Long Term Care Covid-19 Commission Mtg.

Ministry Briefing on CAF
on Friday, November 13, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 13th day of November, 2020, 9:00 a.m. to 10:05 a.m.

BEFORE:

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

PRESENTERS:
Catherine Brown, Interim Executive Lead, Health System Performance and Support, Ontario Health;
Brian Pollard, Assistant Deputy Minister, Long-Term Care Capital Development;

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Policy Unit, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;

Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Sanjay Bahal, Team Lead, Operations, Long-Term Care;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat;
Ashley Dent, Acting General Counsel, Ontario Health;
Jeffery Simser, Legal Director, Agencies;
Louise Verity, Strategic Advisor-Office of the CEO, Ontario Health;
Sunil S. Mathai, Counsel, Crown Law Office Civil;
Roopa Mann, Counsel, Crown Law Office, Civil;
Amy Leamen, Counsel, Legal Services Branch for the Ministries of Health and Long-Term Care;
Judith Parker, Counsel, Legal Services Branch for the Ministries of Health and Long-Term Care.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, we're here.

Mr. Pollard and Ms. Brown, I don't know if you've met Commissioner Kitts and Commissioner Coke. If not, consider yourself introduced.

BRIAN POLLARD: Good morning. I think Dr. Kitts and myself have a little history but all good history.

COMMISSIONER JACK KITTS: Yeah. Hi, Brian.

BRIAN POLLARD: Hi, good morning.

COMMISSIONER JACK KITTS: Hi, Catherine.

CATHERINE BROWN: Good morning. Good morning, Angela. Good morning.

COMMISSIONER ANGELA COKE: Good morning. Hi, Brian.

BRIAN POLLARD: Hello. Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): So I'll dispense with the formalities. The Ministry's been here more than once.

We do have a transcript, and we post the transcript on the website. With your permission, we'll ask questions as we go along, if

there are any. And we're ready when you are.

CATHERINE BROWN: Okay. Well, good morning, everyone. It's Catherine Brown. I will start, and my colleague, Brian, will jump in as we go.

So you had posed a number of questions. I'll just give a bit of a chronology of how things evolved for Ontario as it related to the involvement of the Canadian Armed Forces.

On April 23rd, I was notified that the Province of Ontario was accepting support from the Canadian Armed Forces or the "CAF" as I will call them and asked to provide a list of homes from which we would select five homes for support.

The incident commander of the incident management structure for long-term care, Mike Keenan who is also an ADM at the Ministry of Health, brought this to my attention. And the ask had been initiated through the Ministry of Health through MEOC.

And I understand that was as a result of an exchange between the Solicitor General and Minister Blair on the 22nd of April at the request and the offering of support, but I wasn't a party to those. I just understand that's what initiated

it.

At OH, I was asked to move quickly, within hours, to identify homes that would benefit from the assistance of the CAF. I reached out to each region, and I asked them to submit homes that were in greatest need on that day in area.

And it's important to note that had we done it a week earlier/a week later, it might have been a different group of homes. These were the homes in that moment that were in the greatest need. A list of 11 homes was compiled, and that list is in the slide deck that we provided.

Those 11 homes were identified, and then I discussed with each region where the greatest need was. It was a very difficult selection given all the homes on the list were in significant need. And typically, that was related to the endurance of the outbreak as well as the availability and responsiveness of staff in the home.

There were no restrictions on what homes could be put forward. However, we were advised that larger homes could benefit from the effort of the CAF just given the number of residents and staff that were needed to support

care.

As such, some of the smaller homes were not selected. It should be noted that while the CAF was one important team of support, all regions were working with hospitals and the ministry and other partners to provide supports to homes in need.

And you'll recall, from previous briefings and certainly from the Ontario Health briefing, that included everything from hospital staffing, Ontario Health, and LHIN staff, home care staff. So many other supports were being provided to homes. These were five that were deemed in greatest need.

We selected the following homes for support: Hawthorne, Eatonville, Holland Christian/Grace manor is all in Central Region; and Altamont and Orchard Villa in the East Region.

The long and the short lists were provided to the Ministry of Long-Term Care and to the IMS for further consideration. No changes were made to the large selection of the five homes.

Once the list was confirmed, Ontario Health reached out to all five homes to make them aware and confirm their support to receive the

Canadian Armed Forces' supports.

An OH lead was identified. That was me, and I began working with the CAF as a liaison to begin work with the homes in Ontario.

I was advised that Lieutenant-Colonel Sean French would be my contact, and we began communication immediately on the 23rd. Lieutenant-Colonel French was my ongoing contact throughout the deployments.

I provided the names and locations of the five homes that we had identified to Lieutenant-Colonel French on the 23rd, and work began at the CAF to reach out to the homes or the hospitals that were involved with the homes.

As I said, we reached out to every home to arrange for the initial contact to let them know who would be reaching out to them from the armed forces and provide information about the rep and when they would be in touch and so forth.

Lieutenant-Colonel James Stocker was the frontline contact for homes. I dealt with him occasionally, but typically, my liaison was with Lieutenant-Colonel French.

Once the contacts were identified and initiated, the CAF then began their recognizance

work to meet with each home and identify the needs in the home. They went to meet with the home. They sent a separate recognizance team to assess the area for accommodation and supports where they would get meals, where they would be able to do laundry, things like that, and to plan for the deployment.

The Canadian Armed Forces moved very swiftly to enable the teams to be on site at the home, all five homes, by April 28th. So from the moment we created the list to the date of deployment was five days.

And one of the first recognizance visits, it was anticipated that all five homes could be surveyed in one day. And they found that the first two visits were overwhelming with staff just wanting to talk and to share what was going on in the home, so they were unable to complete all five assessments on the first assessment day.

