Long Term Care Covid-19 Commission Mtg.

Meeting with Dr. Eileen de Villa, Medical Officer of Health,
on Monday, October 26, 2020

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 26th day of October, 2020, 3:30 p.m. to 4:54 p.m.

BEFORE:

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

PRESENTERS:

Dr. Eileen de Villa, Medical Officer of Health for the City of Toronto

Dr. Michael Finkelstein, Associate Medical Officer of Health and Acting Director, Communicable Disease Control, Toronto Public Health at City of Toronto

Dr. Howard Shapiro, Associate Medical Officer of Health and Director, Healthy Environments, Toronto Public Health at City of Toronto

Dr. Elizabeth Rea, Associate Medical Officer of Health at City of Toronto

Persia Etemadi, Lawyer, City of Toronto

Eric Thomson, Senior Policy and Strategic Issues Advisor, Toronto Public Health, City of Toronto

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Jennifer King, Gowling WLG (Canada) LLP

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

I N D E X

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

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 59

INDEX OF ADVISEMENTS

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

INDEX OF REFUSALS

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

-- Upon commencing at 3:30 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm Frank Marrocco, and that's Dr. Jack Kitts who's on the screen, the other commissioner. Angela Coke won't be with us because of a family emergency.

DR. EILEEN DE VILLA: Oh, I'm sorry to hear that.

COMMISSIONER FRANK MARROCCO (CHAIR): And so we will try to carry on in her absence. Well, I think, Doctors, you know, it's fairly clear we wanted to produce some interim recommendations, and we did that on Friday.

And now, we're turning our attention to, I guess, more deep-rooted problems, more how we got into the situation we're in. We're searching for some meaningful recommendations to make on a somewhat more long-term basis.

We haven't ruled out the possibility of making another interim report, but right now, we're just trying to understand the environment that we're in in more detail. So we really do appreciate you taking the time to be with us.

There is a transcript. We've tended to ask -- to interrupt and ask questions as we go along, if that's okay, because it's hard -- we find

it easier to do that than to go back and try to recollect what was being said and so on. So if you don't mind, we would continue to do that.

DR. EILEEN DE VILLA: I think that should be perfectly fine. I may, of course, ask one of my colleagues who's joining me --

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

DR. EILEEN DE VILLA: -- or joining all of us here, as they may be better positioned to answer some of those questions depending on, you know, the nature of the question.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. That's fine.

DR. EILEEN DE VILLA: If that's okay?

COMMISSIONER FRANK MARROCCO (CHAIR): It certainly is. And we're ready when -- we're ready when you are.

DR. EILEEN DE VILLA: Okay. So thank you. And perhaps what I'll do, is I am joined by a few colleagues. That might be a reasonable way to start. I'll introduce myself and then perhaps introduce my colleagues, and then we can launch into the presentation which is being shared on the screen.

So to all of you, members of the Commission and all those who are supporting its important work, one, thank you for having us. I'm Dr. Eileen de Villa. I'm the Medical Officer of Health for the City of Toronto.

And I'm joined today, if I've got things right, I can see that my colleagues, Associate Medical Officer of Health colleague, Dr. Howard Shapiro and Dr. Elizabeth Rea are with us on the Zoom conference this afternoon.

We're also joined by our legal counsel, Persia Etemadi. And as well, our colleague, Eric Thomson, from Toronto Public Health, who is very kindly sharing his screen and driving the slides.

So thank you, Eric, for that.

So with that, we may be joined, and a little bit later or somewhere in the midst of this presentation by another Associate Medical Officer of Health colleague of ours, Dr. Michael Finkelstein. I don't think -- I don't see him on the list right now, but he may be joining us. I know that there were some challenges in respect of scheduling, so he may be joining us in a little while.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I don't see him on the list either. Well, that's fine.

DR. EILEEN DE VILLA: Okay. So if we see an extra name and it looks like a Michael Finkelstein, you'll know who that is.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: All right. So with that, perhaps let's launch into this presentation that we have in front of you, and let's move to our first formal or substantive slide.

So just a little bit on Toronto Public Health. It is the largest local Public Health agency in Canada. As you can see, you've got to the right of this slide, a map of the City of Toronto, fairly sizable jurisdiction. We have roughly 2,000 staff working under the umbrella that is Toronto Public Health, and we do report to the Board of Health for the City of Toronto.

Very high level, we do serve a population of roughly 3 million residents that are distributed over the 140 neighbourhoods that comprise the City of Toronto. And those 140

neighbourhoods are as depicted on that map just to the right of that slide.

Thinking now to the next slide, turning to the role of Toronto Public Health in respect of long-term care, just by way of context, you know, there are almost a hundred long-term care homes in Toronto, 89 to be precise. And when we think about what Toronto Public Health does in regular times -- here on the slide, it's listed as normal times -- you know, let's call it pre-COVID times -- we had roughly 20 to 30 full-time equivalents that are working in support of long-term care homes and other congregate settings; amongst them, retirement homes, childcare centres, et cetera.

So we do have, you know, a number of staff that -- whose work routinely supports the work of Public Health and discharges our responsibilities as the local Public Health unit in respect of our colleagues in the long-term care sector.

But when COVID-19 came along, we clearly needed to change that, and as you can see here at the bottom of this slide, we currently have roughly about 200 staff assigned to what we're calling our COVID-19 long-term care home/retirement

home team. So this just gives you a little bit of a flavour as to what is done in regular times, if you will, pre-COVID times, and that which is occurring now, given that we find ourselves in the midst of the COVID-19 pandemic.

Turning to the next slide, just a very high-level summary around what is the role of Public Health and long-term care. And, you know, I know that -- you know, you, members of the Commission, have been meeting, you know, for a number of months now, weeks. And you probably have heard from a number of people, and I know you have -- local Public Health colleagues of ours from around the Province. But I do think it is worth repeating that which is the role of Public Health as articulated by the Ontario Public Health standards.

And what the standards indicate is that we are to provide things like case management and support during outbreaks, case management, outbreak management support for all institutional outbreaks. This includes enteric outbreaks, respiratory outbreaks, whether it's for COVID-19 or nonCOVID-19 illnesses like influenza. So that certainly is one aspect of our work.

As articulated on the slide, we are also meant to assist homes with their -- helping them to discharge their requirements, you know, providing assistance to them as they seek to discharge their requirements under regulation to implement an infection prevention and control program for their respective site, facility, or home.

And certainly we also have a role in respect of inspecting and managing outbreaks within the context of long-term care settings that are related to food safety.

So very-high level summary, we're happy to discuss further as need be. But this just gives you an overview of that which is the role of Public Health in long-term care. And I suspect you've heard this from other colleagues of ours from around the Province.

Turning to the next slide, there are --

COMMISSIONER JACK KITTS: Dr. De Villa, can I just --

DR. EILEEN DE VILLA: Please.

COMMISSIONER JACK KITTS: Can you go back to the previous slide?

DR. EILEEN DE VILLA: M-hm.

COMMISSIONER JACK KITTS: It seems there's 89 homes. This is your Public Health accountability. You have 20 to 30 FTEs in normal or pre-COVID times. Is that enough to carry out these duties? Is that enough resources?

