Long-Term Care Covid-19 Commission Mtg.

Meeting with Dr. Vera Etches, Medical Officer of Health
on Friday, October 2, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 2nd day of October, 2020, 1:00 p.m. to 1:35 p.m.

BEFORE:

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

PRESENTERS:

Dr. Vera Etches, M.D., CCFP, MHSc, FRCPC, Medical Officer of Health, Ottawa Public Health.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, it's 1 o'clock. You're here yourself, Doctor. Are you expecting anyone else?

DR. VERA ETCHES: It is just me for better and for worse. I think probably some of my team members have more detailed knowledge, but I'll try to convey the big picture of what we've learned.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, you know what we're about. We're a little different than traditional inquiries because normally those inquiries are called after something has happened, and they look back at the event, and then they try to explain it.

We've been called together in the middle of something, and so it changes the traditional way of going about -- the way -- looking back is you investigate, you hold your public hearings, and you write a report. It takes two years, two and a half years, whatever time it takes, and then you're finished.

But, of course, that doesn't work so well in the world that we're in because the Wave 2

is upon us. Maybe there will be a Wave 3, and it really didn't commend itself to us that we would report, like, two years from now.

So we're trying to come up with or trying to see if it's possible -- we kind of turn it upside down to see if there aren't some concrete interim recommendations that we can make and then go about the rest of the, you know, inquiry trying to carry out the rest of our mandate. So that's kind of where we're coming from.

You met us all. There's a transcriptionist, so there will be a transcript of this. And we do have a website, and we tend to post -- we do post as much as we can on the website so that people have some idea of what we're up to.

So, with that, we're ready when you are.

DR. VERA ETCHES: Well, thank you very much for this opportunity. I think that you probably have already come with and have gained a lot of knowledge of the context and the situation.

So I don't want to spend a lot of time speaking about things you already know or have observed. I can certainly start with describing some of our experience in the Public Health field

in Ottawa where it intersects with the experience of long-term care outbreak prevention and control.

There, certainly, are some things we've observed and things we've learned and are doing differently based on the experience of Wave 1 for Wave 2, and I'm happy to describe that and certainly open to answering the questions you think will be most useful.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're looking for ways of improving the response. And we have heard from a number of people, but I think the best way to go about it is to tell us what you want to tell us, and if you're telling us something we already know, we'll tell you.

DR. VERA ETCHES: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. VERA ETCHES: Well, let me start, then, by describing the Public Health work, you know, with long-term care homes around infection prevention and control before COVID.

So typically what Ottawa Public Health does with all of our long-term care homes -- and there are 28 in our area -- is every year we host a

session called Outbreak 101. And it's an education session, actually for retirement homes as well, where we go over what was the previous years' influenza season like, what did we learn from respiratory enteric and outbreak in the last year, what can we reinforce to prevent outbreaks in the coming season.

We also, in pre-COVID times, took a risk-based approach to supporting homes, and so we knew before COVID there were homes that, historically, had more challenge with outbreak management based on, you know, the length of the outbreaks they would tend to have, the number of deaths, and so we would spend more time on site with homes that needed more support.

As COVID was becoming clearly a threat to our area, we were in regular contact with long-term care homes to make sure they not only had the guidance that was emerging from the province but also understood it and what it meant for their operations.

We were part of what was stood up in more of an emergency response to oversee the health system response to COVID. So what I'm speaking about there is that Ontario Health established a

more streamlined expectation that there would be a regional response with hospital and home and community care leadership.

That built on kind of a pandemic plan approach in our region already that included what we call "three-centre decision-making" for a pandemic response or an emergency response.

Ottawa Public Health being a lead for Public Health response and advising over all the City were some of the city responses and social supports needed as well as the healthcare system.

And so we did have a way of connecting amongst those three decision centres. And so when the Ontario Health request to set up a regional response was established, we built on that and made sure that City Public Health and hospitals and the other health system partners were all linked in.