And so that went through the Friday and the Saturday, and so we lost a bit of time there. But overall, a very swift deployment on behalf of the Canadian Armed Forces.

The first five were initially set for two to four weeks. I think we all anticipated it

would be four weeks, but there was the potential for them to move out sooner if they felt the need.

As things progressed, the Canadian Armed Forces notified me that they were seeing substantial progress with Holland Christian manor and would be ready to move on within a week or so of that first conversation about the conclusion of their work there. So we began preparations to identify a rationale for their departure.

The CAF provided a set of factors that they evaluated identified. And you'll see, in the slide deck, an example of -- a sample of what they did. A similar tool had been used in their work in Quebec to determine readiness to depart.

And OH and the Ministry of Long-Term Care reviewed their advice, confirmed with local partners in the home on the advice based on that red/yellow/green assessment and then determined if the timing was appropriate to depart.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there for a second?

CATHERINE BROWN: Yes, you may.

COMMISSIONER FRANK MARROCCO (CHAIR): The Canadian Armed Forces went into Quebec first --

CATHERINE BROWN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- earlier than they went into Ontario?

CATHERINE BROWN: Yes, they did.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you know when they went in?

CATHERINE BROWN: I do not, no.

COMMISSIONER FRANK MARROCCO (CHAIR): In the period up to April 23rd, do you know what prompted --

Did Ontario request assistance? Do you know whether Ontario asked for help or whether the Solicitor General of Canada volunteered help? Do you know?

CATHERINE BROWN: I don't. I know there were letters exchanged, and they were to -- none of them were to me or to the Ontario Health personnel. So I think it would be for Ministry of Long-Term Care or Ministry of Health to answer that question.

I know that we had heard for a couple of days that there were discussions going on behind the scenes that potentially the Canadian Armed Forces would be deployed in Ontario.

And we had seen their work in Quebec, I'd say, for about a week at that point. We had

seen on the news that they had been in Quebec, but I couldn't say for sure, Commissioner Marrocco.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, what --

BRIAN POLLARD: It's --

CATHERINE BROWN: Sorry, we have a response.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry, Mr. Poland.

BRIAN POLLARD: Oh, I was just going -- to add to your question, so we would have formally requested to the Federal Government for assistance on April 23rd. But I'm not entirely sure if there were conversations that happened elsewhere within that home before that formal letter went over.

COMMISSIONER FRANK MARROCCO (CHAIR): And picking these places, how did you do that? How were they chosen? Like, what criteria were applied?

CATHERINE BROWN: So they were homes that had been struggling with outbreak and had had significant staffing issues. And I can't say that we identified it specifically at the time but certainly in hindsight that were also struggling with leadership and getting back on their feet.

And so we looked at, particularly, staffing. A lot of the homes were fearful. And because of the way in which the outbreak was being managed, staff were scared to come back to work.

I should also note that the week prior to the CAF offer, we had seen the first death of a healthcare worker in Ontario, and it was a personal support worker that worked at Altamont, one of the five homes that was eventually selected.

So there was a lot of fear happening at the time, a lot of concern by workers about the risk of going to work. And these five homes, amongst the 11, were deemed to be in critical need of that extra staffing and support.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you say whether those homes asked --

Did they ask Ontario Health for help?

CATHERINE BROWN: They didn't ask for the CAF. They asked for help. And they were in varying degrees of acceptance, I would say, of what was going on and their capacity to respond. So the --

COMMISSIONER FRANK MARROCCO (CHAIR): That --

CATHERINE BROWN: Sorry, go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no. I'm sorry. You weren't finished.

CATHERINE BROWN: No, I think that it was early in the -- it wasn't super early, but it was --

Homes were just starting to see that they were not coming back from this as quickly as others. And I think, as with anything, they wanted to be recovering, and they weren't.

So they weren't -- I wouldn't say they were "resistant." They just felt that they could do it on their own. And so even the hospital supports that we sent into Orchard Villa, there was a little bit of -- not "resistance," but a "we're okay. We don't need this" and us saying "no, we think you do. We think we need to give you this extra help."

And I would say, for some of the homes, that was their reaction with the army as well. They were concerned that they didn't need that kind of help but were glad of it once it got there for sure.

COMMISSIONER FRANK MARROCCO (CHAIR): It seems that this situation was so unacceptable or critical, to use a more neutral word.

I'm having some difficulty understanding why it's a consultation at that stage with them. You've got a very serious problem in these homes. The whole country has a problem, but they have a particularly serious problem.

And I'm having some difficulty understanding why it's really a consultation at this point and why the local Medical Officer of Health doesn't simply make an order.

CATHERINE BROWN: So at that point, we were just starting to understand that kind of flow, as you describe it, and the discussions and that some were not taking help when it was offered.

And we didn't understand, I would say, initially. Maybe that help should have been -- we should have been pushier with the help. We now see that differently, and we move very quickly, and Public Health does issue orders.

Orchard Villa was the first Public Health order that -- where we used that tool to get the hospital in. So I think -- I'm not sure what consultation you're referring to, but when we --

You know, by the time the CAF went in to talk to them about coming in, they were coming in. There was no -- it wasn't going to be based on

that discussion. They weren't going back. It was "what can we do to help?"

Si when they did the recognizance visits, it was already understood. Those were the five homes they were going to. There was no ability to say "no," and then CAF was there to talk about what they needed.

So when they did the recognizance visits on those two days, they talked to the home about what was going on and how they could help them. And they built their teams to support what they thought was needed in the home based on their discussions with the home and, typically, with the hospital that was working with the home. Does that --

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Commissioner Kitts?