DR. EILEEN DE VILLA: Well, you know, I think there are always challenges in respect of resourcing in Public Health, and, certainly, last year would have been a particular challenge. You may have been familiar with the fact that there were some -- there was an initiative under -- that came out with the provincial budget in 2019.

So, certainly, resources are always a challenge, and I would suggest to you that, you know, what's interesting, and you'll see this in the context of the presentation, is that that which is needed is a little bit variable, right? Some homes actually -- you know, the level of support varies from home to home.

So I think that when we look at it in its ideal sense, to the extent that we're actually able to ensure -- and when I say "we," I mean we as the large system -- to the extent that we're able to ensure that we are all appropriately resourced to do our respective parts, I do think that that's

what's likely to give the most success. And, you know, it's hard to look at one piece in isolation, right?

The Ministry of Long-Term Care needs to be appropriately empowered and resourced. The long-term care sector needs to be, and each individual home needs to be appropriately empowered and resourced. And each individual Public Health unit similarly needs to be effectively empowered and resourced.

So it's hard to say what the right amount is without looking at it in the broad context. So -- but I do think that resources are always a challenge in our current environment; I think that's fair to say.

COMMISSIONER JACK KITTS: Okay. Thank you.

DR. EILEEN DE VILLA: So turning now to the next slide, clearly, there are roles for Public Health. And as we were just getting at through that question, there are certainly requirements of long-term care homes themselves and of the Ministry of Long-Term Care. This, I'm sure, is not a surprise or unbeknownst to members of the Commission.

Long-term care homes themselves, through the Long-Term Care Homes Act, have obligations to implement in law an infection prevention and control program that includes the elements described here, whether it's designated staff and information gathering methodology, surveillance, outbreak management and communication.

And similarly, the Ministry of Long-Term Care, also through the Act, has requirements and obligations to actually inspect the long-term care homes to ensure that the -- that these infection prevention and control programs are actually appropriately in place in the various homes across the Province.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, if I can interrupt for a minute, does --

DR. EILEEN DE VILLA: Please.

COMMISSIONER FRANK MARROCCO (CHAIR): Does Toronto do its own inspections of municipal homes for which it's responsible?

DR. EILEEN DE VILLA: That still falls to the Ministry of Long-Term Care. We do inspections in respect of food safety, to be clear.

COMMISSIONER FRANK MARROCCO (CHAIR):

Right.

DR. EILEEN DE VILLA: But with respect to the other aspects, that is a Ministry of Long-Term Care responsibility and obligation.

COMMISSIONER FRANK MARROCCO (CHAIR): Even though it's a municipal home?

DR. EILEEN DE VILLA: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: Shall we proceed?

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, yes. Please.

DR. EILEEN DE VILLA: Okay. So on to the next slide. Just to give you a sense, and very high-level timeline, clearly not with lots of detail. We had our first confirmed case of COVID-19 in Toronto on the 25th of January. And throughout the month of February, our efforts here at Toronto Public Health were focused significantly on reducing community spread through very, very active case and contact management.

We were following up all of the cases as they were coming through recognizing that to the extent that we were able to really, you know, jump on and effectively do case and contact management

as the cases were being identified, the notion was to reduce community spread. And, of course, that has benefits across the entire community including for long-term care settings.

We had our first case of long-term care in early March, and by March 15th, there was the first outbreak declared within the context of a long-term care home in Toronto.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, the first case is in -- is January 25th; that's the first confirmed case.

DR. EILEEN DE VILLA: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): When would you say that Toronto Public Health, the light went on that this -- there was going -- there could be problems associated with this pandemic and associated with long-term care facilities?

DR. EILEEN DE VILLA: You know, thinking about this issue and having had the opportunity to reflect on COVID-19 and the pandemic here in the City of Toronto and what our thinking was, I mean, truthfully, the minute we recognized that this was a disease that was spread through the respiratory route, we knew that there was the likelihood of challenge within the context of

long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: And that's just based on our experience from respiratory outbreaks in, if you will, the regular time, the pre-COVID time within the context of long-term care settings.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you place that on -- you know, if January 25th is the first confirmed case, can you sort of place that realization on that timeline somehow?

DR. EILEEN DE VILLA: You know, I would say it was shortly -- you know, shortly after that, when we -- you know, as -- so the interesting thing is that you might recall that the virus was first sort of identified formally -- I believe it was January the 10th, right, sequenced on January the 10th as a virus; first confirmed case here in Toronto by the 25th. And we were still learning quite a bit at that stage around COVID-19 being a new virus, you know, previously unbeknownst to us. And when I say "us," I mean the entire global community.

So probably by, you know, February, you're starting to realize, look, you have a

respiratory disease. The first few days are often caught up in the, you know, the first case. And there's all the activity around managing that first case and making sure that all the policies and procedures are being followed appropriately.

I think shortly thereafter, as we're starting to really understand more and more, not only from our own experience locally, but from that which was being discovered around the world, that we had a respiratory disease on our hands that, you know, you have to think naturally about long-term care, knowing what we know about them and their challenges during cold and flu or respiratory virus season.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: So that's -- those are the highlights, really, in respect of the brief history and a very early timeline around COVID-19.

Turning to the next slide, you'll see here just a depiction of, you know, the cases within the context of long-term care here in the City of Toronto. This depicts the cases through to October 23rd of this year. And as you can see, as

marked on the slide, there's a total of 4,327 up until that date here within the context of long-term care in Toronto.

The next slide now gives you the perspective over time on long-term care outbreaks in the City of Toronto. And, you know, up until October 24th, that's 152 in total, some of which are clearly marked here in yellow as outbreaks that have closed. And others, as you can see towards the right-hand side of the slide because they're closer and more proximal in terms of time, are ongoing and active, yeah, you know, as of, you know, right now.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: I won't change the -- you seem to be looking at it closely, so I'll leave it for now. I won't advance until you're ready.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. I'm okay.

Dr. Kitts?

COMMISSIONER JACK KITTS: Yeah, I'm fine. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

DR. EILEEN DE VILLA: And one more slide in respect of outbreaks, just giving you a little bit of a closer look as to outbreaks that are, you know, within the last few weeks: Here you have them depicted from September the 13th through to October the 23rd.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: So turning to the next slide, just to give you a sense as to, you know, COVID-19 and long-term care specifically in Toronto. So we've talked about how there are almost a hundred -- or 89 long-term care homes within the City of Toronto. And the homes are extremely variable in many, many respects.

First and foremost, just looking at the size, right, as indicated here on the slide, the range in size is large, when we look at the various homes in Toronto, some as small as 28 beds, and some as large as 400 beds. And this is just one dimension of characteristic of different long-term care homes.

And I think it's fair to say that the experiences, when it comes to outbreaks, do vary

quite considerably across the homes. And this is based on a wide variety of different unique circumstances that the homes have and, of course, their characteristics.