And so under that and through that, we had different conversations that would have touched on long-term care home needs and operations and challenges. Eventually there was a long-term care home task force established to support homes, and Public Health was part of the support offered right on the ground. As well as I was part of the senior leader table that was getting updates and guiding

the response.

We did find early on there was more focus on supports to quickly build up acute care capacity, and there were definitely pressures around some of the supplies and guidance around access to masks and PPE.

We advocated to the Chief Medical Officer of Health on March 18th that there would be universal masking for all healthcare workers in all settings, and we found that that was, again, something we needed to move ahead on locally before the formal guidance came out, I believe, later in April.

So we saw, definitely, that homes struggled with controlling COVID-19 outbreaks more so than they would have traditional respiratory outbreaks, and I think some of that was related to the nature of the virus -- you know, needing to screen people out who have mild symptoms, you know, where it is previously other symptoms that might have been more obvious to people.

The challenge with some of the new practices needed that hadn't always been used for influenza around cohorting, thinking about who's testing positive and separating them from negative

and those who are yet to be determined. We actually found this was not common practice for influenza where a control of the outbreak was facilitated by things like antivirals and more use of physical barriers that just were maybe not sufficient given the new virus.

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

DR. VERA ETCHES: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- universal masking was recommended, you said, on March 18th, but the directive, you said, comes out late in April.

Do you have any sense of what went on between March 18th and late April given that, you know, everybody was -- there was a -- it seemed to me -- right from the beginning, almost -- talk of social distancing and wearing a mask, at least optionally anyway.

Do you have any sense of whether that was a long time or not or why it took that much time?

DR. VERA ETCHES: You know, I really have challenges with how much I can speak to what others were doing. I really have to --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

DR. VERA ETCHES: -- just speak to what I know directly, and so, you know, that was our efforts here on the ground was to spread that message.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. VERA ETCHES: Yeah, right away.

COMMISSIONER FRANK MARROCCO (CHAIR): That's a good reason to avoid answering the question, so I won't pursue it any further.

Dr. Kitts?

COMMISSIONER KITTS: Yeah. So, Vera, can I ask, in Ottawa, you were, early on, promoting universal masks. Was March 18th a time when there was still a lot of concern about availability of PPE and --

DR. VERA ETCHES: Yes, yes, absolutely. So I think while we made the recommendation, there was a challenge to carry it out, absolutely. And so I think maybe you've heard about this more, but the supply of personal protective equipment to long-term care homes was tenuous. It was something we heard that was challenging at that time.

I want to highlight some other observations from the first wave. We did notice that staff worked in multiple locations, and it did likely contribute to spread of the virus between location. And then when staff were limited to working in one home, it was associated with challenges with maintaining higher staffing levels, and it often was the homes in the worst situation that people chose not to work at, and so it actually made the situation harder in some homes in outbreak.

We definitely observed the challenge that personal support workers, environmental -- like, cleaning services staff had with maybe not having access to sick leave or benefits, and so they were more likely to work when ill.

We had quite a few examples of that happening, and it related to this socioeconomic gap in the situation, you know, that we actually have also examples of personal support workers living in shelters and other situations of congregate care where, you know, that also increased the risk of transmission of COVID both within long-term care coming back to the shelters and the other direction.

We observed that -- well, certainly some long-term care homes did not have dedicated infection prevention and control practitioners. And it was often a piece of somebody's work, and that made it harder for homes to take the new directives and implement them to carry out the required ongoing infection prevention and control education and audits.

So our work was certainly to help homes understand the guidance and go on site and try to assist with training. And so throughout Wave 1 and then through into the summer, we partnered with Public Health Ontario to do more of this work to provide on-site training.

And our learnings and our observations were that the training is one piece, but it really requires ongoing oversight and ongoing reinforcement. That means leadership and IPAC supervision really needs to be there seven days a week if not 24/7.

We found that some homes lacked clinicians of who were able to provide on-site support, and this may have contributed to hospitalizations and more serious outcomes without the level of medical support that might otherwise

have been available.