COMMISSIONER JACK KITTS: And just looking at this sequence, so the military was called in to help the worst homes. Was that before hospitals were called in to help the others?

And the second part of the question is in the pandemic plan or the emergency preparedness plan, was hospital support and/or military support envisioned in that plan?

In other words, did we hit a point where we had to trigger the plan to bring in the military or the hospitals?

CATHERINE BROWN: So to your first question, hospitals were already working with homes in varying degrees, and so that work was already well underway in differing degrees across the province.

But certainly where homes were struggling, there were lots of hospitals that were working very closely with homes. So that support was already in place.

And, in fact, Orchard Villa, one of the homes that received the CAF as well as, I think, Hawthorne and Eatonville, all had substantial hospital involvement and still benefitted from the additional supports of the Canadian Armed Forces.

To your second question about preparedness planning, you know, we probably -- if we had many teams from the CAF, we probably could have deployed many more teams, especially in the peak of sort of April -- early April to early May where we were seeing homes hardest hit.

Five teams were made available. That was what was contracted with the province. We did

ask for additional teams. They were unable to provide it because they weren't providing supports to Quebec. And they were -- by that point, were starting towards the end of -- our time, they were start to go provide supports to Alberta as well, I believe.

So we were only able to have the five teams. We did redeploy one team and part of another team when they came out of the first five. They were redeployed to two other homes. So we were able to benefit -- or seven homes in Ontario were able to benefit from the extraordinary supports of the Canadian Armed Forces.

COMMISSIONER JACK KITTS: So it was in escalation of severity when the hospitals couldn't manage, then, for certain homes to call in the military?

CATHERINE BROWN: Yeah, I understand the question. It's a good question. It wasn't -- I wouldn't say they had the option to call in the military. Because it happened so quickly, the first five, we were just told that "you have this option, and it's happening. Can you pick the homes? And we need to know today."

And so I don't recall -- to be honest,

I don't recall contacting the hospital saying "would this be helpful?" I might have done that. I'd have to check my notes.

But we certainly conferred with the regions who were in touch with the hospitals, and we knew those homes were in extraordinary trouble, and so we accepted the armed forces.

I do recall having the discussion with a couple of CEOs, certainly for you Downsview and Woodbridge, both head of hospitals involved, and their hospitals were eager and active to -- and happy to get the supports of Canadian Armed Forces, yeah.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Brown, how was it that Ontario Health knew that those homes were in difficulty?

CATHERINE BROWN: So Ontario Health's role in long-term care through the pandemic was -- we got involved early on as homes were reaching out for help with personal protective equipment and with staffing.

And you may recall the Pinecrest was the first significant outbreak in a long-term care home in Bobcaygeon, Ontario. And that was at the

end of March, I think around the 22nd of March, and they reached out to Ontario Health.

We have a relationship with long-term care homes for a long-term care placement, and so they know us, and so they called us to say "can you help us with PPE, and can you help us with staffing?"

Because we also have the home care operation, so we have a liaison with all of the service providers that provide home care services which typically are the same health human resources personnel, personal support workers, nurses, et cetera.

So they reached out in Pinecrest to us for help. And in parallel, around the same time in Central Ontario, they reached out from Camilla to the LHIN or Ontario Health to ask for help, and then it kind of just went from there. And so we got very closely involved with connecting hospitals and other supports to long-term care homes on the ground.

We have capacity on the frontline and are connected to the rest healthcare system, so that's how we came to be part of it in the way that we were.

COMMISSIONER FRANK MARROCCO (CHAIR): When you say "capacity on the frontline," what do you mean?

CATHERINE BROWN: We work very closely with -- so we had been doing health system capacity planning for COVID. We had been working with hospitals to reduce their capacity so that they could take in COVID patients and to down the scheduled surgeries and to do all of those things.

So we had built a very close relationship with all of the health partners in the regions. Each region of Ontario Health -- there are five regions -- had established a COVID response table early on in the pandemic. I'm going to say late February/early March.

And those tables became the central focus for COVID response preparedness across Ontario for the regions. So we had easy access to the other partners. Long-term care was typically involved in some way at those tables. Although, as things progressed, homes were less and less able to participate in a normal kind of way, and we became their partner in responding.

COMMISSIONER FRANK MARROCCO (CHAIR): One sort of final -- I don't mean to monopolize

this. But there were, I think, 34 health units in Ontario.

CATHERINE BROWN: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm curious -- was there a reason why Ontario Health dealt with it on a region-by-region basis rather than dealing with each of the 34 health units that were all -- than each of the health units?

CATHERINE BROWN: That's a good question. The way in which Ontario Health was configured, there were 14 Local Health Integration Networks. They each have their own geography. And those geographies were kind of pulled together into five Ontario Health regions. They don't align with the Public Health boundaries. They are more -- they are health boundaries.

So we did work with all 34 Public Health units, and we established local relationships for all of the homes and all of the hospitals, wherever they resided so that, currently, when we have an outbreak or a response to an outbreak, it typically involves Ontario Health, Ministry of Long-Term Care, the local Public Health unit, and the hospital partner.

And we pulled together very quickly to respond to homes. It was less smooth at the outset because we didn't have a long-standing relationship with Public Health in that way because we've never worked with them in this kind of environment, this kind of long-standing crisis environment, so...

But we worked with them from the outset as best we could, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

CATHERINE BROWN: Thank you.

COMMISSIONER ANGELA COKE: Catherine?

CATHERINE BROWN: Yeah.