As I mentioned, I am joined here on this Zoom conference by my colleagues, Dr. Howard Shapiro and Dr. Elizabeth Rea. They are a little closer, if you will, to the action happening within the context of long-term care homes. And if you're interested in hearing some specific examples as to how outbreaks, you know, vary and the outbreak experiences vary from home to home, I would ask them -- or I would ask you to direct questions to them to give you a flavour or a sense as to, you know, the experiences and how they can vary given the unique circumstances and characteristics of the various homes around the city. So I'm not sure if you'd like to do that now or perhaps save that for later?

COMMISSIONER JACK KITTS: Yeah, we hear that outbreaks can be as small as one or two patients or residents or staff. And an outbreak with -- involving, you know, dozens if not more, they're both called an outbreak.

Do you categorize outbreaks -- because

I think in long-term care it went from one or two to, I don't know, almost a hundred with a large number of deaths. Are they -- are they considered different, or do you treat them differently?

DR. EILEEN DE VILLA: Well, I think there are certainly different methods that are used depending on the nature of the outbreak. And clearly, the size is one of those elements. But, you know, you're right. Once you've reached the technical definition of an outbreak, you're on the outbreak list.

The issue around outbreaks is -- you know, and the declaration of an outbreak, is really meant to bring the resources to bear in order to address those circumstances.

But -- and what those resources look like, what's required in order to bring that outbreak under control will vary from setting to setting.

I don't know, Elizabeth, whether there's further comment you would like to add to that being a little bit closer to the circumstances than I am.

DR. ELIZABETH REA: Sure. I guess I -- I -- there's a real distinction to make, I think,

between a single staff case. Now, at a time when everybody's using universal masking, there's been a ton of effort to bring IPAC practices up to -- you know, up to standard.

So a single staff case in those circumstances, with luck, I mean, there's no guarantees, but the goal, obviously, is to contain it at that one staff case. So it's -- essentially, it's an exposure with no transmission. And we are seeing more of that situation this fall than we did in the spring by a long shot.

So there's a big distinction between that initial case and being able to contain it from that initial exposure to there actually being transmission within the home.

Eileen was talking about the control measures vary by the size, and that's true, but it's -- the tools are the same, right? Even if you have that one case, you're still doing -- depending on what the exposure looked like, you'd still be doing testing and isolation and droplet contact precautions perhaps on a -- on a smaller scale with identified -- or sometimes you can identify a discrete set of contacts rather than, boom, putting an entire home into lockdown. But the tools are

the same. Whether it's one case or 50, the tools are the same.

COMMISSIONER JACK KITTS: Okay. And did you say that so far in the fall, compared to Wave 1, you're seeing a lot more -- I guess you're seeing a lot more single outbreaks that are contained better or more quickly; is that what you said?

DR. ELIZABETH REA: That's true with the caveat that, you know, we're only a number of weeks into the second wave, right? So if there was an exposure 13 days ago, like, a single staff case 13 days ago, they haven't hit their 14-day ability to really confidently declare it over yet. So that's my caveat. But broadly, yes, I think there's more successful containment at a single staff case.

COMMISSIONER JACK KITTS: And I know this is probably not a fair question, but do you feel that sort of forecast that we're doing much better than we did in Wave 1, so -- with the long-term care homes?

DR. ELIZABETH REA: I mean, what happens in long-term care is a reflection of what happens in the community, right? It's not possible

to somehow isolate them, so there's a lot of exposures happening.

You know, Eileen put up data about the number of actual outbreaks where there is transmission in the home. But right now, we're tracking, I think it's 69 sites today that have at least one case. So there's a lot of long-term care homes that are grappling with at least one case --

COMMISSIONER JACK KITTS: Right.

DR. EILEEN DE VILLA: -- and all of those containment measures that need to go into place.

COMMISSIONER JACK KITTS: And are you confident that we have the containment measures? Are we equipped to do that this time?

DR. ELIZABETH REA: We're kind of leaping ahead to some of things that Eileen is going to talk about.

COMMISSIONER JACK KITTS: Okay.

DR. ELIZABETH REA: I can dive in, but --

COMMISSIONER JACK KITTS: I can wait.

DR. ELIZABETH REA: -- Eileen, what would you like to do?

DR. EILEEN DE VILLA: Sure. You know

what, Elizabeth? I think, you know, if it's fruitful, I don't want to disrupt the conversation. We can always hit them again with the same, right? I think that if the --

DR. ELIZABETH REA: Okay.

DR. EILEEN DE VILLA: -- if the message bears repeating, we're going to say it again.

COMMISSIONER FRANK MARROCCO (CHAIR): We're a little slow. So sometimes you have to repeat it over and over.

DR. EILEEN DE VILLA: Oh, that was not the implication by any stretch.

COMMISSIONER FRANK MARROCCO (CHAIR): I didn't take it --

DR. EILEEN DE VILLA: But, you know, I do find that I, myself, receive the message better when it's said once or twice or maybe even seven times.

COMMISSIONER JACK KITTS: I'm with Frank. You can hit us again.

DR. ELIZABETH REA: Okay. So --

COMMISSIONER FRANK MARROCCO (CHAIR): So, you know, just if it's convenient to answer, if you think it's better answered when Dr. de Villa gets to the slide, that's fine. We'll wait 'til

she gets there.

DR. ELIZABETH REA: Okay. Go ahead, Eileen, unless you want me to talk about the examples.

DR. EILEEN DE VILLA: Well, you know what? I actually think that there's a lot of richness in the examples. You know, that may actually help to --

DR. ELIZABETH REA: Okay.

DR. EILEEN DE VILLA: -- illustrate some of the points that are going to be made further on in the presentation.

DR. ELIZABETH REA: Okay. All right.

DR. EILEEN DE VILLA: Do go on. Thanks, Elizabeth.

DR. ELIZABETH REA: Okay. So I had thought to talk about two examples that are both significant outbreaks, and they both happened in older homes with multi-bed and shared rooms: so one in the spring, and one that's just wrapping up now.

So the first one is kind of a -- one of the classic tragedies from the spring. So this was a medium-sized long-term care home about 160 beds. They wound up with close to a hundred percent of

their residents getting COVID. They had 55 deaths; they had at least 67 staff cases, and one staff death. And it took two-and-a-half months before that outbreak could be declared over.

So in addition to the difficulties with the building itself, it was early in the pandemic. We really didn't know very much yet about transmission dynamics and control measures. This happened at a time when there was very limited testing. There were terrible PPE shortages, as you'll remember. They also lost a huge whack of their staff when the work-in-one-facility policy came out.

So they lost -- I don't -- I know this is going in a transcript, but don't quote me on the number. They lost something like a third of their staff when that policy came out.

They had internally no IPAC, nobody with IPAC training. So they had a designated person, but not a dedicated person, if that makes sense, or a trained person. And they had a really minimal leadership layer at the home.

They also had no physician care on site during this outbreak or at least the bulk of the outbreak, and as the outbreak got worse and worse,

they not only had an increasing number of staff cases, they had staff who were increasingly afraid to come to work.

So they wound -- they're one of the places that wound up in this terrible negative spiral and a staffing collapse. And at that time, I mean, this was one of the early outbreaks. There was no clear external support infrastructure, particularly for, you know, concrete, on-the-ground resources and help. And this was one of the sites that the Armed Forces actually came in.