And we definitely heard about negative impacts on mental health of both residents, staff, and families. Many, many families reached out to me about the concern they had for the isolation of their family members and the impact on themselves.

So we needed to pull more people in to our team that usually works on infection prevention and control, so we reinforced the team adding inspectors and nurses from other parts of our organization where they would have worked with, you know, other kinds of inspection.

So they're not necessarily the certified infection prevention and control practitioners that we would, you know, consider have the highest level of training even on our own team, but we've continued to build their capacity.

We continue to reach out to all homes, so homes not in outbreak, to try to prevent outbreak both through on-site visits but also phone calls and meetings with management. So for homes that were flagged as red or yellow, having more concerns for their capacity, those involved meetings with management to go over what their needs are and what supports they need.

We are finding, through these regular calls that continue, they're proactive but we also have responsive calls as well. You know, any time a home calls us, we respond very quickly. But we're finding there is still ongoing need to understand the guidelines and to uphold them.

So maybe going back to the Public Health view of COVID in the community, you know, we saw first people testing positive in March. Two weeks later, we saw our first outbreaks in long-term care homes.

So we see the very real connection between community level of virus and then it being introduced into homes. We saw in the summer when the outbreaks were under control and the level in our community was lower, there was a relaxation of the measures in the public to decrease our contacts, to wear masks.

And we see, then, again, with COVID rising in our community, again, it's being reintroduced into homes. So the sense of relaxation in the summer related to how active the screening is to keep people who are ill and showing symptoms from working, and that -- so, you know, we see the need again for this ongoing reinforcement.

It is really important.

The other thing around the screening and the surveillance testing in long-term care -- I know there's lots of interest in that. And in the first wave, we actually didn't find any new outbreaks through that surveillance testing. Where we had an outbreak, we found more people infected. It uncovered more of the spread.

Now what we're finding with the regular implemented surveillance, we actually are detecting staff first through some of that surveillance testing as well as symptomatic staff going for testing.

And, you know, there's some good news here that with that identification of the staff, in 14 out of 15 outbreaks, for instance, since August, it's a staff index case that was identified. And then in 10 out of the 15, the infection was limited to staff, so it did not spread beyond into residents.

So homes on the whole are doing better controlling their outbreaks, and I think I found some graphs to share with you, for the record, that show that. The duration of outbreaks in long-term care homes is coming down compared to Wave 1, and

the number of people infected is also coming down.

And, you know, it's just quite different except for when it's not, and so this is, again, where I think it's important, maybe, to focus on what's the difference between homes that do prevent outbreaks or manage outbreaks well and those where we see ongoing challenge.

So I think what we've learned is that it's very related to the management of the home and the leadership in the home on the ground that would instill confidence in staff and support staff to show up for work, to feel protected.

And this is something that, you know, is a bit qualitative and hard to, you know, think about our Public Health inspectors and our public nurses having a role in judging, you know, the ability of managers in homes. That's something we really didn't, you know, consider in sort of their role, necessarily.

But it is the case that our Public Health inspectors and nurses observe things that challenge outbreak management, like levels of staffing, and it is linked to leadership in terms of oversight of you know, how staffing is managed, the targets that are set. All homes have been told

to staff to higher levels given we can predict there may be some absenteeism, and so this is something that we've learned.

It has led us to use new tools in the second wave. For example, the Section 29.2 of the Health Protection and Promotion Act is a tool that I've used, had never used before, but found that it is a rapid way to address, you know, more supports to leadership and management in the homes. And seeing the importance of that, we've used that tool twice now.

So the difference between homes -- I've mentioned leadership. It's about having supervision on site, you know, 24 hours a day, 7 days a week; being able to address the staffing --

The practices that lead to retention of staff definitely seem to be linked to staff having access to sick leave, full-time hours. You know, people are more likely to want to stay and work in those settings where, then, they build expertise.

We also see that some of the differences relate to the population served. So where there are more residents with dementia, more residents with mental health and substance use

challenges, then that is likely a riskier situation and harder, you know, for the homes to control the outbreaks.