COMMISSIONER ANGELA COKE: Just generally speaking, in hindsight, are there any sort of lessons learned from this deployment process from OH's point of view? Anything you would have done differently?

CATHERINE BROWN: That's a good question. I don't know. You know, we learned a lot about -- and I think part of it was through the CAF.

We learned a lot about that readiness and what was really going on in the home. And I think to some of Commissioner Marrocco's questions,

we probably let it ride a little bit longer.

We heard from homes initially "no, we've got this. We're doing the best we can, and we're trying really hard." And we would give supports, and we would offer and wait for them to take it up.

And very quickly, we learned we needed to be a little more aggressive and say "it's not your choice. We are giving you this help. We are not letting you fail and that being an impact for residents. So we're helping you whether you need the help -- whether you believe you need the help or not."

And we still see that. We still see homes saying "we're okay" and us saying "you're not." And maybe you are. And if the help is unnecessary and we throw some resources at you and it further helps to accelerate the response of the home and the stabilization, that's all for the better. We'd rather that than say "you take your time and try to figure it out."

So I think between early into Wave 1 -- I'd say sometime around the CAF response time, we started to realize we have to be a little more aggressive in offering supports.

And I know you've heard this before, but it was all happening so fast. Like, you couldn't fathom how quickly things were changing for homes and across the healthcare system.

I think for hospitals, as well, it was often their first time working in this way with long-term care homes. Long-term care homes had never had IPAC support of this kind or needed IPAC support. It was for everybody.

It was a disease that was just beyond anyone's comprehension. And so rallying that response, it seemed to take a long time, but it was relatively quick.

And certainly, in terms of the government response, it was extraordinarily quick. That -- it took weeks, not months and months. But at the time, it just felt like forever sometimes to get things turned around even though it took a couple of days.

So I know, for example, people said "what took so long to get the army in there?" And it was -- like, it was five days from the time we first talked to them to the time they had boots on the ground in those homes. It was five days which is extraordinary quick including recognizance

visits. They had to find hotels. They had to identify personnel. They had to screen them and train them. So it was a very quick turnaround, all things considered, but five very long days for those homes.

COMMISSIONER JACK KITTS: Catherine, can I ask a question about decision-making at the regional or even the local level?

So does the Ministry of Long-Term Care, the Ministry of Health for the hospitals, Ontario Health, and then the Public Health -- what was the relationship between Public Health's reporting to those different areas? And was Ontario Health sort of the leader that brought them all together? Just give us an idea of how that worked.

CATHERINE BROWN: Thank you. So we were more of a coordinator, I'd say, in pulling people together. And Public Health, as you know, reports municipally, and so they were certainly cooperative in most areas of the province.

Some places, they were a little more reluctant to participate at the local tables, but we worked with them as best we could in all of the communities.

I would say they had -- with long-term

care, they were typically involved as it related to testing and outbreak management. That is their role.

And in some areas, they were more adamant about keeping in their lane and telling us kind of after the fact. It was harder to get information. I think that's a learning that is vastly different in Wave 2. Much more communication and information going back and forth in a more collaborative way.

And so our role, at that time, was to pull the parties together. And we started creating -- I think I spoke to this last time, and you've heard about the red/yellow/green sort of list.

We started creating those, and that had input from Public Health from as well as the Ministry of Long-Term Care and Ontario Health which included input from the hospitals and other partners to track the status and response, more importantly, for each of the homes.

COMMISSIONER JACK KITTS: Excellent. Thank you.

CATHERINE BROWN: Thank you, Dr. Kitts.

Shall I resume? I think I'm

almost done.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. Go ahead.

CATHERINE BROWN: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): I don't think there are any further questions at this point.

CATHERINE BROWN: Okay. So just on the determination of homes -- departing of homes. The factors that the armed forces considered and then we reviewed and made a determination were four factors, as you can see the chart.

The first one was an assessment that the CAF support was not -- required any further.

The second one was the number of COVID-19 cases, that they were able to self-manage existing cases, that new cases of COVID were decreasing, and the number of recovered cases.

The third area and fourth area were typically the areas that, I'll say, languished the longest and were the ones that we often waited for to go green for at least a week before we came out.

And that was IPAC, that appropriate PPE was available. You'll recall, at that time, PPE was still quite challenging but also that there was

a management plan established for the home, that they knew how to use PPE, that there was appropriate donning and doffing procedures in effect as well as cleaning procedures had been established, waste management had been established, many issues that were later identified by the CAF in their report. And then, last but not least, staffing.

And so one of the critical things that the armed forces offered was that stabilization so that sufficient staff could return, allowed the employers and the homes to start working with their staff that were off to get them to return to work, that there were medical staff available for day and night shifts.

As you may have heard, medical staff coverage was not where one would have hoped it would have been at that time, and so they worked on ensuring that was in place. And then, as I said, sick staff coming back.

And so in most cases, the armed forces stayed for the duration of their time. In some cases, they stayed a little bit longer, and the departures were maintained to allowed times for the homes to really adjust.

Once the homes -- the CAF indicated they wanted to come out, we would pick a date. Give the home about a week to adjust to that. We often had to extend it for a day or two because they wanted an opportunity to have a farewell celebration with the CAF and thank them for the contribution.

As I mentioned, the CAF then came out -- the first two homes they came out of, they were then redeployed. So from the Holland Christian manor, they went into Downsview, and they went into Downsview which was a very troubled home on June the 2nd.

They didn't stay there a long time. The hospital had been there for quite a while at that point. And we were also moving into June, so outbreaks were settling down.

But Barb Collins -- the CEO of the hospital, Humber Regional Hospital that was working with Downsview -- felt that there would be a benefit there, and so they went in for a couple of weeks there.

