

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

1 PRESENTERS:

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

4
5 Dr. Brad Birmingham, Medical Director Belmont House

6
7 PARTICIPANTS:

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

11
12 Angeline Hawthorn, Senior Policy Analyst Long-Term
13 Care Commission Secretariat

14
15 Angela Walwyn, Senior Policy Analyst Long-Term Care
16 Commission Secretariat

17
18 John Callaghan, Co-Lead Commission Counsel Gowling
19 WLG

20
21 Lynn Mahoney, Counsel Gowling WLG

22
23 ALSO PRESENT:

24
25 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

1 -- Upon commencing at 9:00 a.m.

2 MARIA ELIAS: Good morning.

3 BRAD BIRMINGHAM: Good morning.

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

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

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

19 So thanks, Ms. Elias.

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

22 Nice to meet you, Doctor.

23 BRAD BIRMINGHAM: Good morning to you.

24 MARIA ELIAS: Good morning.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

4 COMMISSIONER ANGELA COKE: Good
5 morning.

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

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

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

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

24 LYNN MAHONEY: Can I just interject for
25 one second.

1 Janet, I don't -- I --

2 Commissioners, can you see the

3 screen --

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 No.

6 LYNN MAHONEY: -- the presentation?

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 No, I can't. There we go.

9 LYNN MAHONEY: Thank you very much,
10 Janet.

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

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

1 supply of those PPEs and the N95 masks.

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

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

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

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

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

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

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

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

25 In Wave 1, Chester Village had one

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

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

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

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

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

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

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

4 Both executive directors are
5 extensively involved in the community beyond the
6 homes itself representing long-term care. Maria is
7 presenting to you for the second time today.

8 Cynthia Marinelli, who's the ED at Chester Village,
9 has been representing long-term care on several
10 important committees such as the committee
11 regarding the specialized care centre. Both homes
12 have fostered a workplace culture that rewards
13 staff and includes all staff as part of the Chester
14 Village of Belmont family. Staff at both homes are
15 working incredibly hard because they feel a part of
16 the solution.

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

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

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

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

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

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

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

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

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

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

1 secured communication between the physicians and
2 the frontline staff.

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

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

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

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

20 BRAD BIRMINGHAM: Yes, please.

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

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

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

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

25 I sit on the Toronto Region LTC

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

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

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

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

25 MARIA ELIAS: So to give an example of

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

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

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

24 COMMISSIONER JACK KITTS: Thank you.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

4 MARIA ELIAS: So what --

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

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

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

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

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

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

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

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Okay.

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

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

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Yes.

8 LYNN MAHONEY: Okay.

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

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

20 LYNN MAHONEY: Ms. Elias, could you --
21 until we -- I think we're going to switch to page
22 5.

23 MARIA ELIAS: Okay.

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

1 MARIA ELIAS: Sure.

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

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

10 Many conference calls were held with
11 Government in UHN for a few days prior to that
12 rollout including on the weekend of December 11,
13 12, and 13 to prepare for the staff vaccination.
14 And the Michener Clinic started off on December
15 14th with a photo opportunity and had five
16 long-term care staff from the Re kai Centre
17 vaccinated.

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

25 But if you see, you know, during the

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

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

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

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

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

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

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

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

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

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

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

7 MARIA ELIAS: Yes.

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

10 MARIA ELIAS: Yes, only staff --

11 LYNN MAHONEY: -- and not caregivers?

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

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

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

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

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

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

19 LYNN MAHONEY: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

21 BRAD BIRMINGHAM: Do you mind if I
22 interject --

23 MARIA ELIAS: Sure.

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

1 MARIA ELIAS: Go ahead.

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

10 MARIA ELIAS: Thank you,
11 Dr. Birmingham.

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

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

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

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

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

24 So again --

25 LYNN MAHONEY: Ms. Elias, at this point

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

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

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

17 BRAD BIRMINGHAM: So --

18 MARIA ELIAS: Again, both testing --

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

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

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

6 LYNN MAHONEY: Okay. Thank you.

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

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

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

23 LYNN MAHONEY: Slide 10? Okay.

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

1 long-term care vaccination --

2 LYNN MAHONEY: Right.

3 MARIA ELIAS: -- rollout.

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

12 BRAD BIRMINGHAM: That's the essential
13 caregivers.

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

18 LYNN MAHONEY: Okay.

19 MARIA ELIAS: -- what we needed to
20 prepare.

21 LYNN MAHONEY: Okay.

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

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

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

3 LYNN MAHONEY: Okay. Great.

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

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

21 LYNN MAHONEY: Okay.

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

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

5 After a considerable amount of
6 lobbying, we did get approval on January 6 to have
7 a vaccination clinic for essential caregivers on
8 the afternoon of January 8th and January 9th, and
9 we received the vaccines the morning of January
10 8th. The vaccine --

