant in monitoring for typical or atypical symptoms in our residents and actively and quickly isolating and testing. Both homes have not been hesitant to spend money that it takes to protect our residents and staff. Belmont House has a history, as Maria alluded to a bit, going back well over 150 years. We have a strong foundation. We -- between the foundation and retirement income, we supplement for the betterment of both the retirement wing and long-term care, including with additional staff.

Chester Village is financially very sound and tremendously well run allowing it to use its resources on additional staff and PPE, et cetera.

Both homes have excellent structure of architecture, large open spaces that allow distancing; large rooms, mostly private rooms; large semi-private rooms; outdoor gardens, good ventilation. Both have a strong team of physicians, four physicians per home, six in total

because two of us work at both places. I tallied up last night, and Chester Village has four physicians whose total experience in long-term care is approaching a hundred years.

Both have strong IPAC leadership. For Chester, again, much of this was initially through Michael Garron and her own IPAC champions and past experience with outbreaks, SARS, H1N1.

At Belmont House, we're extremely fortunate to have an assistant director of care whose passion is infectious disease and IPAC. We'll talk a bit about vaccine, but she herself vaccinated everyone during the 2009 H1N1 pandemic. She did it on her own.

Both have strong entry screening skilled front-desk workers. Both have strong recreation staff who have been crucial in supporting things like virtual visits, outdoor visits, and also, in maintaining as close to a normal level of recreation for our residents as possible.

Both have embraced technology including iPads for virtual visits, and we got Tablets through a group that I'd plug named Frontline Connect Canada that allows better communication,

secured communication between the physicians and the frontline staff.

Both homes have had clear and frequent communication with our staff, our families, our boards and have received strong support in return. Both have supported the safe return of essential caregivers including with testing and vaccination.

And above all, both have an overriding understanding of our fundamental purpose which is to provide a true home that's a home for our residents, to respect them as valued persons, to treat them as individuals, provide them with the best quality of care and treatment based on their goals and desires.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. Thank you very much for that rather concise description of what works.

COMMISSIONER JACK KITTS: Can I ask a question, Doctor?

BRAD BIRMINGHAM: Yes, please.

COMMISSIONER JACK KITTS: So you talked about, clearly Belmont Home is an older home, yet you talked about the architecture being big spaces, and you said single or semi-private rooms. Do you have any three or four-bed wards?

BRAD BIRMINGHAM: We have none. And I should clarify: Belmont is a campus with two buildings, if you will. The older building dates back a long time but has been renovated. The newer building was built in 1992, so I still consider that new, but they were both built with very forward-thinking concepts and only large semi-privates and privates.

COMMISSIONER JACK KITTS: Okay. The second question is more recent. In your testing, which is very impressive in Wave 2 for all staff, caregivers, and residents, are you using rapid testing? Is that the key, or are you still doing it the other way?

BRAD BIRMINGHAM: That's a great question. No. We're still doing PCR testing. Rapid antigen testing is coming. I could talk for hours about rapid antigen. I think that rapid antigen testing has a very useful role especially in, sort of, a Public Health setting. If it were up to me, I'd have rapid antigen testing in every individual's home, and they would test twice a week. It is coming. It's an additional burden, as you can well imagine.

I sit on the Toronto Region LTC

congregate care table, and the estimate from where it's been piloted is it essentially takes a full day to do the rapid antigen testing, and the expectation is likely to be two or perhaps three times a week. So you can imagine that -- the load that that's going to place on staff will be. But I'd have to say I'm a strong supporter of the concept of rapid antigen testing.

COMMISSIONER JACK KITTS: So what's the barrier? It sounded like you -- your last comment was the rapid testing isn't quite so rapid. Is that true?

BRAD BIRMINGHAM: It's -- it is rapid in the sense that it's done on site so that for an individual test, you'll get the result in 15 minutes. But if you are testing 150 people, you need the staff to do that, and you need to do that, if you will, in allotments of 15 minutes in order to get it done.

So it is much quicker than having a swab sit in a tube that goes down to a lab and gets tested, and you get the test result back at some point. You have it on site, but it also is very -- it's much more labour-intensive.

MARIA ELIAS: So to give an example of

that, it's just another example of downloading workload down to the long-term care homes. Yes, it's a great idea because we will know the results at the end of every day or at the end of, you know, a couple of hours of testing. But it is additional workload.

So right now, we spend three days a week COVID testing. When we move to the rapid tests in the next few weeks, we will not put the essential caregivers on rapid testing at this point in time, but we will be COVID testing from Monday to Friday. So every day, we will be COVID testing Monday to Friday to ensure that we provide the minimum of two COVID tests per employee per week.

And so it's a tremendous amount of workload. We're going to have to add additional nursing staff and administrative staff to support all the paperwork and the registration of everyone coming in to be COVID tested. So it is doable, but it takes a significant amount of employee time to do it. But it is something that we feel it's important to do, so we will be moving to that rapid testing.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Has there been a hold up with that? Because I seem to recall reading in November references to rapid testing and rapid testing --

MARIA ELIAS: So what --

COMMISSIONER FRANK MARROCCO (CHAIR): -- being a game changer and so on.