And then last but not least, when they came out of Orchard Villa, which they were in for quite a while, they moved to a home called

Woodbridge Vista, and they were there just under a month.

And the Canada armed forces had planned to be out by early June, but they extended their time to be out by -- later in June but extended to July the 3rd very graciously, and we were very grateful for that.

So that, in short, is all of the information I have to share this morning. I don't know, Brian, if you had any other comments you wanted to make.

BRIAN POLLARD: No. Thanks, Catherine, no further comments. I'm happy to answer any questions.

COMMISSIONER FRANK MARROCCO (CHAIR): I did have a question. One of the criteria was the personal protective equipment.

Was there a requirement that each home have a supply of personal protective equipment on site sort of pre-pandemic? Was there any requirement like that?

CATHERINE BROWN: Brian would be better to speak to that one, I believe.

BRIAN POLLARD: Yeah. So we would have always required homes to have the supplies that you

would need to deal with outbreaks especially relating to the flu because that's such a prevalent disease that obviously impacts long-term care.

But in terms of requiring the homes to have X weeks of supply of PPE, that would not have been an existing requirement.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you think that, given what's happened, that would be a useful requirement to impose?

BRIAN POLLARD: I do.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you. Was there any problem in terms of a duplication of authority or confusion about boundaries?

There seemed to me -- the uninitiated, really, I guess, of the --

There's a number of organizations trying to help here, each with its own jurisdiction, if you like.

CATHERINE BROWN: That's a great question. The one area that there was some -- so the military was very clear. They came with their own command. Their staff reported to them. They worked in parallel with the home. That's why those recognizance visits and those leadership

partnerships were critical. They needed to know who their counterpart was, and they needed a medical and an administrative counterpart.

So they set that up initially, but they were very clear. Their staff reported to them. The PPE rules were theirs. They were going to maintain that oversight of their own teams, and they were not overseeing staff in the home. So the staff of the home remained the employees under the oversight of the home or the hospital that was managing the home.

The one area that they sighted as problematic in some homes early on was that homes were not providing the medical coverage that was necessary particularly on night shifts. They were deferring to the Canadian Armed Forces.

They flagged that for us early on that that was not acceptable to them, that they are working for and with the home. They cannot be the only medical oversight in the home. That's not the contract.

So we made that clear to the one or two homes where that was an issue, and then we raised it with all five homes to say "you need to be mindful of the fact you're still responsible for

coverage. And they will support you, and they will add additional boots on the ground, but you're responsible for medical coverage on all shifts." And they can augment it, but they still had to have their own medical people on to make decisions.

COMMISSIONER FRANK MARROCCO (CHAIR): I guess I was more directing my question to the initial period when everybody's trying to respond to this.

It just seems to me there are so many different parts of the public -- well, you could call a "Public Health system," each with its own boundary, if you like, or each with its own jurisdiction.

I was wondering -- I don't want to ask you an awkward question, but it just seems like maybe there's --

CATHERINE BROWN: But you're going to.

COMMISSIONER FRANK MARROCCO (CHAIR): I am, yes. I was just trying to extricate myself from...

It seems like there's too many. Do you have a sense of whether the predicament the long-term care homes found themselves in was a function to some extent of the various

participants, there being too many participants?

CATHERINE BROWN: I would say it slightly differently. I think that there were certainly a lot of different parties involved. And prior to COVID, the health system has always operated a bit in different ways and different silos and partners.

You know, it's an age-old problem. I've worked in healthcare my whole career, and issue of silos has been ever thus. And some communities do it better than others and work more collaboratively.

Long-term care homes, I think, have typically been a -- this is my opinion. They're sort of the end of the line, right? You typically do not return from a long-term care home.

So when you're discharged from home or hospital into a long-term care home, you are then the -- you've moved into that home. You are living the final months and years of your life in that home.

Hospitals respond when residents move in and out for care in a hospital, but there isn't a system of care in the way that we needed it in this moment. And Public Health, as well, have

their own responsibilities, and we weren't set up to operate in a smooth way for this kind of pandemic response.

So do I think there were too many? Not necessarily.

Do I think that there was a lack of clarity about who should be doing what and how quickly they could step up to do that? Yes, there was a lack of clarity.

COMMISSIONER FRANK MARROCCO (CHAIR): And how do you impose that? I mean, I'm not -- you may not be able to answer this question, but are you able to say how one could impose that kind of clarity at least in respect of long-term care homes?

CATHERINE BROWN: That's a tough question. You know, we've learned a lot about how we could do better and how we are doing better. I think putting in place clear rules that allow flexibility but also make clear who is supposed to be doing what and what their responsibility is in that regard.

That said, you know, a home is responsible, for example, for staffing. In normal times, a long-term care home wouldn't go to the

hospital and say "can you give us some staff for a weekend shift?"

And all of those responsibilities were in place and will remain in place going forward. It's "how do you amount that crisis response in a time like this allowing people to remain responsible, putting in place whatever those rules need to be, holding people accountable but also allowing for that flexibility to help each other respond in that moment?"

And I think you've made suggestions in your interim recommendations about staffing and how things might have been differently supported from a staff perspective.

I think, in hindsight, having had those things in place prior to this would have been great, but that wasn't thus. You know, we've known for years in Ontario there's a personal support worker shortage, and we've been working on that but never with the clarity and focus that we have now.

So I think that's all of those things, as a crisis often presents an opportunity, that has happened here. But I'm not sure what the lever is to make those roles and responsibilities clear but still flexible enough that we can help one another

in a moment like this.

