

Long Term Care Covid-19 Commission Mtg.

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



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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

1 PRESENTERS:

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

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

9

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

13

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

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17 Persia Etemadi, Lawyer, City of Toronto

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

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Dawn Palin Rokosh, Director, Operations, Long-Term

6 Care Commission Secretariat

7 Jessica Franklin, Policy Lead, Long-Term

8 Care Commission Secretariat

9 Jennifer King, Gowling WLG (Canada) LLP

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12 ALSO PRESENT:

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14 Janet Belma, Stenographer/Transcriptionist

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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

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 I'm Frank Marrocco, and that's Dr. Jack Kitts who's
4 on the screen, the other commissioner. Angela Coke
5 won't be with us because of a family emergency.

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 And so we will try to carry on in her absence.
10 Well, I think, Doctors, you know, it's fairly clear
11 we wanted to produce some interim recommendations,
12 and we did that on Friday.

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

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

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

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

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

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Sure.

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

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

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

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

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

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

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

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

16 So thank you, Eric, for that.

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

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

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

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

19 Turning to the next slide, there are --
20 COMMISSIONER JACK KITTS: Dr. De Villa,
21 can I just --

22 DR. EILEEN DE VILLA: Please.

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

25 DR. EILEEN DE VILLA: M-hm.

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

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

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

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

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

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

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

16 COMMISSIONER JACK KITTS: Okay. Thank
17 you.

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

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

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

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

18 DR. EILEEN DE VILLA: Please.

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Right.

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

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

7 DR. EILEEN DE VILLA: That's correct.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

10 DR. EILEEN DE VILLA: Shall we proceed?

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

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

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

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

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

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

12 DR. EILEEN DE VILLA: Correct.

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

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

1 long-term care.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Okay.

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Can you place that on -- you know, if January 25th
10 is the first confirmed case, can you sort of place
11 that realization on that timeline somehow?

12 DR. EILEEN DE VILLA: You know, I would
13 say it was shortly -- you know, shortly after that,
14 when we -- you know, as -- so the interesting thing
15 is that you might recall that the virus was first
16 sort of identified formally -- I believe it was
17 January the 10th, right, sequenced on January the
18 10th as a virus; first confirmed case here in
19 Toronto by the 25th. And we were still learning
20 quite a bit at that stage around COVID-19 being a
21 new virus, you know, previously unbeknownst to us.
22 And when I say "us," I mean the entire global
23 community.

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

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Okay.

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

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

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

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

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay.

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

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

22 Dr. Kitts?

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

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

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

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

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

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

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

25 Do you categorize outbreaks -- because

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 COMMISSIONER JACK KITTS: Right.

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

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

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

19 COMMISSIONER JACK KITTS: Okay.

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

22 COMMISSIONER JACK KITTS: I can wait.

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

25 DR. EILEEN DE VILLA: Sure. You know

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

5 DR. ELIZABETH REA: Okay.

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

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

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

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

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

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

21 DR. ELIZABETH REA: Okay. So --

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

1 she gets there.

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

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

9 DR. ELIZABETH REA: Okay.

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

13 DR. ELIZABETH REA: Okay. All right.

14 DR. EILEEN DE VILLA: Do go on.

15 Thanks, Elizabeth.

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

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

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

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

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

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

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

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

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

12 So --

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

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

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

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

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 But I understand that.

5 DR. ELIZABETH REA: M-hm.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 But in -- even in the Toronto homes, I mean, there
8 are problems with the flu and that sort of thing --

9 DR. ELIZABETH REA: Yeah.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 -- year after year.

12 DR. ELIZABETH REA: Yeah.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 It's not as if it's -- it's a new problem.

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

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Actually, Ms. Rea, I wasn't doing anything with
23 long-term care homes either before this started.

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

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

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

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

19 DR. ELIZABETH REA: I hear you.

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

22 DR. ELIZABETH REA: Yeah.

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

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

1 hear you.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Yeah.

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

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Did the Toronto homes have the same problem that
8 the municipal -- the City of Toronto homes.

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 M-hm.

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

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

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

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

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

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

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

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay. Thanks.

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

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

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

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

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

1 So the second home I want to talk about
2 is a little bit smaller, about a hundred beds. And
3 they're just -- they're just coming to a close of
4 their outbreak now. So they've had 57 residents,
5 12 deaths; 26 staff cases, and no deaths. And that
6 outbreak is coming to a close, helpfully, in about
7 a six-week span.