MARIA ELIAS: Well, that was -- yes, the early excitement of the rapid test was that, yes, it would be a game changer. But before it was widely implemented, the Government did go through a pilot testing program with the rapid tests, and homes that participated in the pilot test were required to not only conduct the rapid test which would then be sent to the hospital laboratory, but they were also required to do the regular PCR.

So these -- so the rapid test went through a period of about six, seven weeks of testing to determine its efficacy in comparison to the PCR.

Now, what's really interesting is that, unless I've misunderstood, the recent communication from the Government is that if a home is in outbreak, they cannot use the rapid test. They have to go back to the PCR test because that is more accurate, in its -- in its reading. So the

rapid tests are beneficial if you're not in an outbreak, but if you're in an outbreak, you have to use the standard testing method which sounds a bit counter intuitive from that sense.

BRAD BIRMINGHAM: So I can expand it a little bit. The PCR test is more of a, I would say, a medical diagnostic test. It looks for bits of viral RNA, and those are there for a longer period including when someone has recovered.

The rapid antigen test, if you think of it this way, looks for bits, if you will, of actual virus or antigen, so it is more likely to be positive at the time when you are truly infectious or have a higher viral load. So the rapid antigen test is truly more of a screening test, I would say, whereas the PCR is more of a diagnostic test. That's a bit of a difference.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BRAD BIRMINGHAM: If you're interested -- sorry. And one final thing, if you're really interested in rapid antigen tests, I'd refer you to a gentleman named Michael Mina, M-I-N-A, out of Harvard. I don't know how many of you -- he wrote in New England Journal. He has an

active Twitter account, and he does a great job in terms of education and supporting rapid antigen testing.

LYNN MAHONEY: Thank you very much. So, Commissioners, are you okay to proceed?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

LYNN MAHONEY: Okay.

MARIA ELIAS: So now we go to page 4 where we'll focus now on the vaccination rollout. And I'll address it in different components. The early stage, which was the pilot project, the week of December 14th, the weeks that followed and where we are today, and the role of the Vaccination Task Force, hospitals, long-term care homes, and any comments and recommendations that we have.

So on to page 5, chronologically, I just wanted to give you a sense of how the vaccination pilot project --

LYNN MAHONEY: Ms. Elias, could you -- until we -- I think we're going to switch to page 5.

MARIA ELIAS: Okay.

LYNN MAHONEY: And then we'll just give Janet a moment so she can --

MARIA ELIAS: Sure.

LYNN MAHONEY: -- continue to take notes. Thank you. Okay. Thank you.

MARIA ELIAS: Okay. So this is why I'm on page 5. I'm actually going through the dates. So UHN was given the authority to receive holds and distribute the Pfizer vaccine. And that week of December 14th was the pilot test for Toronto long-term care homes that were partnered with UHN.

Many conference calls were held with Government in UHN for a few days prior to that rollout including on the weekend of December 11, 12, and 13 to prepare for the staff vaccination. And the Michener Clinic started off on December 14th with a photo opportunity and had five long-term care staff from the Rekai Centre vaccinated.

Then the full rollout in the pilot test happened December 15, 16, 17, and 18 for long-term care staff, and staff had to book online for their appointments. I'm going through this because it's important to note there was a lot of media attention as to why so many days were taken off, and UHN said, well, we just took off two days.

But if you see, you know, during the

period of December 14th to the end of the month, you will see that many days were taken off that weren't dedicated to staff vaccination.

So we move on to December 21st, and vaccination days were booked for the 22, 23, and half a day on the 24th. There were no vaccinations held on the 25th, 26th, 27th, and 28th, and the next scheduled dates were 29 and 30.

With that media backlash, then UHN started adding more days to the vaccination program for the employees. But during those periods, those three weeks in December, Belmont actively, in our conference calls with UHN and Toronto Public Health, we actively indicated that we would be interested in vaccinating our own long-term care residents and essential caregivers as soon as the Moderna vaccine arrived.

And at that point, no, it's not much of a response from hospital, but we continued to pursue that, and we also offered ourselves as a pilot site for vaccination testing for -- sorry, vaccination rollout for retirement homes and long-term care homes.

We were selected for our retirement home as a pilot test, and Chester Village was

selected as a pilot test for the long-term care home rollout.

Now, I'd like to move to page 6 where we just have some comments on the vaccination rollout. We do fully understand that because of the Pfizer vaccine, that we needed tighter control of the rollout. But it was quite obvious that there was a lot of control by UHN based on their scheduling, and we felt that they were not maximizing the times of the long-term care sector and not recognizing the skillset in the long-term care homes to carry out our own vaccinations with the arrival of Moderna.

We also felt that the staff vaccination program with UHN using Pfizer was very well organized that first week, but we did indicate that we can certainly help out and move the vaccination program further along by conducting our own vaccinations on site.

So but we did also feel that a lot of the planning was just in time and that many appointments went to hospital employees versus the long-term care employees. Because the planning was so rapid and short, it didn't give the long-term care homes enough opportunity to promote the

vaccine and to deal with the vaccine hesitancy in our employee population.