COMMISSIONER FRANK MARROCCO (CHAIR): Now, it --

BRIAN POLLARD: May I have a bit of colour here?

CATHERINE BROWN: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

BRIAN POLLARD: Yeah. So the most persistent relationship and existing relationship we would have had here would have been between the long-term care home and their local Public Health unit.

And the reason that that relationship exists is because of what I mentioned before which is outrage of flu. So usually long-term care homes would be interacting with their Public Health units regularly in terms of any incidents and prevalence of flu to determine if there's a need for the home to be in outbreak.

So if you consider that as an existing relationship, many homes would have turned to their Public Health unit, I think, as an initial place to -- you know, for help.

Now, the challenge comes in in that,

you know, the service that many of our Public Health units provide would be advisory as opposed to on the ground on -- you know, in homes kind of helping homes turn a situation around.

And you can just look at IPAC as an example. Certainly one of the big learnings we've taken away from this is that, really, what we were provided in the early days generally, you know, was IPAC advisory services and what homes needed where people could come in and actually help them implement those recommendations.

So above and beyond kind of the silos is also the type of service those silos provide to help with the issue.

And certainly, to Catherine's point, you know, staffing became such a critical issue very, very quickly. But it's not just staffing. It was also the type of staffing you needed.

So, you know, they were looking for -- you know, homes were looking for PSWs as an example. And, you know, hospitals would not naturally -- and I think Dr. Kitts would know this.

You know, hospitals wouldn't naturally have a ton of PSWs just lying around. Hospitals have nurses. So, you know, even getting the mix

right is part of the complexity here in terms of being able to support homes, and the list goes on.

So you have IPAC. You have staffing. You have PPE, et cetera. So in talking about coordinating in the system, there is certainly, I think, room for clarification on who is on first on whatever issue, but also a recognition of we also need to kind of recognize what kind of service and what are the limits to the service that they can provide in dealing with the pandemic.

COMMISSIONER FRANK MARROCCO (CHAIR): It just seems -- it just seems to me -- and I want to get some help with this. Not necessarily your responsibility to help me, but maybe you can.

It would seem to me that the long-term care facility would be most closely connected with the local Medical Officer of Health in the unit where the home is located. And local Medical Officer of Health and the Chief Medical Officer of Health seem to me, under the Health Protection and Promotion Act, to have a lot of power to make orders to give direction.

And so I'm having a little difficulty with the idea that there would be a lack of clarity. I could imagine at the beginning there

would be a lack of clarity because this had never happened before, but there seems to be an institutional structure there for clarity to emerge because they're our decision-makers. And I'm trying to understand whether that's correct or not.

BRIAN POLLARD: From my perspective, Justice Marrocco, nothing you said is incorrect. But I go back to, you know, my point around, you know, "yes, an order has been served. What next?"

And I think -- you know, if we kind of think ahead to kind of, you know, a future state, it's unclear how those Public Health units -- and this is probably what we need to think about collectively.

It's unclear to me how those Public Health units actually help with the implementation and the support. And I'm not talking just about virtual support but the support on the ground to help homes turn their situation around.

And I think that that is where -- you know, that is where a lot of the concerns sit. And so, you know, I'm obviously speaking to my Public Health unit. I'm getting -- you know, "they're going to be declaring outbreak on my home. How do I get out of this?"

And, you know, what homes were looking for was not someone who is just on the phone saying "well, you need to cohort residents, and you need to cohort staff. You need to do A, B, C."

They were actually looking for tangible help and how they do that to match their physical surroundings and some of the very unique issues they were dealing with.

So I just -- you know, not to kind of belabour the point. I just think that, you know, that ability to kind of wrap around the service and the expertise in terms of how you solve the issue and not just be an advisory service, I think, is going to be important here as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

COMMISSIONER ANGELA COKE: So I just want to clarify. So you're saying obviously they have the authority to do certain things but not the implementation and capacity?

BRIAN POLLARD: Yeah. Yes, thank you. That's a succinct way of saying it.

COMMISSIONER ANGELA COKE: Okay.

BRIAN POLLARD: Yeah. I mean, like, let me give you an example. Like, we had -- you

know, I have cross in my desk, you know? We had spoken to a home about IPAC, and I would kind of get on the phone and be like "what does that mean? Does that mean that you actually just spoke to the operator? Did you actually go to the home and see the structure and figure out what they could do or not do?" And invariably, I think it was -- you know, I think it was more of the former.

And that comes back, Commissioner Coke, to your point about implementation and capacity. You know, we didn't have enough of that skill set, you know, to go around.

And you know, then we look at, you know, the homes that the CAF went into. And Catherine mentioned this earlier in passing around leadership: One of the elements we were dependent on is that for pretty much, I think, four of them out of this five were parts of larger chains.

So we were anticipating and expecting that they would have been able to rally corporate resources to help them. But, you know, that didn't occur.

COMMISSIONER ANGELA COKE: Okay. If I could just --

CATHERINE BROWN: If I --

COMMISSIONER FRANK MARROCCO (CHAIR): So --

COMMISSIONER ANGELA COKE: Go ahead. I had a question for Catherine, but go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no, no. Go ahead, Commissioner. I've asked a lot of questions.

COMMISSIONER ANGELA COKE: Okay. No, I'm just following up on some of the comments you made. And, you know, in terms of your ability to provide a very coordinated response, you have inherent challenges pre-COVID in the healthcare system being a very decentralized model.

So I mean, once a crisis hits, you have -- at least from what I can see, even more challenging to sort of rally and move quickly. Is that fair to say, relative to some other jurisdictions who have different models that I think they can probably trigger a response quicker?