The physical infrastructure also matters, so I think you've probably heard about that. You know, older infrastructure, shared rooms, there are physical impediments to cohorting and moving people.

So I think maybe just to get, shortly, to your questions, I would reinforce, then, that ongoing oversight and instruction on infection prevention and control, the importance of the staffing levels. And another thing I haven't mentioned yet is the test results need to be prioritized for long-term care homes in the laboratory system. And right now, it's not happening enough.

Certainly our laboratory systems are strained with the volumes of swabs they need to process through the labs, but we definitely see it impacting homes' ability to cohort and, you know, potentially, through those mechanisms, control outbreaks.

The last thing, also, for, you know, sort of, like, immediate things that could be

changed right away, I think sometimes we, in Public Health, are not getting guidelines that change before they're released to long-term care homes and retirement homes. And it makes us need to catch up, and, you know, it misses the opportunity for us to do things in a more coordinated way and provide consistency and direction in messaging. So I think that is also a quick win.

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

COMMISSIONER KITTS: You spoke to the common elements where homes weren't able to contain the outbreaks, and you really stressed the on-site leadership 24/7 and basically the IPAC staffing, that all of that falls out of good leadership and management. You then said that you used Order 29.2 to ensure leadership and management into the homes quickly to get them.

Where do you feel the leadership and management comes from? And in Wave 2, can you get the leadership and management into the homes before the outbreaks?

DR. VERA ETCHES: So in Wave 1, long-term care homes turn to hospitals for more of the expertise and support both around infection

prevention and control and medical support.

And so when I issued the order, I did turn to a hospital to provide that support to the homes, and I do hear from my team that long-term care homes are still turning to hospitals seeking support from hospitals for some of these aspects. I've seen a difference in Wave 2 in the ability for hospitals to provide that support.

So I am concerned about that not being a solution that's as available at this time given hospitals' need to address growing pressures around other critical healthcare needs.

And so to me, I would be interested in a model that actually draws on learning within the sector. There were many homes and are homes now that are managing outbreaks well and so taking a look at, potentially, leadership within other homes that are doing well to support homes that are struggling.

In terms of trying to have that happen before there's an outbreak, absolutely a good idea. And so, you know, the place we're looking to start, of course, these conversations we're having with the management of homes that is the yellow homes and the red homes.

And so as we've gone out and had those conversations with management, we have not found any others at this point where I feel that it's likely we need to get into an order situation. So we are trying to assess that in our phone calls and our meetings.

COMMISSIONER KITTS: You have 28 homes in your Public Health unit catchment area. Do you know what state of readiness each of those 28 homes are in, and how many are you concerned about?

DR. VERA ETCHES: Yes, we do. Through these, with the outreach we've done, you know, we have a good idea and, again, a historical pattern of who struggled.

You know, we have a list of 14 where they've had at least two outbreaks, so recurring outbreaks, so those were the ones we start with. In some of those cases, management has changed since the first wave and we have, you know, a lot of confidence.

And, you know, I think that that's the list that we're working off of because of these other aspects too, the nature of the physical layout that help us predict where people could run into trouble.

COMMISSIONER KITTS: And you haven't assigned a hospital to those homes at this point?

DR. VERA ETCHES: No. And I'm not sure I have the authority to do that either, but we are continuing to work in partnership with, again, this regional structure. But that's not the understanding right now, I think, in terms of what could be accomplished by the hospital.

COMMISSIONER KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

COMMISSIONER COKE: I just wanted to ask a little bit more about your relationship with the Province. One of the things you mentioned before was the issue of not getting the guidelines in advance that would be more helpful.

Are there other things that you feel, based on lessons learned out of Wave 1, that would improve where there's information flow or any other interactions with the provincial level?

DR. VERA ETCHES: I think what is happening now is useful in terms of a daily report to the Emergency Operation Centre. This allows us to flag the current situation and any recommendations or requests or support on a daily

basis, and I'm finding that is useful.