LYNN MAHONEY: Ms. Elias, could I just -- I just want to clarify, so during this entire time from the -- from the beginning of the vaccine rollout, middle of December, the --

MARIA ELIAS: Yes.

LYNN MAHONEY: -- only people who were being vaccinated were staff, not the residents --

MARIA ELIAS: Yes, only staff --

LYNN MAHONEY: -- and not caregivers?

MARIA ELIAS: And not caregivers. So I will get to that at a later slide, but I'll talk about that briefly here. During the second -- sorry -- the week of December 20th, there were communications that came out from the Task Force and Government, again, focusing on the priority of the vaccination rollout. And the priority was always communicated to us as being long-term care homes, which means the long-term care home employees and essential caregivers were supposed to be done first, followed by long-term care residents.

What we found was that we pushed and pushed for the essential caregivers, but they were

not a focus for UHN until sometime in January. Actually, I think the week of January 4th, they started focusing on essential caregivers. So very early on in the vaccination rollout, we kept emphasizing that essential caregivers are no different than employees.

When we look at the outbreaks that we have in our homes, it's about 50-50; 50%, you'll have an employee test positive. The other 50% is an essential caregiver.

So for us, it was important to count the employees and the essential caregivers as the same group in terms of the priority for the vaccination.

It isn't the long-term care residents that bring COVID into the home. It's an employee or an essential caregiver. And so I will come back to that --

LYNN MAHONEY: Okay. Thank you.

MARIA ELIAS: -- at a later slide. Now I'd like to move on to page 7 where I did talk about, you know, what we felt was the priority that the Task Force had identified with long-term care employees and essential caregivers being first then followed by residents, but you could quickly see

that those priorities were changing as we moved along. It appeared -- and through the media attention, it appeared that when long-term care staff did not book for an appointment, those appointments were going to hospital staff.

First, we thought it was going to UHN staff because we thought, well, that makes sense, right? If you have few extra doses, it makes sense. Don't waste it. Give it to staff that work in ICUs, you know, emergency rooms and so forth.

But soon we came to discover that everybody on University Avenue was being given a chance to fill those appointments, and I do believe it was related to the fact that we weren't given the opportunity to have our essential caregivers take those spots and that the rollout was strictly controlled to long-term care employees and hospital employees versus what we felt was the priority of long-term care employees and essential caregivers.

We did challenge the Toronto LHIN and UHN. I sent emails to both the Toronto LHIN and UHN expressing my frustration and concern that those appointments were not going to essential caregivers and that there was mixed messages coming out from different levels of Government to the

point where, on the Monday of the second week of the rollout, there was communication on a Sunday, Monday, and Tuesday about essential caregivers having access to the vaccine.

We quickly invited our essential caregivers, and we have approximately 230 of them. On a Monday afternoon, within three hours, we had a hundred essential caregivers interested in going down to UHN at the Michener site to get their vaccination. By 7 o'clock that Monday night, we were told by UHN that they were not doing essential caregivers, and there appeared to be a misunderstanding even though -- even though I said there are many communications that came out that said, yes, essential caregivers were supposed to be vaccinated.

So media pressure certainly did help, you know, that last week of December, early January, and Michael Garron stepped in to start vaccinating essential caregivers, but, again, I felt it was related to media pressure more than any -- more than an organized approach to the rollout for essential caregivers.

A conference call was organized on December 31st at 3:30, and we were told that we

would be welcome to send ten essential caregivers on that New Year's weekend to Michael Garron to be vaccinated. And I clearly stated in that conference call that I didn't think it was an effective or efficient process. I can't spend a weekend trying to get ten essential caregivers when I have 230.

And so I said, we'll wait for when there's a more effective and efficient system for the essential caregivers. But I still continue to push for the issue of us doing our own essential caregivers here on site, similar to the fact that we do our own COVID testing for essential caregivers. We get a great response. It's done, and we know that it's working.

The other interesting thing with the rollout was that there are a lot online booking system technical difficulties.

So just moving on to page 8, just some very brief comments on that first phase.

BRAD BIRMINGHAM: Do you mind if I interject --

MARIA ELIAS: Sure.

BRAD BIRMINGHAM: -- just to draw a little --

MARIA ELIAS: Go ahead.

BRAD BIRMINGHAM: -- a little exclamation point on that? We did immunize our own essential caregivers on site over the course of a Friday and Saturday. I think it was January 8th and 9th. One other attending physician here and myself with great support from our own Belmont House staff immunized somewhere in the order of 150 essential caregivers.

MARIA ELIAS: Thank you, Dr. Birmingham.

So I did talk -- on page 8, I talked about some of our -- you know, our feelings about that. We felt that the priority got shifted to include hospital employees versus essential caregivers and that the booking constraints were very tight. Employees had to book by 3:00 p.m. I feel that there isn't the recognition or an understanding that it's not so easy for long-term care employees to book online, get themselves down to the Michener site to get that vaccination. And that's why we continued to push for us to be able to do all our vaccinations here on site as soon as the Moderna vaccine was available, which it was available on December 31st because we rolled out

the Moderna vaccine to our retirement tenants and got them all vaccinated.

So now, I just want to -- oh, just one more thing about that is that -- no, I did cover that already.