CATHERINE BROWN: Yeah. I think making clear -- I'm going to go back, if I can, to Brian's point for a second.

I think that at the start -- and to Justice Marrocco's "shouldn't it have normalized by now," maybe it should have been should have.

Public Health had a very distinct role. The Ministry of Long-Term Care Inspections had a very distinct role with long-term care homes.

They each -- as things started, homes didn't know who to turn to. They didn't know -- to Brian's point, IPAC was something that they should have been doing for regular infection prevention and control, for flu, for C difficile outbreaks, for things like that.

But this kind of IPAC was different for them, and Public Health was giving advice virtually, not necessarily on the ground.

To your earlier question, Justice Marrocco, we see that still that some of the Public Health units are doing a phone audit of what's going on with IPAC as opposed to going into the home and doing an IPAC audit.

So I think clarifying -- to your question, Commissioner Coke, I think, you know, clarifying who was expected to do what and then ensuring they have the capacity to do it.

So I go back to Brian's point on Public Health. Public Health was struggling to do testing; to do contact tracing; you know, IPAC on top of that. And I think it's regularized a little

bit, but there's still a capacity stretch as we've seen with contact tracing and other things. So identifying those roles and responsibilities and clarity of who is responsible.

And I think the system, I will say, has worked better together than I think might have been anticipated. It's actually been quite an extraordinary response in many communities and in many ways.

And Public Health, in many of those communities -- Ottawa as an example; Toronto as an example; there's many others -- has been central to that in driving that response.

The last thing I just wanted to note was -- and I was going to say this earlier. Ontario Health didn't really exist before COVID in any functional way. We were formed early in 2019, but remained 21 separate agencies until December of 2019.

And so we had just started to kind of come together as an organization to look at what Ontario Health would be going forward. And early days in COVID, we were asked to step in and set up those regional tables and help to drive that capacity response on the ground.

And so we were another partner that people were sort of, like, "who are they and where did they come from? Why are they calling us?"

But very quickly, to my earlier comment, people needed some place to go. To your comments, Justice Marrocco and others, like, they needed to know who was responsible and where they could get answers.

And we filled that void in some ways when Public Health and others couldn't get back to them as quickly or weren't able to respond in the way they needed. Public Health would never be the one to give them staffing or help connect them with where they would get that.

So I think structuring that somehow going forward and looking at how we can maintain some of the gains here on how the system has rallied to respond and connect in will be critical.

And that's over to you to do, Commissioners. I put that back to you to figure out.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, go ahead.

COMMISSIONER ANGELA COKE: Sorry, I just want to clarify. In terms of how Ontario

Health has set itself up now and the five regions, the anticipation, then, is, going forward, there's more coordination or collaboration driven through those five regions?

CATHERINE BROWN: Absolutely, yeah.

COMMISSIONER ANGELA COKE: Okay.

CATHERINE BROWN: And so we continue to have ongoing tables, we're just establishing more sort of IMS response structures on the ground, working through those tables and through those regions.

And the Ministry of Health, Ministry of Long-Term Care, we work very closely with both of them on mounting the response to COVID, system capacity building, funding of hospitals, expansion of beds, that kind of thing all through those tables and through Ontario Health regions, yes.

COMMISSIONER ANGELA COKE: And the long-term care folks, a tighter knit as you go forward? You don't fund them. Some things you do for the system but not for long-term care.

CATHERINE BROWN: We don't have a legal relationship with long-term care. We do the placement and waitlisting, and we fund in a flow-through kind of relationship but not in an

oversight relationship. The oversight is the responsibility of the Ministry of Long-Term Care.

But that relationship on the ground is vastly different now, so we are working very closely -- hospitals and OH and our long-term care partners and with the Ministry of Long-Term Care, we're working very closely with them.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Commissioner Kitts?

COMMISSIONER JACK KITTS: Just following along that vein: So as you said, Catherine, in Wave 2, it's much easier to bring these four -- what would -- what I would say pre-COVID would be "four silos" together to work together against a common threat. And it sounds like you're all working collaboratively much more so than in the first wave.

So when you look at the ultimate structure for who is responsible or who is the lead, you have Public Health, you have Ontario Health, you have Ministry of Health, and you have Ministry of Long-Term Care responsible for all the parties that need to be involved on the ground and in the front.

It sounds like if the hospital or

long-term care or primary care -- if anybody has a problem, Ontario Health would be the first place to call; am I correct?

CATHERINE BROWN: That is correct. That is our role. Our role is to bring together the parties, and we will grow more and more into that oversight and functional response role. And this COVID foundation has been an early start for us and how that work will evolve, yeah.

COMMISSIONER JACK KITTS: And you have a regional CEO for Ontario Health, and you have local leaders as well for Ontario Health?

CATHERINE BROWN: So the five regional leads are also the CEOs of the LHINs. So they are our CEO level. There are regional leads, and then there are vice presidents of -- typically home and community care that are working on the long-term care response and that are leading the response locally with other health partners and their teams that are working on that on the ground. And we also rely on the partnerships with hospitals, homes, Public Health, and others to build that capacity, yeah.

COMMISSIONER JACK KITTS: Okay. So regardless of the reporting relationship, if

there's an issue in the local area, Ontario Health is open to take the call and bring things together?

CATHERINE BROWN: Absolutely, yes. And we've done so, yeah.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm still trying to understand the role, then, of the local Medical Officer of Health and the Chief Medical Officer of Health.

I'm still trying to understand why, given that we have 34 health units, we wouldn't work through those 34 units. I believe I'm missing something about -- this seems, to me, to be -- that the decision is that that system isn't working and we needed a new system.