So --

COMMISSIONER FRANK MARROCCO (CHAIR): Can you just -- can I just ask, how is it -- do you have any sense of how it is that there's an IPAC shortage or a shortage of PPE?

DR. ELIZABETH REA: You know what? I cannot speak to PPE supply chains. I can speak a little bit more to IPAC resources. There's basic infection control training that's pretty widely available. You do have to fork out money to send your staff to that training or pay more for someone who's got that training.

If you're looking for anything beyond the pretty basic level, it takes a good three years

to train up an infection control practitioner. You cannot invent them out of thin air.

COMMISSIONER FRANK MARROCCO (CHAIR): But I understand that.

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): But in -- even in the Toronto homes, I mean, there are problems with the flu and that sort of thing --

DR. ELIZABETH REA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- year after year.

DR. ELIZABETH REA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): It's not as if it's -- it's a new problem.

DR. ELIZABETH REA: I hear you. But, I mean, our -- my experience -- and I have to say I was not working with the long-term care home sector until this all started. I normally work with tuberculosis. But so this was -- it was a huge eye-opener for me.

COMMISSIONER FRANK MARROCCO (CHAIR): Actually, Ms. Rea, I wasn't doing anything with long-term care homes either before this started.

DR. ELIZABETH REA: Okay. So but my experience has been that in most homes, the

designated infection control person is a nurse where this is tagged onto their duties. They don't have any specific training at all in infection control. They're just kind of carrying the baton; that's it. And sometimes, or in a lot of places, it's not even the designated infection control contact. That baton actually gets handed randomly to whichever RN is charge nurse that shift.

So it's -- it is hard to understate how widely that lack of infection control expertise and dedicated time is in the sector.

COMMISSIONER FRANK MARROCCO (CHAIR): It's interesting, though, because it's the problem -- you would think if you're in a sector where there's a problem that is recurring, which is curbing the spread of infections, that this is something people would know about, if nothing else, simply by experience.

DR. ELIZABETH REA: I hear you.

COMMISSIONER FRANK MARROCCO (CHAIR): But not that I'm -- I'm not disagreeing --

DR. ELIZABETH REA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm just commenting.

DR. ELIZABETH REA: Yeah. Oh, no, I

hear you.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

DR. ELIZABETH REA: It's been a well-recognized problem.

COMMISSIONER FRANK MARROCCO (CHAIR): Did the Toronto homes have the same problem that the municipal -- the City of Toronto homes.

DR. ELIZABETH REA: So that actually brings up an interesting twist on this. So homes that are part of a group -- so the City -- the City of Toronto Long-Term Care Division runs, operates, ten homes. So in effect, it's like a little not-for-profit City-run corporation.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

DR. ELIZABETH REA: Right? And then there's the big for-profit corporations like Sienna or Extendicare. All of those groups do have some central resources, and they have had central infection control resources. So, you know, Sienna head office may have an infection control specialist or advisor.

The difference is them actually being on site and running an actual infection control

program as opposed to being somebody that you could call up or, you know, get some input for a policy and procedure.

But in the granular, actually operating things on the ground, very few homes have somebody who actually has dedicated hours to do that as opposed to it being kind of tagged on or specific training.

The City of Toronto, I mean, you brought up the issue about what's the interaction between Toronto Public Health and the City-run homes. They -- we -- yes, we're within the same City government, but -- but they're a separate division, and we interact with them often to the same -- in the same relationship that we would with other -- any other home.

COMMISSIONER FRANK MARROCCO (CHAIR): But you can make orders affecting them and any other home, right?

DR. ELIZABETH REA: And any other home, yeah. M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thanks.

DR. EILEEN DE VILLA: I think there were some questions -- sorry -- that were asked

around PPE. And again, not really our area of expertise, but as I recall at the time, Elizabeth is quite right; there were a number of shortages and challenges with access to personal protective equipment.

And, you know, to the best of my knowledge, part of that was due to places that were a little ahead of us in respect of their own outbreaks, so personal protective equipment supplies were already drawn quite heavily upon; and I think that was a challenge, not just for long-term care homes, but frankly, for many other sectors, for anyone who was really trying to access personal protective equipment at that time.

And as well, my understanding is that a number of those -- a number of the manufacturing sites for personal protective equipment were actually within the Province in China that was locked down by the end of January. So there were some challenges with respect to manufacturing the equipment in the first place.

DR. ELIZABETH REA: I want to talk about the second example from the fall with some -- to make some points about, you know, how are we doing now.

So the second home I want to talk about is a little bit smaller, about a hundred beds. And they're just -- they're just coming to a close of their outbreak now. So they've had 57 residents, 12 deaths; 26 staff cases, and no deaths. And that outbreak is coming to a close, helpfully, in about a six-week span.

And very much like the first home, again, it's an older home, crowded, cramped, shared rooms, and they also had fairly rapid spread on the two floors that had the initial exposure, so those initial staff cases.

But they've been able to protect the third floor entirely through this time, no cases at all on that remaining floor. Their attack rate, by contrast, is running just over 50 percent instead of almost a hundred percent, and the death rate is way lower.

Their infection control prep was better. I mean, they absolutely benefitted from, you know, the huge increase in knowledge and experience over that gap. But they've also had extensive on-site IPAC support from the hospital linked with them as well as the IPAC extender teams from the Toronto Central LHIN.

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

DR. ELIZABETH REA: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): That was -- that was one of our recommendations. And in your experience, do you find that a useful thing to do in an emergency? Because if they don't have the expertise --

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- really, the only place -- it seemed to us, the only place you can find it --

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- instantly is in a hospital setting.

DR. ELIZABETH REA: Yeah. So a couple of things: One, absolutely it's useful. I mean, for one thing, even with the -- with good infection control baseline training, when you actually press the big red button and say, Okay, deploy; everybody is in droplet contact precautions. That's a lot to actually operationalize with frontline staff in a hurry. So it does need, you know, or it certainly benefits from having a bunch of reinforcement and

coaching as you go to help staff actually get it operationalized tightly.

The other thing that always helps a lot is having a second pair of eyes and a second pair of expert eyes. It's like that -- it's that thing about the difference between, you know, a clinical nurse who's done some extra training in infection control, the difference between that, and a fully trained experienced infection control practitioner. So having that -- you know, another set of eyes is incredibly valuable.

So, yes, I think part of where -- where this -- your recommendations are kind of intersecting with the hub-and-spoke model for infection control support that the Province announced a few weeks ago, and with funding, which I think is really important.

It's -- you know, hospitals have been doing this from their existing infection control staff. It's not at all sustainable for them to do it without a set, you know, separate body of staff to do that.

COMMISSIONER JACK KITTS: Can I just ask that -- we've heard about the hub-and-spoke model.

DR. ELIZABETH REA: Yeah.

COMMISSIONER JACK KITTS: Is -- are the infectious disease specialists only found in hospitals? Are they -- is that the hub?

DR. ELIZABETH REA: No. I mean, there are infection control specialists or infectious disease specialists who practice in the community as well. But if you're doing infection control, that -- that's a facility issue, right?

COMMISSIONER JACK KITTS: Right.

DR. ELIZABETH REA: It's not an office practice piece to be a consultant in infection control. So people with infection control and outbreak control experience, you're going to find those in hospital IPAC programs and Public Health.