If we can move on to page 9, I just wanted to briefly talk about the retirement home vaccination. That was organized -- that was the pilot test, and it was organized with Toronto Public Health and UHN. That went very well. We used the Moderna vaccination. It occurred on December 31st in the morning, and we vaccinated 70 retirement tenants, and then the remaining 14 tenants that we were working on getting the consents were vaccinated on the following Monday.

We did have a physician from UHN observe our process of the vaccination, and he indicated that everything was excellent, and -- but I do want to emphasize that the vaccination took place using our nursing staff. I think that's important to note because there is such a mix of communication in terms of who is supposed to be doing these vaccinations.

So again --

LYNN MAHONEY: Ms. Elias, at this point

in time, so this is December 31st, and this is the residents of the retirement home, not the long-term care home, so as of this point in time, still no vaccination of residents of the long-term care home?

MARIA ELIAS: Right. What's important to note is that on December 31st, there were two pilot tests going on at the same time. We were selected for the retirement home, so we did the retirement home vaccinations. Chester Village, on December 31st, did the pilot test for long-term care.

So on both those days, pilot tests were running for vaccinations for retirement home in the gray lockdown, and long-term care homes in the gray lockdown. -

BRAD BIRMINGHAM: So --

MARIA ELIAS: Again, both testing --

BRAD BIRMINGHAM: From my perspective, I had quite a busy day December 31st because in the morning, with that, Chester Village, in tandem with the Michael Garron NLOT team and a physician from Michael Garron and our own staff, there was a real team effort to vaccinate about 192 of our 203 long-term care residents. That was the morning of

Chester Village -- or the morning of December 31st.

I then got in my car, raced here, and observed and participated in the pilot rollout of the retirement tenant vaccination of Belmont House, so it was quite a successful day.

LYNN MAHONEY: Okay. Thank you.

MARIA ELIAS: And on that day, we also organized our appointments to have our long-term care residents vaccinated on the following Wednesday, so all the long-term care homes that were associated with UHN, we had to book our particular slot and time to have the UHN team come out to conduct the vaccinations. Even though we did offer, once again, that the home was quite capable, we have the medical and nursing expertise, that we could have done it ourselves, but again, that was not permitted, and the UHN team came out on January 6 to do the vaccinations for the long-term care residents.

LYNN MAHONEY: So I see your slide, I believe you're now on slide 11 --

MARIA ELIAS: Sorry. I'm on slide 10.

LYNN MAHONEY: Slide 10? Okay.

MARIA ELIAS: Yeah, I've just slipped into slide 10 where we're talking now about the

long-term care vaccination --

LYNN MAHONEY: Right.

MARIA ELIAS: -- rollout.

LYNN MAHONEY: Yeah, and I note -- I note, actually, on slide 11 -- we don't need to go there, Janet -- but the vaccinations for the residents of long-term care homes, your long-term care home was scheduled -- it was approved on January 6th by -- I don't know, actually. It was approved on January 6, but they weren't scheduled 'til January 8th and 9th?

BRAD BIRMINGHAM: That's the essential caregivers.

MARIA ELIAS: Sorry. No. For long-term care, we were scheduled on December 31st, and on January 4 and 5, we had conference calls regarding the arrangements of what need to be --

LYNN MAHONEY: Okay.

MARIA ELIAS: -- what we needed to prepare.

LYNN MAHONEY: Okay.

MARIA ELIAS: And so the long-term care residents happened on January 6th.

LYNN MAHONEY: Okay. Perfect. Thank you. Okay.

MARIA ELIAS: So that is -- that's on slide 10.

LYNN MAHONEY: Okay. Great.

MARIA ELIAS: What's important to note is that the UHN teams that came out that day were actually vaccinating two long-term care homes that day. And again, that just reinforces what we were always saying all along the way which was, let us do it ourselves. You go to homes -- you know, the hospital teams can go to homes where they don't have the resources or need the assistance, and where homes are quite capable of doing it, save your resources and let us get on with it. But that wasn't the case.

But what happened on January 6th is that we were able to have a very good conversation with the doctor that came out from HN, again, trying to convince and advocate that we could do this ourselves and that we really wanted to do our own essential caregivers.

LYNN MAHONEY: Okay.

MARIA ELIAS: So through that conversation, we then -- he then connected with someone higher up in UHN, and we had a conference call that afternoon, and they said that they would

be willing to allow us to do our own essential caregivers. And this is where I'm moving into Slide Number 11, where on Slide Number 11, I'm focusing on that process.

After a considerable amount of lobbying, we did get approval on January 6 to have a vaccination clinic for essential caregivers on the afternoon of January 8th and January 9th, and we received the vaccines the morning of January 8th. The vaccine --

LYNN MAHONEY: This is for essential caregivers?

MARIA ELIAS: For essential caregivers.

LYNN MAHONEY: Yeah.

MARIA ELIAS: What's important to note here was that the only way that UHN would agree to us vaccinating essential caregivers is under the condition that the medical director, Dr. Birmingham, would be putting the needles in the arm.