It goes to the Emergency Operation Centre, but we can flag things for the Ministry of Health, the Ministry of Long-Term Care, and Public Health Ontario.

COMMISSIONER FRANK MARROCCO (CHAIR): As you look forward to Wave 2, what do you think is the most significant vulnerability that needs to be addressed?

DR. VERA ETCHES: So I've already spoken about the leadership and the oversight. After that -- and they're related, but more homes are struggling with staffing than with leadership.

So "staffing" meaning personal support workers, other healthcare staff, just having the ability to have more people on site to deal with the greater demands in an outbreak. This is a real need, and we know there are plans underway to address that to try to recruit more people.

Also, there's interest in our region to actually create quick training programs through the colleges. So we have La Cité and Algonquin College in Ottawa, and both of them have said that they would be able to set up rapid programs to bring people in to that personal support worker training

that would lead to certification but could get people into homes more quickly. And they do need funding to be able to run those programs, but that is an option that's being discussed here.

COMMISSIONER FRANK MARROCCO (CHAIR): It seems to me the difficulty with putting a person in a course is that that doesn't put them in the home. And are they talking about some kind of on-the-job working and ongoing education?

DR. VERA ETCHES: That's correct. So it would be an initial short period of training and then training on site and then the option to return to the classroom to finish, you know, the certification.

There are others. Of course, I think we'll be interested in returning to personal support work when they have the right incentives, and I think some of that work has also been announced recently. I think it will make a difference.

We actually saw when personal support workers, especially, had the pandemic pay, it made a difference to their ability to meet their needs. And so going again to extend their income so that it's an incentive to work, that is important.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Anything further?

Okay. Well, I don't hear anything. So well, thank you very much for coming here unguarded. It was very helpful to us.

DR. VERA ETCHES: I would maybe like to make a comment, then, overall about the --

COMMISSIONER FRANK MARROCCO (CHAIR): Go ahead.

DR. VERA ETCHES: -- you know, the governance of the health system. I think that what we've put in place as emergency response structures are voluntary and collaborative, and everyone's trying to do their best.

But we still have, you know, people who are most responsible and accountable to run their organization's operations, and it's harder to move people and resources to where they're most needed when there are, you know, different accountabilities and reporting structures.

So I just would make that observation that it's getting harder now that all organizations are under pressure to move resources around.

COMMISSIONER FRANK MARROCCO (CHAIR): Who should make that decision? Who should

decide -- let's assume you switched it from a consensual model to the command model. Who is the commander, do you think?

DR. VERA ETCHES: I think that's part of the question. It's not necessarily obvious. We have Ontario Health that funds agencies, but we have agencies that also have boards and owners. And it's not clear that Ontario Health has the authority to direct in all of those instances.

COMMISSIONER FRANK MARROCCO (CHAIR): I mean, yeah, I appreciate that the current situation makes it unclear, perhaps, whether you or anybody else has the authority. But if you were setting -- who should have the authority? That's what I'm trying to understand.

DR. VERA ETCHES: Yeah, I'm not, you know, the best person to say necessarily what should happen. I can make observations that in other provinces where there's a regional health authority and everyone is an employee of the regional health authority hat people can be moved around more easily, and there is one accountable person. So that's a different model entirely, but there may be some advantages to that.

COMMISSIONER FRANK MARROCCO (CHAIR):

That kind of a change would take a long time?

Yeah.

COMMISSIONER COKE: Oh, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Anything further?

DR. VERA ETCHES: No, thank you. I just thought I would add that. I appreciate the opportunity, and thank you for this. It's important work that you're doing.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you for taking the time to help us understand this a little bit better and get a little bit more improved perspective on it. So it's very helpful from us, and thank you.

COMMISSIONER COKE: Thank you.

DR. VERA ETCHES: Bye-bye.

COMMISSIONER KITTS: Bye, Vera.

-- Adjourned at 1:35 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, 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 2nd day of October, 2020.

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WORD INDEX