But, yeah, if you're looking at the hub-and-spoke model, it's hospitals and Public Health. It's not community practitioners per se.

COMMISSIONER JACK KITTS: So the hub in some areas could be Public Health; in others, it could be a hospital? That's --

DR. ELIZABETH REA: Yeah.

COMMISSIONER JACK KITTS: Okay.

DR. ELIZABETH REA: I think the key is having an additional funding stream to -- I mean,

to support that big piece of not just training, but site-specific application of infection control issues.

COMMISSIONER JACK KITTS: Okay.

DR. EILEEN DE VILLA: I think that gets to the point of adequate resourcing for --

DR. ELIZABETH REA: Yeah.

DR. EILEEN DE VILLA: -- for --

DR. ELIZABETH REA: For sure.

DR. EILEEN DE VILLA: -- you know, the supports that are needed.

DR. ELIZABETH REA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): But -- and I understand. I don't dispute that for ten seconds. But in an emergency, you know, January 25th or whatever you've got your first case, but very shortly after that, maybe a month later, you have a real problem.

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): But -- well, the first case was a real problem, but it's on a much larger scale. In that circumstance, you don't have really a lot of time --

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- to either collaborate or arrange for funding. I mean, funding has to be sorted out, but --

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- you've got the immediate problem. I -- what are your alternatives -- not your alternatives, but what are the alternatives apart from the local hospitals in the local -- in the area -- in the catchment areas that -- of the nursing --

DR. ELIZABETH REA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- or the long-term care home.

DR. ELIZABETH REA: Yeah. A part --

COMMISSIONER FRANK MARROCCO (CHAIR): It just seemed so urgent to me at that moment.

DR. ELIZABETH REA: Yeah, and it was. Like, really, it was urgent.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

DR. ELIZABETH REA: So, yeah, I mean, if you were going to ransack all available people with infection control and outbreak control experience, you'd be looking to ransack hospitals as one of the key pieces, Public Health units, absolutely. But again, the scale difference is the

piece that's not -- was -- isn't -- wasn't manageable within the existing resource. I mean, across the health sector, this has been the issue. COVID is a scale-up challenge across the board. It was absolutely a scale-up challenge for Public Health.

So you can raid Public Health. You can raid the hospitals. To a limited extent, you can raid the corporate -- long-term care corporations. But, again, you know, I can't speak for Sienna or Extendicare or whatever, but they may -- in their whole corporate group, they may only have one infection control specialist to pull on, right, to cover however many homes.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

DR. ELIZABETH REA: So it's a limited group of people who, off the shelf, have expertise and experience.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. ELIZABETH REA: Okay. Back to my example about going somewhat better in the fall, so that was the infection control stuff.

The other piece is they were way better

able to cope with the staffing issues. They were -- they were on the staffing danger, if you like, right from the beginning and staffing up through corporate, I believe this home was part of a group, so they were able to get immediate HR backup from their corporate centre to hire more staff. They were able to pull on agency contracts that they already had lined up before the outbreak hit.

They did have some additional clinical support in particular from the hospital that they were linked with, and their physicians were on site from the beginning around clinical care.

So even though they had a severe outbreak, there was enough mitigation in place that the clinical outcomes have been way better. Yes, it's a significant outbreak, but it didn't -- it hasn't spread to the extent that it would have in the spring.

And I think most importantly, they didn't have a staffing collapse. And if this outbreak had happened in April, they would have been one of the homes that collapsed. They absolutely would have.

So to that extent, I think we are doing

much better with mitigating. And having said that, they still had a significant outbreak with multiple resident deaths.

And part of my point there is, you cannot -- the best infection control in the world, the best staffing in the world, it's not possible to overcome the problems of crowded older homes. It's just not.

DR. EILEEN DE VILLA: I think you're on mute.

COMMISSIONER JACK KITTS: Thank you. I think that was going to be my question. Is both were older homes.

DR. ELIZABETH REA: Yeah.

COMMISSIONER JACK KITTS: We've heard that IPAC measures are very difficult to --

DR. ELIZABETH REA: Yes.

COMMISSIONER JACK KITTS: -- to employ in older homes. So neither were -- had any advantage over the other in terms of isolating and cohorting patients; is that correct?

DR. ELIZABETH REA: Well, in terms of the basic issue that when you -- you know, if there's one person in the room that has COVID, they have almost certainly spread it to their roommates.

COMMISSIONER JACK KITTS: Yeah.

DR. ELIZABETH REA: You know, there's no way to get around that. The same issue applies in hospitals, actually, wardrooms and hospitals.

COMMISSIONER JACK KITTS: Yes.

DR. ELIZABETH REA: So I guess one of the -- there's a couple of -- sort of related but not necessarily from those two experiences that I wanted to flag. One is around bench strength in long-term care administration. There are -- there's just so many homes where there's really only two senior people who can organize a response, you know? There's a lot of homes where it's still just a DOC and an administrator.

And over and over, if there wasn't a strong DOC and administrator or even worse, if the DOC or the administrator got COVID themselves, that was a massive handicap for coping with outbreak response.

They're -- I can't see being able to cope with this without a deeper and stronger leadership layer, so numbers, and also leadership skill development in long-term care.

The other one is around

professionalization of medical care in the long-term care sector. I really -- I really feel like it needs to be a recognized subspecialty of primary care. There are some absolutely brilliant long-term care physicians, but it's really variable. And there's no sort of recognized qualifications or training programs for long-term care home physicians. And -- and their contributions to any kind of care, but also care during an outbreak, is -- is just as critical as having enough PSWs. And that -- that was really striking from home to home.

There's one more specific long-term care home story that we had wanted to raise from a couple of weeks ago. This was a home in outbreak, but the critical reason for this story is we realized that their HVAC system was non-functional, which means that they had no ventilation in the home basically.

And so it's very likely that that contributed to the extent of the outbreak in that home, not because COVID-19 is airborne, but just regular ventilation dilutes the number of droplets that are going to build up in the air and on surfaces.

So it's my understanding that part of the licensing for long-term care homes is that the HVAC systems are supposed to have regular maintenance every six months with documentation of that and everything.

But the Ministry of Long-Term Care doesn't routinely inspect any of that, so this may be tangled up in issues around the change in long-term care home inspection from being a standardized inspection that happened for every home to going to complaints-only basis. But that was a -- that was a pretty awful thing to realize in the middle of the outbreak that they had no functioning ventilation.

COMMISSIONER FRANK MARROCCO (CHAIR): Would that be a Ministry of Labour issue? Because the people working there --

DR. ELIZABETH REA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- are working in an unhealthy or unsafe environment.

DR. ELIZABETH REA: Potentially. To be honest, this is -- it's all pretty recent, so I have not, kind of, put together all of the implications. But you're right. I mean, and to

that point, I mean, the Ministry of Long-Term Care is involved anytime there are staff cases, right?

So the Ministry of Long-Term Care obviously knows about this situation, and my understanding is that they are undertaking some further work to make sure that that gets flagged across the Ontario long-term care homes to make sure that they're -- going into the winter, that their HVAC systems really are working the way they're intended to.