So Dr. Birmingham and another one of our physicians volunteered to come in on the Friday and Saturday, and with the assistance of our nursing staff and a lot of admin staff, they were able to vaccinate, through the Friday afternoon and

Saturday morning, 175 people.

So we felt that that was a very successful approach to vaccinating our essential caregivers versus having them booking online, and when you have that many essential caregivers, it would have taken over a month to get them all done. So we felt that it more efficient to have them done here on site.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Elias, Dr. Kitts had a question.

COMMISSIONER JACK KITTS: I'm just wondering, during the flu season or hopefully just before it, do you do all your own vaccines of residents and staff and caregivers?

MARIA ELIAS: Yes, we do.

BRAD BIRMINGHAM: Yes.

COMMISSIONER JACK KITTS: So --

BRAD BIRMINGHAM: And we have for -- we have for decades.

MARIA ELIAS: And that --

COMMISSIONER JACK KITTS: Okay. I'm sorry. Go ahead.

MARIA ELIAS: And that is quite common in long-term care homes.

COMMISSIONER JACK KITTS: Yes.

MARIA ELIAS: [Indecipherable] that did their own.

COMMISSIONER JACK KITTS: So it's not that you don't know how to vaccinate. And do you think it had to do with the concerns around the Pfizer having to be at minus 70 or colder, and then when Moderna came, they loosened up the -- who could use the vaccine? Do you -- because it doesn't sound like UHN ever gave you the reason why that it was so strict.

MARIA ELIAS: Yeah, so absolutely. We fully understood and supported the fact that with the Pfizer vaccine, it had to have been more tighter controlled, centralised location, even though we were hearing that in Quebec, they were bringing the Pfizer to the long-term care homes; we were hearing in Europe that they were bringing the Pfizer into the long-term care homes, but I was quite -- and we were all quite willing to accept that.

But all along the way, we kept pushing that as soon as the Moderna was available, that we should then move into a different strategy where long-term care homes and retirement homes take on -- take on that partnership with the hospital,

and we do it ourselves. We don't need to be supervised by a hospital staff as to vaccinating, you know, employees, essential caregivers, residents, and tenants.

So right up to the point when we were lobbying, when you think about January 6, the Moderna vaccine came to Ontario that last week of December. We were still lobbying for us to do our own as soon as we heard that Moderna was in the country, right, in the province, in the city. But still, it was tightly controlled, and it was the hospital staff that were required to come out.

So they did not switch the methodology when the Moderna came in. They were still following, you know, a Pfizer type of approach where, okay, you didn't go to the hospital. This time, the hospital would come to you.

And what our focus was, we don't need the hospital to come to us. We just need the vaccine to come to us. So I hope that answers your question, Dr. Kitts.

COMMISSIONER JACK KITTS: Yes, I understand. Thank you very much.

MARIA ELIAS: Yes. Okay. So now we can move on to page 11, slide 11. I just wanted to

give you our vaccination rate.

BRAD BIRMINGHAM: I think we're 12, actually.

LYNN MAHONEY: Yes, 12.

MARIA ELIAS: Oh, is it 12.

LYNN MAHONEY: Twelve, yeah.

MARIA ELIAS: Sorry. [Indecipherable] 12. Vaccination rates, as of January 10th, like every home, like everywhere in healthcare, there is a vaccine hesitancy. Even when we look at the regular annual flu vaccination program, you'll see hesitancy. You'll even see -- especially in hospitals, you will see lower rates of flu shot vaccination for the medical and the nursing team compared to long-term care. The long-term care homes have always done very well even in the flu vaccination process.

Having said that, there's a lot of -- there are many things that have contributed to a lower employee vaccination rate, but we're maintaining and continuing to focus on improving our vaccination rate. So for employees, we're at 64%; long-term care residents, 92%; you have ten families refusing; retirement tenants, a hundred percent; and essential caregivers, 74%, but we are

also in the process of developing waitlists for employees and essential caregivers so that we can run some additional vaccination clinics here on site. What I'd like to now --

LYNN MAHONEY: Commissioner --

COMMISSIONER FRANK MARROCCO (CHAIR): Oh --

COMMISSIONER ANGELA COKE: Sorry. You've mentioned that your -- obviously, your employee rate is better than most. I'm just curious as to some of the tactics or strategies that you used with employees to overcome the hesitancy aspect.

MARIA ELIAS: Yes. So I'll mention it here. I do have a slide on vaccine hesitancy. But I have to tell you that the -- we already appreciated the fact that there's vaccine hesitancy compared to the long-term care -- sorry -- compared to the long-term care Vaccination Task Force who didn't seem to address that issue early on.

We know that there's vaccine hesitancy, so very early on, we were sending out materials to the employees. We've created poster boards. Dr. Birmingham would go on all the nursing units and talk with the staff. All the directors were

required to go to their individual departments to talk about the vaccine, and when the vaccine rollout started the week of December 14 and we were participating in that pilot project, we specifically identified and priorised individuals from each department in the home. And we encouraged them, if it was possible, to take a selfie of them getting the shots, and then we would post the photos of those individuals here at Belmont, again, to find cheerleaders to come back to encourage other employees to go forward with getting the vaccine.