11 LYNN MAHONEY: This is for essential
12 caregivers?

13 MARIA ELIAS: For essential caregivers.

14 LYNN MAHONEY: Yeah.

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

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

1 Saturday morning, 175 people.

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

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

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

15 MARIA ELIAS: Yes, we do.

16 BRAD BIRMINGHAM: Yes.

17 COMMISSIONER JACK KITTS: So --

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

20 MARIA ELIAS: And that --

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

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

25 COMMISSIONER JACK KITTS: Yes.

1 MARIA ELIAS: [Indecipherable] that did
2 their own.

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

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

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

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

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

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

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

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

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

1 give you our vaccination rate.

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

4 LYNN MAHONEY: Yes, 12.

5 MARIA ELIAS: Oh, is it 12.

6 LYNN MAHONEY: Twelve, yeah.

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

18 Having said that, there's a lot of --
19 there are many things that have contributed to a
20 lower employee vaccination rate, but we're
21 maintaining and continuing to focus on improving
22 our vaccination rate. So for employees, we're at
23 64%; long-term care residents, 92%; you have ten
24 families refusing; retirement tenants, a hundred
25 percent; and essential caregivers, 74%, but we are

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

5 LYNN MAHONEY: Commissioner --

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Oh --

8 COMMISSIONER ANGELA COKE: Sorry.

9 You've mentioned that your -- obviously, your
10 employee rate is better than most. I'm just
11 curious as to some of the tactics or strategies
12 that you used with employees to overcome the
13 hesitancy aspect.

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

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

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

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

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

1 try and get it up to 80% at least.

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

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

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

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

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

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

4 COMMISSIONER ANGELA COKE: Okay. Thank
5 you.

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

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

15 MARIA ELIAS: Okay. So I can answer
16 that question. I'm really addressing slide number
17 19, so when we get to it, I'll skip it. We knew
18 that we had to show that leadership, and so we also
19 took selfies of the management team, and we had a
20 hundred percent compliance in the management team
21 and in the medical team in getting vaccinated. And
22 it was important to show that we had faith in the
23 vaccine both on the medical side and on the
24 leadership side.

25 And through all those photos that we

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

15 COMMISSIONER JACK KITTS: Thank you.

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

25 But I think the most burdensome of it

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

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

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

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

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

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

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

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

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

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

8 LYNN MAHONEY: So, can -- Ms. Elias,
9 can I ask you, you have a comment at the -- at the
10 bottom of slide 16, you -- about you don't feel
11 that the Government is being transparent as to why
12 the process is taking so long for long-term care
13 homes. We know that there's been different dates
14 that the -- that the Government has indicated. I
15 believe, originally, it was January 21st that all
16 long-term care homes were to be vaccinated by, and
17 now, I believe that's been changed to February
18 15th.

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

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

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

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

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

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

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

24 LYNN MAHONEY: Thank you.

25 MARIA ELIAS: So on slide 17, so

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

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

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

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

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

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

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

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

25 On page 21, just want to focus on the

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

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

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

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

25 Again, you know, looking at long-term

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

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

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

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

22 So in conclusion, on page 23 --

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

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

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

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

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

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

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

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

6 COMMISSIONER JACK KITTS: Just --

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

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

15 MARIA ELIAS: Practice.

16 BRAD BIRMINGHAM: Yes, I --

17 MARIA ELIAS: Yeah.

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

20 MARIA ELIAS: A piece of paper, right.

21 BRAD BIRMINGHAM: Yeah. Yeah.

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

25 COMMISSIONER JACK KITTS: So is it

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

8 BRAD BIRMINGHAM: But I think it should
9 be --

10 MARIA ELIAS: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

20 COMMISSIONER JACK KITTS: Okay. Thank
21 you.

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

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

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

6 Ms. Elias, thank you again.

7 Doctor, nice to meet you.

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

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

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

19 MARIA ELIAS: Great. Thank you.

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay. Bye.

2 COMMISSIONER JACK KITTS: Okay. Thank
3 you.

4 LYNN MAHONEY: Thank you.

5 COMMISSIONER JACK KITTS: Bye.

6 COMMISSIONER ANGELA COKE: Thank you.

7 -- Adjourned at 10:10 a.m.

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1 REPORTER'S CERTIFICATE

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

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

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

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 20th day of January, 2021.

19
20 *Janet Belma*

21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: JANET BELMA, CSR

25 CHARTERED SHORTHAND REPORTER

1 CLARIFICATIONS:

2

3 Pg. 30 - Line 22 - "Enlaw" should read NLOT

4

5 Pg. 50 - Line 18 - the sentence should finish with
6 '... any policy or vaccination program in a long-term
7 care home.'

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