But we did want to raise that as an unexpected additional dimension to COVID-19 and long-term care homes and intersecting with the Ministry of Long-Term Care.

COMMISSIONER JACK KITTS: Would that be something where the Ministry of Long-Term Care, who's looking after the well-being of people in the home, the residents and staff, Ministry of Labour, they're bound by the Occupational Health & Safety for staff -- for workers. And I think Public Health, you do inspections as well, is that -- so there's three types of inspectors. Would that be -- this would sort of reach all of them?

DR. ELIZABETH REA: Well, I want to circle back to -- Eileen probably wants to talk

about this as well. When we say Public Health inspectors, that's kind of a traditional name that gets used for basically a people with a specific set of training. It's kind of like saying nurse.

So they're not always doing inspections. Some of them do restaurant inspections, food kitchen inspections.

Our work with the long-term care homes, other than the kitchens, isn't on an inspection basis.

DR. EILEEN DE VILLA: That's correct.

DR. ELIZABETH REA: It's --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. ELIZABETH REA: -- really around training, support, advice. It's not inspecting a long-term care home. That role rests entirely with the Ministry of Long-Term Care. I'm going to look to Eileen and Persia on this.

DR. EILEEN DE VILLA: Yes, so you're right. So our role in inspection and long-term care relates to the food safety aspects, the kitchen, and to the extent that they operate a food premise.

COMMISSIONER JACK KITTS: Okay. Thank

you.

DR. EILEEN DE VILLA: Otherwise, our role when it comes to the other elements of long-term care are supportive in respect of IPAC and supportive in terms of providing them assistance to discharge their obligations to have a proper infection prevention and control program and to manage -- to help them manage outbreaks and to facilitate, you know, the work that's required, lab testing, that kind of thing around outbreak management.

COMMISSIONER JACK KITTS: Okay. Thank you for clarifying. Thank you.

DR. ELIZABETH REA: Those are my --

DR. EILEEN DE VILLA: So just --

DR. ELIZABETH REA: -- are my three examples.

COMMISSIONER FRANK MARROCCO (CHAIR): They're good.

DR. EILEEN DE VILLA: Yeah, they are. Thank you, Elizabeth. And actually, I think what's interesting, is is that, you know, Elizabeth's examples bring to life the summary of observations which comes in the next slide, right?

These are, again, very high-level

summary, and thank you, Elizabeth.

Because I think Elizabeth's examples give us even more by way of delineating what we mean by these observations, but even take us that extra step further, and you'll see some of the elements that Elizabeth spoke about reflected in some of the recommendations that we're putting forth to you for your consideration.

But clearly, there are challenges and things that we've observed that require addressing. We did note that there were challenges around role clarity amongst health system partners. And I think some of the questions that you asked around, so who best to come in, particularly within the context of an emergency, and who should do what, right? Who inspects? Who does -- and what do we mean by inspection, in respect of which issues?

You've heard about the lack of dedicated -- like, truly dedicated, not designated, not, you know, you're it for today, but actually real dedicated infection prevention and control support and expertise was a challenge.

You know, a coordinated testing strategy for the long-term care sector was also something that was wanting, you know, in the

earlier phase of this pandemic. And you've heard very specific examples of the challenges that are presented. So even in the face of the best infection prevention and control programs and supports, there are challenges that simply, you know, are huge, and maybe even -- maybe even insurmountable when you talk about certain types of aging physical infrastructures and physical structures.

Older multi-bedded rooms have certain challenges that even with the best infection prevention and control program, may not be overcomable. So I --

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, just before you go on --

DR. EILEEN DE VILLA: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): It does seem -- I would have thought there'd be a plan in place, not so much anticipating a pandemic, which I think is something nobody anticipated. Well, maybe there were people who anticipated it, but nobody who really thought it was imminent, if you like. It's just that there's going to be one someday. The time's about up. There should be one, that sort of -- okay. Fine.

But in terms of a lack of clarity among the system partners and a need for coordinated testing strategies, I mean, wouldn't that be part of a plan, what we're going to do if? And --

DR. EILEEN DE VILLA: Yeah, I think that's a fair question. I do think that, you know, much of -- well, all of the testing strategy did come courtesy of our provincial counterparts. They were the ones driving -- and they're the ones in charge of the whole laboratory system as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

DR. EILEEN DE VILLA: So certainly, you know, we look to them, and, you know, to their expertise. They did have -- they do have experts who work in this area, and I do think that there is a significant role, and the primary role that they play there.

COMMISSIONER FRANK MARROCCO (CHAIR): Could Public Health mandate a plan, though? Could -- not a specific plan, but could Public Health mandate that every long-term -- that there shall be a plan within Toronto?

DR. EILEEN DE VILLA: So I think that's an interesting question that you raise. And I did

note that my colleague, Dr. Michael Finkelstein joined us as well. You know, it would be interesting to hear his perspective because I think, you know, having had experiences here in the City of Toronto around outbreaks and long-term care, there have been a number of efforts made by Toronto Public Health over the years to engage with long-term care partners on how better to support them through outbreaks.

And ideally, right, from a Public Health perspective, the notion is for prevention first and foremost, right? Rather than waiting until trying to figure out what to do when the outbreak hits, first and foremost, the approach of Public Health is always to prevent wherever possible.

So, Michael, I don't know whether -- I did see you pop in. I assume you're still here.

DR. MICHAEL FINKELSTEIN: Yeah, I am indeed.

DR. EILEEN DE VILLA: Yeah. So might I ask you to comment a little bit on the question that's just been asked around planning for Toronto and how best to think more preventively, you know, in respect of preventing outbreaks?

DR. MICHAEL FINKELSTEIN: Certainly, when -- thank you. Thank you, Eileen. When the -- when the Long-Term Care Act and the Ontario Public Health Standards were, you know, were changed -- or sorry -- were enhanced and modernized, the language and the protocol that, you know, supports our interaction with the long-term care facilities had some very good language about the importance of preparing for outbreaks and assisting people in the long-term care in doing that.

But my experience is it really takes two parties to interact and have that planning. And my colleagues and I, when we started to attempt to work with the long-term care facilities, we really did not find that they were that engaged with us in an attempt to do that kind of planning and preparation for outbreaks, that they have a whole bunch of other issues on their plate. And we found it -- we found it quite a struggle to engage and to continue to engage with the leadership, which we needed to be engaged, to work proactively to have those plans you've just described to come to complete -- or to start even, to complete -- or sorry -- let alone complete.

So it was a huge struggle. We tried.

We did. We certainly did. But we -- and for -- you know, for instance, with the homes, the long-term care homes that were run by the City, we started to have meetings with them, and so there were, kind of, the early shoots of some collaboration there.

But you can imagine, these homes have lots going on, so it was -- we really found that there was a lacking in our -- in the receptivity for our work in that area.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor -- Mr. Finkelstein -- or is it doctor?

DR. MICHAEL FINKELSTEIN: Yes, it is.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Doctor, is it -- over what period of time was this happening?