As you know, many people are afraid, you know: Am I going to, you know, get blind from it? Am I going to be infertile? Am I going to have severe reaction? So there were typical kind of concerns and fears that you would have with any vaccination rollout. So we tried to deal with it that way. It's still a work in progress.

But in surveying my colleagues in other homes last week, I did find that the average was around 40 to 50% for vaccination rates for the employees. And some homes were as low as 7%. And so I'm pleased with the 64, but our flu vaccination rate last fall was 84%. So that's my goal, is to

try and get it up to 80% at least.

BRAD BIRMINGHAM: I'll just make a quick comment. I think we find that the path to better participation among staff is through support and education, not through scolding or pressuring.

And I think with discussions with staff and with going through some of the myths in terms of vaccine and also being very open about some of the expected side effects, some of that hesitancy is overcome.

I think there are really a couple of groups. I think this is humans in general. There will be a group who very eagerly go towards getting the vaccine. They would like to be the front of the line. And, frankly, anyone who has experienced firsthand COVID, they were right there.

There will be others who want to sit back a bit and wait and see, and certainly, that's normal; that's human, and we did have that. And there was sort of a second wave -- sorry -- that's a bad phrase -- second tier, if you will, of staff who said, okay, it seems to be going okay.

There are a third group that really have quite a lot of fear, and with that group in particular, if you can go through what their fears

are and explain to them the method of the vaccine, the technology of the vaccine, then we found that that was quite successful.

COMMISSIONER ANGELA COKE: Okay. Thank you.

MARIA ELIAS: I'm going to go to page --

COMMISSIONER JACK KITTS: Can I just ask a -- can I just ask a follow-up on that. The question I would have is what is the compliance rate of the leadership and management teams as well as the physicians and nurses? Because I think that's where a lot of the staff would take their cue from.

MARIA ELIAS: Okay. So I can answer that question. I'm really addressing slide number 19, so when we get to it, I'll skip it. We knew that we had to show that leadership, and so we also took selfies of the management team, and we had a hundred percent compliance in the management team and in the medical team in getting vaccinated. And it was important to show that we had faith in the vaccine both on the medical side and on the leadership side.

And through all those photos that we

took, we ended up actually producing a YouTube video that that was very entertaining but also motivational. And we run it inside our home on two different TV monitors. And if you have the opportunity, I did provide the link on page 19. It's a three-minute video, but it shows our journey from, you know, PPEs to getting vaccinated at the -- at the Michener, and also having the long-term care vaccinations and the retirement people vaccinated here on site and the essential caregivers. So it's very -- it's a very motivational, uplifting video that we have sent out to everyone to, again, encourage them to get the vaccine as we -- as we move forward.

COMMISSIONER JACK KITTS: Thank you.

MARIA ELIAS: On page 13 and 14, we talk about the burdensome administrative process. As Dr. B mentioned early on, there's a lot of work that has to be done to prepare for vaccinating everyone, and we were responsible for all of that, so we did not get support, actually, from the hospital consent form that came very late. So we had to develop our own consent forms, and so a very administrative burdensome process.

But I think the most burdensome of it

all, on page 14, was this COVAX system. Okay. I don't know how they did it in the 1950s with the polio vaccine without having these [sic] million-dollar technology to keep track of everybody getting vaccinated, but I'll have to tell you that this COVAX system, training the staff to document the information on the system was extremely frustrating when it could have been far more simpler by recording everything on an Excel spreadsheet and then just sending it to UHN, and they could upload it themselves.

So we did find that the technology took a lot of time, got in our way. There were technical difficulties, and we felt that it was such an unnecessary part of the process, and it could have been simplified more easily.

The other interesting thing to note is that recently, the Government has given us the requirement to report to them three times a week on the vaccination rates by category of residents, employees, and essential caregivers, another burden on the home to report back to the Government on their vaccination rates that are pretty much being used in the media to just show the progress of what's going on. So the question for us is,

basically, can't they get it from the COVAX system, you know?

On page 15, just briefly talking about the inconsistencies in the rollout, and I'm sure you've read enough about those inconsistencies in the media, so I won't touch on it too much on there, but I just have that page there to reference for you.

On slide 16, delays in the vaccination program, we talked a lot about that. We felt that there was too much control by the hospitals, and the vaccination rollout, we felt, was too slow, not enough days dedicated to it.

We also felt that the Task Force did not identify who would do the vaccinations within the phases. So the rollout, the framework for the vaccination program is very high level, but there aren't details as to who will be the players that will assist in this rollout.

What's interesting to note is that the Government now is talking about using pharmacy students for future rollout and all of that sort of stuff, so it seems to me that the Task Force is planning this as they go long. I don't feel that the Task Force was established early enough and

that enough planning went into identifying exactly how this rollout was going to operationalize itself.

And again, similar to Wave 1, we seem to get the -- we seem to get more information from CP24 than we do from Government on this. Sorry. The masks --

LYNN MAHONEY: So, can -- Ms. Elias, can I ask you, you have a comment at the -- at the bottom of slide 16, you -- about you don't feel that the Government is being transparent as to why the process is taking so long for long-term care homes. We know that there's been different dates that the -- that the Government has indicated. I believe, originally, it was January 21st that all long-term care homes were to be vaccinated by, and now, I believe that's been changed to February 15th.