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

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

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

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

4 DR. ELIZABETH REA: Sure.

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

10 DR. ELIZABETH REA: M-hm.

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

14 DR. ELIZABETH REA: M-hm.

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

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

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

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

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

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

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

1 DR. ELIZABETH REA: Yeah.

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

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

10 COMMISSIONER JACK KITTS: Right.

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

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

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

22 DR. ELIZABETH REA: Yeah.

23 COMMISSIONER JACK KITTS: Okay.

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

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

4 COMMISSIONER JACK KITTS: Okay.

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

7 DR. ELIZABETH REA: Yeah.

8 DR. EILEEN DE VILLA: -- for --

9 DR. ELIZABETH REA: For sure.

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

12 DR. ELIZABETH REA: Yeah.

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

19 DR. ELIZABETH REA: M-hm.

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

24 DR. ELIZABETH REA: M-hm.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

3 DR. ELIZABETH REA: M-hm.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 -- you've got the immediate problem. I -- what are
6 your alternatives -- not your alternatives, but
7 what are the alternatives apart from the local
8 hospitals in the local -- in the area -- in the
9 catchment areas that -- of the nursing --

10 DR. ELIZABETH REA: Yeah.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 -- or the long-term care home.

13 DR. ELIZABETH REA: Yeah. A part --

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 It just seemed so urgent to me at that moment.

16 DR. ELIZABETH REA: Yeah, and it was.

17 Like, really, it was urgent.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Yeah.

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

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

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

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 M-hm.

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Okay.

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

25 The other piece is they were way better

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

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

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

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

25 So to that extent, I think we are doing

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

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

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

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

14 DR. ELIZABETH REA: Yeah.

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

17 DR. ELIZABETH REA: Yes.

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

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

1 COMMISSIONER JACK KITTS: Yeah.

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

6 COMMISSIONER JACK KITTS: Yes.

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

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

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

25 The other one is around

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

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

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

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

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

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

18 DR. ELIZABETH REA: M-hm.

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

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

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

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

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

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

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

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

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

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

11 DR. EILEEN DE VILLA: That's correct.

12 DR. ELIZABETH REA: It's --

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Okay.

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

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

25 COMMISSIONER JACK KITTS: Okay. Thank

1 you.

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

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

14 DR. ELIZABETH REA: Those are my --

15 DR. EILEEN DE VILLA: So just --

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

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

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

25 These are, again, very high-level

1 summary, and thank you, Elizabeth.

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

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

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

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

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

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

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

16 DR. EILEEN DE VILLA: M-hm.

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

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

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

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Right.

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

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

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

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

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

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

19 DR. MICHAEL FINKELSTEIN: Yeah, I am
20 indeed.

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

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

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

25 So it was a huge struggle. We tried.

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

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

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

13 DR. MICHAEL FINKELSTEIN: Yes, it is.

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

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

1 work.

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

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

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

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

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

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

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

15 DR. MICHAEL FINKELSTEIN: That's right.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Okay.

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

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

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

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

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

20 PERSIA ETEMADI: So Section 29.2 is --

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

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

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

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

9 U/T COMMISSIONER FRANK MARROCCO (CHAIR):

10 No. We can -- no, we can do that. I was just --

11 PERSIA ETEMADI: Sure.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 -- wanted to get your view of it.

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

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 And your understanding is that nowhere in that Act
21 is there -- are you -- do you get the authority to
22 say to them we need to have a plan; you need to
23 have a plan; we're trying to engage with you;
24 you're not engaging with us; and so we're ordering
25 you to engage with us?

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

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

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Okay.

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

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

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

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

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

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

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

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

3 DR. EILEEN DE VILLA: Of course.

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

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

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

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

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

17 COMMISSIONER JACK KITTS: Yes.

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

20 COMMISSIONER JACK KITTS: Yeah.

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

23 COMMISSIONER JACK KITTS: So
24 nobody's --

25 DR. ELIZABETH REA: I can carry on. I

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

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

5 DR. ELIZABETH REA: Okay.

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

10 DR. ELIZABETH REA: Okay.

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

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

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

21 COMMISSIONER JACK KITTS: Thank you.

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

24 COMMISSIONER JACK KITTS: No. No
25 apologies.

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

3 COMMISSIONER JACK KITTS: None needed.
4 Bye-bye.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Well, what does -- what does underway mean?

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

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

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Right. Right.

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

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

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

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

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

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

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

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

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

15 And I think that's the last slide.

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

20 DR. ELIZABETH REA: Okay.

21 COMMISSIONER JACK KITTS: Thank you.

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

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

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

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Okay.

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

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

14 -- Adjourned at 4:54 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, JANET BELMA, CSR, Certified
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6 That the foregoing proceedings were
7 taken before me at the time and place therein set
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9
10 That all remarks made at the time
11 were recorded stenographically by me and were
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14 That the foregoing is a true and
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