DR. MICHAEL FINKELSTEIN: Oh, this would have been probably in the -- I'm going to say in the area of just before the H1N1 pandemic was when we started. The protocols and Ontario Public Health Standards were refreshed in the, you know, time right around 2008. And so we started during the late part of that decade and early part of this decade were the principal times -- this is many years ago now that my colleagues and I started this

work.

And, you know, you can imagine there's a wealth of things that we can -- that we're up to too. There's lots of Public Health issues that we're dealing with, and so we've tried our best.

And in fact, we were working on a new way of trying to engage the long-term care facilities with a report that would place each long-term care facility's outbreak history alongside their peers in an attempt to get -- to -- simply to show them how they were doing compared to others. And in fact, that we were working on that before the pandemic struck, and once we're back there again, we're going to hopefully restart that work. But that was an attempt to once again engage the long-term care facilities the best way we could, we thought, with, kind of, data about how their outbreak experience was going.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you -- can you not order them to have a plan? Can you? I'm not -- I'm legitimately asking. I'm not suggesting --

DR. MICHAEL FINKELSTEIN: So they're required -- we don't necessarily have to order them. They're required to have that plan under the

Long-Term Care Act. The Act and the regulation that are part of the Act do specify that each -- each long-term care home must have an infection prevention control plan, and it sets out some of the high-level requirements for those plans.

And so it's -- my understanding is that the mandate and the oversight of that comes from the Ministry of Long-Term Care. That's their responsibility.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, I see. So you're saying that because it's in the Act, it's the responsibility of the Ministry of Long-Term Care and not Toronto Public Health to make sure there's a plan in place.

DR. MICHAEL FINKELSTEIN: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. MICHAEL FINKELSTEIN: And the wording in our documents is for us to assist them in doing that.

PERSIA ETEMADI: I would also, Eileen, I don't know, or Michael, I don't know if you want me to add a couple comments on that as well.

DR. EILEEN DE VILLA: Sure, Persia, please.

PERSIA ETEMADI: Just in respect of mandating a plan or ordering, I guess, it would be under the HPPA, we do have, you know, very specific powers under that Act and would have to meet a legislative test. So the kind of plan you might be thinking about, especially if it's more of a preventative or regulatory requirement is not something that the HPPA would really lend itself towards. I think that's something that we would be looking to the Ministry of Long-Term Care to implement in accordance with the Long-Term Care Act.

COMMISSIONER FRANK MARROCCO (CHAIR): But let me just pursue that with you for a minute. Each -- not just Toronto, but each local medical officer of health has power under -- under the Health Protection and Promotion Act to make orders that deal with -- I guess, I don't know what that section says. I'd have to see it, but --

PERSIA ETEMADI: So Section 29.2 is --

COMMISSIONER FRANK MARROCCO (CHAIR): Point 2, yeah.

PERSIA ETEMADI: Yeah, so that requires that there be an outbreak in a specific facility. And it is really intended to be more of a -- you

know, directed at a specific management of an outbreak in a specific facility. So once we get into the question of broader orders or imposing broader measures, it becomes a bit more murky and nuanced.

And certainly, I'm happy to follow up on these questions if, you know, if you'd like written submissions or anything of that nature.

U/T COMMISSIONER FRANK MARROCCO (CHAIR): No. We can -- no, we can do that. I was just --

PERSIA ETEMADI: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): -- wanted to get your view of it.

PERSIA ETEMADI: M-hm. Yeah, I don't think the -- at least with respect to Section 29.2, it is a very specific legislative test, and they are intended to be orders directed at specific institutions.

COMMISSIONER FRANK MARROCCO (CHAIR): And your understanding is that nowhere in that Act is there -- are you -- do you get the authority to say to them we need to have a plan; you need to have a plan; we're trying to engage with you; you're not engaging with us; and so we're ordering you to engage with us?

PERSIA ETEMADI: I mean, there are other order-making powers in the Act. Again, it's a very -- you know, it is sort of a fact-specific analysis and does require that a legislative test be met.

So, you know, it's hard for me to, I guess, answer in the abstract whether we would meet that test. But again, where we're talking about sort of health unit-wide or sector-wide requirements or mandates, it's really -- we would be looking to the Province to do -- to use their authorities to implement, you know, via, whether it's directives by the Chief Medical Officer of Health or other provincial powers, we don't -- we don't have a directive power under the Health Protection Promotion Act.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. EILEEN DE VILLA: So if I can, Commissioners, I'm just -- sorry, I'm conscious of time, and I am a little pressed, I have to admit, so...

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. Go ahead, Doctor. We'll stop for a minute. We'll stop asking questions for a while.

DR. EILEEN DE VILLA: Well, yes, unfortunately, I am actually supposed to be -- my understanding was that we were running 'til 4:30, and I'm sorry; I do have, you know, a next appointment to get to, so I do apologize.

I'm thinking through, though, that we have -- if you go through the next slides, we have a number of recommendations some of which are specific to long-term care homes and the Ministry of Long-Term Care, some that are general.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, perhaps we could do it this way, Doctor, given your schedule: Perhaps we could take a look at the recommendations and engage with you again if we have questions. And that way you can at least stick to the schedule you're on today.

DR. EILEEN DE VILLA: Yes, I do apologize for this. I am rather tightly scheduled, I will say, on most days.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I'm sure. No doubt. And so, if we could leave it on that basis, then we will take a look at the recommendations, and we may not require your personal intervention, but if we can come back to Toronto Public Health to get some clarification on

the recommendations, then we could just take them and read them. We probably --

DR. EILEEN DE VILLA: Of course.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. I mean, I'm in your hands, but I'm sensitive to what you're saying.

COMMISSIONER JACK KITTS: Would another option be that one of your colleagues finishes the slide deck?

DR. EILEEN DE VILLA: That's certainly an option.

COMMISSIONER FRANK MARROCCO (CHAIR): Whichever you'd prefer.

DR. EILEEN DE VILLA: I'm not sure what their calendars are like. I don't want to impose on them --

COMMISSIONER JACK KITTS: Yes.

DR. EILEEN DE VILLA: -- without having given them the opportunity --

COMMISSIONER JACK KITTS: Yeah.

DR. EILEEN DE VILLA: -- to tell us what their schedules are like.

COMMISSIONER JACK KITTS: So nobody's --

DR. ELIZABETH REA: I can carry on. I

don't know if -- however, Michael might want to do it.

DR. MICHAEL FINKELSTEIN: I'm very happy for you to continue, Elizabeth.

DR. ELIZABETH REA: Okay.

DR. MICHAEL FINKELSTEIN: And I can -- I can certainly stay for -- I do have an appointment at 5, but I'm otherwise available until then.

DR. ELIZABETH REA: Okay.

DR. EILEEN DE VILLA: So with that, my apologies to all of you. Elizabeth, thank you, I leave you, Commissioners, in the very capable hands of Dr. Rea. I have no doubt that she will carry the flag for us admirably as she always does.

And if there are further questions that you have of me or of us as a group after the presentation, we, of course, are happy to oblige.

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

COMMISSIONER JACK KITTS: Thank you.

DR. EILEEN DE VILLA: Thank you. My apologies again for this rather --

COMMISSIONER JACK KITTS: No. No apologies.

DR. EILEEN DE VILLA: -- abrupt departure on my part.