Do you have a sense of, from your discussions with colleagues, as to why the rollout of the vaccination process in long-term care homes is taking so long?

MARIA ELIAS: What's important to note is the difference in the dates. So originally, it was for the gray lockdown zone, so pretty much

Southern Ontario, the target date was January 18th. Then they moved it to January 21st.

The mid-February date is for the rest of the province, but I challenge this Government to say that there was enough Moderna vaccine in this province and enough Pfizer in this province to have done all long-term care homes as of last week, not the middle of February.

Think about the number of doses that are available in the province. Think about the number of residents, the number of homes, the number of employees. We certainly had sufficient stock in doses, in my opinion, that we could actually do all long-term care homes in Ontario by the end of January.

Now, then, of course, we do have some issues now with delays in vaccines, but I do believe that if you look at what was made available, we could have done a better job.

BRAD BIRMINGHAM: The only thing I'd add to that is the Province of Alberta completed vaccinations for all their long-term care homes this past weekend.

LYNN MAHONEY: Thank you.

MARIA ELIAS: So on slide 17, so

really, we've run out of time. The role and control of the hospital, we've talked about that, okay. The role and perception of long-term care: Overall, we feel that Government looks too quickly to hospitals and academia to solve the problems, and we're still being left out as part of the solution and participating in making the rollout more successful.

Now, I have to say that the Task Force has started conducting webinars as of, I believe, January 9th, and so we've had the opportunity of asking questions. But when I have asked questions of the hospital staff or the LHIN staff in the past, basically -- or provide some feedback, it was, well, we'll bring it up; we'll bring it up. But we never got responses.

But we're getting some responses from the Task Force now, and they are acknowledging that long-term care can participate and do their own vaccination.

On slide 19, we talked about the vaccine hesitancy and some of the strategies we used. On slide 20, this communication, education, and strategy, it goes back to the Task Force itself. I know that they were established late,

but when you think about it, even last summer, the summer of 2020, we knew vaccines were coming, so why wasn't this task force established then? Why wasn't this task force given the focus, also, of communication, education, the detailed rollout of who is going to help in this process.

Like I said, we haven't gone through -- yes, you know, when you hear from government officials, you hear the fact that this is the biggest rollout, you know, in terms of vaccination.

Yes, it is the biggest, but it is no different than previous kind of vaccination rollouts. The components of vaccination rollout is the same. The magnitude is larger, so you're going to need more players in the game. You're going to need more vaccination clinics and sites.

But still, you need to give thought to communication, education, who the players are, and how you're going to do it, and how quickly you're going to do it, and that is not identified in the framework from the Task Force. And some simple things like, you know, clear and consistent messaging. They could have developed a tool kit to help long-term care homes, et cetera, et cetera.

On page 21, just want to focus on the

representation of the Task Force. So when I looked at the membership, I don't know or see anyone that has any expertise on communication or education. I don't -- maybe there's expertise on how to deal with vaccine hesitancy, but we haven't seen that addressed. It's just become an issue lately in the past week where we're -- that conversation has come up about vaccine hesitancy when we know that that's an issue in healthcare overall.

And were there any, you know -- another issue, again, about long-term care home involvement, were any long-term care operators advising on rollout? And I actually mean operators, not the Ministry of Long-Term Care.

The Ministry of Long-Term Care doesn't know the logistical problems of dealing with any policy or vaccination program in a long-term care home.

And on page 22, I just wanted to take the opportunity before we conclude to bring forward a couple of other long-term care issues. You know in the media that there's an issue -- they're identifying the issue of not enough hospital beds, ICU beds, and so forth.

Again, you know, looking at long-term

care as part of the solution and not the problem, there are currently many long-term care beds that are empty due to outbreaks in the GTA, and yet we have hospitals that need to find and create more beds at convention centres.

So I do feel that long-term care homes get forgotten, and they're not seen as part of the system and, therefore, part of the solution.

If we get our outbreaks under control, then we could admit those hospital patients that need long-term care and then free up hospital beds. So put the priority back on getting everyone vaccinated in long-term care homes. Let's get the outbreak under control. Let's fill our empty beds so that there are available beds in hospitals, and let's move people out of hospitals and into long-term care where they would be better able to receive the care that they truly need.

And I just talk about the fact that we feel that there's enough of vaccine to vaccinate all the long-term care homes.

So in conclusion, on page 23 --

COMMISSIONER JACK KITTS: Can I just interrupt you, Maria? I may have missed -- I may have missed it, but is there a directive or order

or recommendation to hospitals not to send patients to long-term care homes? I'm just -- I'm just trying to reconcile, the hospitals are full with ALC patients, and you've got empty beds, and you're -- and they're creating more space, so can you -- can you help me with --

MARIA ELIAS: Yes. So the situation right now in the GTA -- and I just survey my colleagues -- right now, we have 18 empty beds. Another home, I won't mention their name, has 80 empty beds. So what happens is that when you are in an outbreak, you're not allowed to admit.