And I just -- if somebody says that, then I'll understand that. But other than that, I can't really appreciate why this wouldn't have devolved to the local unit to deal with the local long-term care home to be responsible for inspecting and --

Because that's where the legal decision-making -- the legal power is to overcome resistance. It seems almost schizophrenic to me. I don't mean to be provocative, but I'm just having

some difficulty understanding what appears to me to be a duplication. Can you help me with that at all, or am I beyond help as far as that goes?

CATHERINE BROWN: Not beyond help. I would say I have learned differently in this experience about the challenges of the autonomous role of the Public Health units. And I see that as --

I understand the value of that and why that decision-making remains distinct and cannot be directed and why that needs to be, and that's very clear to me.

But I have seen that there was a challenge, as you described, in the capacity to be able to take on that responsibility. I don't say it in a critical way. I think some of those smaller Public Health units were overwhelmed with the amount of demand.

And so to Brian's comment about the relationship with long-term care homes, certainly they had that ability. Did they have that capacity?

So I see what you're saying, and I understand that if that is the way of the future, that those entities would need to be strengthened

such that they could oversee a response like this. Then I think there's a question to them about did they have what they needed to do that or what -- and I can't answer that, "what happened that that didn't evolve in the way that you've just described?"

It might have been capacity all along or other things. I don't know. But certainly capacity was part of it. There was just too much going on.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, I think we've --

CATHERINE BROWN: Can I just -- I feel I just have to add this, sorry, because I'm mindful.

I think that the Public Health units, for the most part, have done extraordinary things in their response to this pandemic. And there have been some challenges for all of us in how we've mounted the response.

And I'll go back to the example of Ottawa. We could not have done what we did in Ottawa without the Public Health unit there. They have been extraordinary, and they are an example of how that can function and should function, and

there are many others like that.

So I don't want to leave the impression that Public Health did not respond in a full way, and that includes the chief and the Associate Medical Officer of Health and how they guided that response. It has been nothing short of extraordinary in most communities if not all communities across the province in some degree.

BRIAN POLLARD: Agreed, Catherine. Agreed. And very responsive.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I accept that, but then that would seem -- is that the way to organize this, then? If you have these proper-functioning local health units and all doing their job well and discharging their responsibilities, then wouldn't that be the way, then, to bring order in this kind of a crisis?

It should emanate from them. They're in the -- I'm not an apologist for the current system, not in the slightest. I'm just posing the question. They're already there. They're functioning very well. They have the legal authority they need. Why duplicate it?

That's the problem I bump up against. If they're not functioning properly and it was

necessary to supplement what went on, then I think that speaks to, among other things, a structural issue.

And as you said, Ms. Brown, you know, it's one thing that -- maybe, perhaps, they were overwhelmed. I don't know. But I'm having trouble understanding why, if everything's okay, we don't reinforce what's there. If it's not okay, I understand why you have to change it.

CATHERINE BROWN: So maybe I'll offer a personal opinion in -- around the hospital system that might help to illuminate.

So the ministry has oversight of the hospitals. If a hospital is not undertaking its responsibilities in accordance with how the province wishes to see them do that, they have numerous levers in their tool kit to be able to say "we're going to do the following funding. We're going to do the following things."

When they direct the hospital to do something, hospitals have to respond, and they have to respond in the way in which they're asked to do it by the province. And they have flexibility in many ways in how they do that, but they can't do it in a different way than the province requires them

to do so.

And so in my mind -- and if they do, they can put a supervisor in. They can take over the responsibilities of the hospital until it's stabilized. In my mind, the structure of Public Health, in order to ensure that response is even -- and "consistent" is too strong. It doesn't have to be cookie-cutter. It has to be reliably similar across the Public Health units just as it has to be reliably similar across the hospitals.

So the structural piece of that needs to allow for that while balancing the autonomy of the Public Health officers, if that makes sense.

COMMISSIONER FRANK MARROCCO (CHAIR): Right. I understand what you said.

CATHERINE BROWN: Okay. Now I'm blushing. Yeah, sure. I'm trying to be respectful of the current structure, and I see its value. I do.

I think there just has to be -- the balance in how that is operationalized needs to be considered in a response like this in order to enable it to be relied upon in a crisis.

And that -- again, that is not to say Public Health has been extraordinary. They have

been extraordinary in their response to this pandemic.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we've finally stopped asking questions for now.

Thank you very much for the presentation, and thank you for the answers to the questions which I think took you far beyond the --

CATHERINE BROWN: Well beyond any --

COMMISSIONER FRANK MARROCCO (CHAIR): -- the Canadian Armed Forces and five long-term care facilities. Thank you for constructive responses to the questions.

And Mr. Mathai is here, so I don't have to as you to tell him we may be back.

SUNIL MATHAI: Thank you, Justice Marrocco.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Thank you.

CATHERINE BROWN: Thank you, Commissioners. Thank you, Justice Marrocco.

SUNIL MATHAI: Have a good day, everybody.

CATHERINE BROWN: Thank you. Bye now.

COMMISSIONER JACK KITTS: Thank you

both.

COMMISSIONER ANGELA COKE: Thank you.

-- PROCEEDINGS CONCLUDED AT 10:05 A.M. --

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, Chartered Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination 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 13th day of November, 2020.

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CHARTERED SHORTHAND REPORTER

C L A R I F I C A T I O N S:

Throughout the document "recognizance" should be "reconnaissance."

Page 38, line 4: “may I have a bit colour here” should be “Maybe I can add a bit of colour.”

Page 38, line 16: ”outrage” should be “outbreak.”

Page 39 line 18: “incidents” should be “incidence.

WORD INDEX