COMMISSIONER JACK KITTS: None needed. Bye-bye.

DR. EILEEN DE VILLA: Take care. Thank you. Thanks Elizabeth, Michael, Howard, and Persia, and Eric. Okay. Thank you.

DR. ELIZABETH REA: Thanks. Okay. So could we go to the next slide? All right. So I'm pretty sure you've seen slides like this from every single conversation that you've had. So it may not bear, you know, going over it again, but there's obvious -- an obvious need for, I guess, breadth and depth of infection control training and operationalizing in the long-term care home sector.

Next slide. So this is -- this is for the Ministry of Long-Term Care because again, I mean, Persia has kind of alluded, they have -- they have very clear legal authorities around this. I -- this again, to some extent, intersects with the hub-and-spoke models which I recognize are still very much in development. Not all of those accountabilities or mandates are clear.

But I -- on a -- on a home-by-home basis, reviewing the current status of the

infection control program and what the specific needs in those homes are, is really important. And there is a specific inspection function through the Ministry of Long-Term Care to make sure that those infection control and outbreak management programs are in place.

They sort of -- they have the stick, as it were, in a way specifically around this as a preventive kind of layer, as a development layer, that neither the hospital -- the hub-and-spoke models, nor Toronto Public Health does.

Okay. Next slide. For long-term care homes, strengthening staffing and training, again, you've probably seen this line many, many times, basic infection control training for all staff. It's not on this slide, but you could kind of expand that to say there ought to be better infection control programming -- training as part of PSW training programs as well, so not just at work, but from the beginning when people get their initial training and qualifications as a PSW and skilling up pretty broadly in long-term care.

I mentioned the medical issues, but they also apply in nursing, right, that anyone who's in nursing in long-term care should be pretty

comfortable with palliative care, as one of many examples, and a clear ability to scale up. That kind of ties to the more recent example of the home I spoke to where they already had agency contracts on tap. They knew what the corporate backup would be able to look like, that kind of thing.

Next slide. Improving the physical structure, yeah, this isn't something that's easy to fix quickly, obviously. But, you know -- and again, you probably have been hearing this many, many times. From what I understand, there are many, kind of, long-term plans and timelines around, you know, rebuilding the older homes. COVID-19 kind of -- kind of says it might be more urgent than ten years from now. So I'll leave it at that.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that doesn't address -- it might be, but it doesn't address the shortage.

DR. ELIZABETH REA: Exactly, yes. So there's not just --

COMMISSIONER FRANK MARROCCO (CHAIR): You could run out of beds.

DR. ELIZABETH REA: It's not just replacing existing homes, but you're right.

There's also a broad capacity issue in the sector about having enough long-term care beds at all.

I guess one of the things I would flag there is, you know, if we're building any new long-term care homes or replacing existing ones, it seems pretty obvious not to have shared rooms; to have a physical layout that allows for staff break rooms on each floor, rather than, you know, having staff -- designing a place so that staff have to mix between floors and so on.

I also have to say I worry about really large long-term care homes. You know, if an outbreak really, worst-case scenario runs right through a place, if it's a home of a hundred residents, that's as far as it gets, a hundred residents. But if it's a home with 400 residents, in the worst-case scenario, it's going to run right through 400 people.

So I think that issue of size is something to think about. It's a variation on that cohorting issue. I think it's really important to be able to really cohort to smaller units than 400 residents, put it that way.

We put the HVAC system on this slide because it's a really specific recent example.

There may well be other physical infrastructure things, but that one kind of hit us on the head recently, so it's there.

Next slide. Right. So general issues around clarifying roles and external partner support, a bunch of this is underway. This is -- in many ways, this is just kind of underlining those are really important, and going into a second wave, they're urgently important.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, what does -- what does underway mean?

DR. ELIZABETH REA: Well, so, for example, the hub-and-spoke models are -- the way the Province announced that, it's obviously at a very high level, but it's trying to lay out what does the hospital hub do, and Public Health is integrated into that. And there's a direct kind of granular on the ground support piece for the long-term care homes. And they're supposed to be tied to the Ministry of Long-Term Care.

It's not entirely clear what that's going to look like. The roles are, like, as right now, trying to be hammered out. But it is an attempt. It's one of many attempts underway to get there.

There's also, to speak of a very Toronto-specific example, we had talked in the pre-meeting about the role of the LHIN, or at least the Toronto Central LHIN in Toronto, and that they've played a large role in acting as a focus for integrating the different partners in the sector.

And that role clarification is still ongoing in the Toronto Central LHIN. I have less experience with the other LHINs in Ontario health regions --

COMMISSIONER FRANK MARROCCO (CHAIR): Right. Right.

DR. ELIZABETH REA: -- but there you go.

I think -- I think we're all realizing long-term care homes are one of the places that are -- so many ministries and pieces of the health and social service sector broadly intersect in long-term care. It's -- it is a bit of a tangle at the moment, and it's going to take, obviously, a lot of work to clarify it.

Comprehensive testing strategies, that's come up a bunch of times. You already have, in your interim recommendations, a piece around

trying to -- wanting to prioritize testing for the long-term care home sector for COVID, and I would say especially during outbreaks.

And then effective cohorting and isolation, and that that may involve decanting residents to a separate facility in order to create enough room to effectively cohort and isolate. That's a piece that we've definitely used in some of the Toronto outbreaks, decanting residents.

One of the difficulties is that, from an infection control point of view, the safest people to decant are people who have already had COVID and recovered, right? It's a -- it's a fraught thing to take someone who currently has COVID and they're infectious and move them to a separate facility for fear that, you know, if it can't be entirely contained, then you may just be triggering another outbreak in a new facility, so just want to flag that. It's easy to say on paper, but, in fact, it means you have to wait until someone, a resident with COVID, has already passed the ten-day mark and is -- and is okay, that they're not infectious to move now.

Next slide. There we go, closing remarks. So the reason this starts off with

mitigate the size and health impact of long-term care outbreaks, is -- goes back to that piece I was saying that what happens in the community is going to show up in long-term care. So long as there is COVID transmission in the community, there are going to be exposures and positive staff. The goal is to -- is to not have transmission from those initial exposures.

So these are kind of the three sort of pillars, the proactive work, the training and practices especially around infection control, and I think we all feel there's a real role for re-expansion, if you like, of the Ministry of Long-Term Care inspection function.

And I think that's the last slide.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much. This is very helpful, and we do appreciate you taking the time and effort to meet with us. And thank you very much.

DR. ELIZABETH REA: Okay.

COMMISSIONER JACK KITTS: Thank you.

DR. ELIZABETH REA: Happy to -- to, you know, answer additional questions in the future or circle back around if you have any follow-up questions or issues to talk about.

COMMISSIONER FRANK MARROCCO (CHAIR): We certainly will remember that you made that offer.

DR. ELIZABETH REA: I'm also offering up the rest of the Toronto Public Health crew, so...

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER JACK KITTS: Yeah, thank you very much. That's much appreciated. Thank you.

DR. ELIZABETH REA: Thanks very much for the invitation to speak.

-- Adjourned at 4:54 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 27th day of October, 2020.

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