But when we had -- or traditionally, during the flu season, we have an outbreak. You know, you isolate that nursing unit, and you still can admit to other nursing units.

But there has -- there has been a decision but nothing in writing that says, well, don't admit because you have an outbreak, so, you know, you don't admit until your outbreak is over.

The issue becomes, how are we going to get these outbreaks under control? We have to vaccinate everybody. We have to get these outbreaks under control so that you don't have one person testing positive every week which continues

to keep the home in an outbreak situation which means the homes cannot fill their empty beds.

We have never, in the 21 years I've been here, have never had this many empty beds ever.

COMMISSIONER JACK KITTS: Just --

MARIA ELIAS: But we're looking forward to starting to fill those beds as we come out of outbreak this Wednesday.

COMMISSIONER JACK KITTS: Okay. So let me see if I understand. You said there is no document or direct order telling you you can't take patients when you have an outbreak, but that's the practice; is that -- am I correct?

MARIA ELIAS: Practice.

BRAD BIRMINGHAM: Yes, I --

MARIA ELIAS: Yeah.

BRAD BIRMINGHAM: To be honest, I don't know if there is or not a --

MARIA ELIAS: A piece of paper, right.

BRAD BIRMINGHAM: Yeah. Yeah.

MARIA ELIAS: No. There's nothing -- there's nothing in writing, but that is -- that's the practice.

COMMISSIONER JACK KITTS: So is it

feasible, and I believe I am hearing that you -- both of you, Dr. Birmingham, and you, Ms. Elias, would take patients because you can -- you can isolate them from where the outbreak is because you have one or two people with infection. So you would -- so is there anything stopping you from calling the hospital and saying we can --

BRAD BIRMINGHAM: But I think it should be --

MARIA ELIAS: Yeah.

BRAD BIRMINGHAM: -- clarified a little bit. What we are tending to deal with is suspect outbreaks, is the term. And that generally is when it's a staff person or an essential caregiver who tests positive. The residents themselves, as I said, aren't testing positive, so in that circumstance, we still put everyone on isolation.

I would distinguish that from when you actually have an outbreak that includes residents. And that's just based on the nature of the virus and its potential to spread. So I think those two situations should probably be dealt with separately.

So if you are in a suspect outbreak, which I'll categorize as a safer scenario, I think

that you can feel a little more free in terms of admitting people. I think if you truly are in an outbreak that involves residents, then the priority really has to be protecting those residents, controlling the outbreak.

So in that circumstance, I wholeheartedly agree with not admitting other new residents.

COMMISSIONER JACK KITTS: Yeah, that makes sense. Thank you, Dr. Birmingham.

But I guess the question remains, discussions between a long-term care home and hospitals that you may receive long-term care patients from and filling the beds if it's felt -- deemed safe to do so; is that a possibility?

MARIA ELIAS: Right now, many of those long-term -- sorry -- many of those hospital patients that need long-term care are on our list already throughout the GTA.

Back in Wave 1, the LHINs and the Government made those hospital patients that are on long-term care -- or that need long-term care, made them a priority, so they are currently identified as crisis on the waitlist for long-term care homes across the GTA.

But the issue goes back to, let's get -- let's get the long-term care sector stabilized and control these outbreaks so that we can be part of the solution, you know, but we just need to have long-term care seen as a priority ASAP.

COMMISSIONER JACK KITTS: So I think what you said, then, is, let's stabilize it and then have that discussion; is that correct?

MARIA ELIAS: We can do both at the same time, as Dr. Birmingham had indicated, right? If you -- if you have residents that have COVID, then, yes, don't admit until you have your home stabilized, under control.

But if it's just a suspect with no transmission, we can move forward with a more manageable admission process, but we need to have that -- the whole sector stabilized as soon as possible.

COMMISSIONER JACK KITTS: Okay. Thank you.

MARIA ELIAS: That concludes our presentation, and I hope that you'll have the opportunity to see our little video that we put together. And I know that we've run past the time,

so we'll leave it up to you if you have any other questions about --

COMMISSIONER FRANK MARROCCO (CHAIR): There don't appear to be any other questions. Well -- you know, so thank you both.

Ms. Elias, thank you again.

Doctor, nice to meet you.

And thank you for a very informative presentation. We've been very interested in how this is happening as part of what we're looking into, and it's quite helpful, so thank you very much.

U/T MARIA ELIAS: Thanks. And I'll also take the opportunity to send Dr. Birmingham's notes to you later today.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, please do. You can send it to Ms. Mahoney, and she'll make sure we see it.

MARIA ELIAS: Great. Thank you.

LYNN MAHONEY: Could I ask, once the Commissioners are -- can sign off, but I would ask everybody else to stay online so that Janet can verify the names and attendances for the transcript. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay. Bye.

COMMISSIONER JACK KITTS: Okay. Thank you.

LYNN MAHONEY: Thank you.

COMMISSIONER JACK KITTS: Bye.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 10:10 a.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 20th day of January, 2021.

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CLARIFICATIONS:

Pg. 30 – Line 22 - “Enlaw” should read NLOT

Pg. 50 – Line 18 – the sentence should finish with ‘… any policy or vaccination program in a long-term care home.’

WORD INDEX