Long Term Care Covid-19 Commission Mtg.

Dr. Gary Garber
on Monday, February 1, 2021

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 1st day of February, 2021, 3:30 p.m. to 4:24 p.m.

BEFORE:

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

PRESENTERS:

Dr. Gary Garber;
Ann Christian-Brown, Counsel, Crown Law Office - Civil, Ministry of the Attorney General;
Roopa Mann, Counsel, Crown Law Office - Civil, Ministry of the Attorney General;
Alwin Kong, Public Health Ontario;

PARTICIPANTS:

Alain Daoust, Team Lead, Long-Term Care Commission Secretariat;
Angeline Hawthorn, Senior Policy Analyst, Long-Term Care Commission Secretariat;
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Gowling WLG;
Lynn Mahoney, Counsel, Gowling WLG;

Michael Finley, Counsel, Gowling WLG;

Joshua Shoemaker, Counsel, Gowling WLG;

ALSO PRESENT:

Carissa Stabbler, Stenographer/Transcriptionist

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

JOHN CALLAGHAN: Commissioners, today we have Dr. Gary Garber who had worked at Public Health Ontario and recently went over to the Canadian Medical Protection Association, and so he's going to tell us a little bit about his experience in Public Health Ontario.

I don't know, Commissioner, if you want to say anything in advance. Or Chair, I should say.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, just welcome, Doctor. You know what we're about, so I won't waste any time with that. There is a transcript which we will post on the website to make sure that people can follow the investigations and inquiries that we're making.

And we will, with your permission, just interrupt and ask questions as we go along rather than waiting and then circling back.

And if that's all okay, we're ready to go when you and Mr. Callaghan are.

JOHN CALLAGHAN: And, yes, we're going to do sort of a more traditional format where I'll just ask Dr. Garber questions.

So, Dr. Garber, I mean, many of us know your background, but could you share your background for the benefit of the others?

DR. GARY GARBER: Sure. Went -- grew up in Montreal, got my BSc at McGill, MD degree University of Calgary. I did my internal medicine training at University of Toronto, infectious disease and research training at the University of British Columbia, and I've been at University of Ottawa in the Ottawa Hospital since 1986.

My specialty, of course, is infectious disease. Soon after I got to that hospital as the first ID physician at the Ottawa General at that time, I was asked to get involved with infection control work because there was no one with expertise at the time.

And I was involved within the hospital incorporating infection control activity for, jeez, about 22 years, I think, until Jack -- until I was able to recruit Virginia to take over.

I was division chief of infectious disease at the hospital for 20 years and helped set up a number of programs at the hospital, the AIDS program, hepatitis C program, and a number of research programs as well.

I then moved to -- I've retained part-time clinical activity with the Ottawa Hospital about eight years ago. I went to Public Health Ontario initially as the medical director of infection prevention control to take on more a provincial lens as a change.

That role changed to being chief as they separate out infection control as a department. And then last year, there were changes as well within the department where it was no longer a separate department. I was then called an IPAC physician.

And then I joined the CMPA in December in the role of director of medical care analytics, basically the patient safety arm of the Medical Protective Association.

JOHN CALLAGHAN: Before we go into your years at Public Health Ontario, could you just provide a little background in the Regional Infection Control Networks and how they got absorbed into Public Health Ontario?

DR. GARY GARBER: I'll try and describe that as best I can. Basically -- Dr. Kitts would remember this actually. Coming out of SARS, there were really three key elements that were put into

play.

One was the Ontario Agency for Health Protection and Promotion which, you know, the nickname now is Public Health Ontario, and that's obviously the name that's being used, PIDAC or the Provincial Infectious Diseases Advisory Committee, and the third aspect was Regional Infection Control Networks.

And the Regional Infection Control Networks were a series of 14 offices across the province, and their goal was to try and improve communication across the province so there'd be harmonization of policies both for acute care and long-term care as well as the general clinical community and with liaison to Public Health.

The reason why I know Dr. Kitts would remember this was he was on the SARS Commission, and at that time, we had already previously put a proposal together to try and set up some kind of regional infection control model for eastern Ontario, particularly Ottawa, and Dr. Kitts asked me for that proposal, and that proposal actually was imbedded as an appendix in the original SARS report.

So they were set up for that purpose.

They were operational for -- you know, I haven't checked back exactly when they started, somewhere around '86, '87, and they still exist today in a slightly different form.

But in 2011, I believe it is, I was no longer -- so I was -- so Ottawa for the Champlain region was one of the first four of the 14 that were established.

Myself and Dr. Roth were -- we were co-led as medical co-leads for the Ottawa -- what we called RICN at that time. And did that for, I'd say, about four years.

I stopped being actively involved in that around 2010 when I started being involved with setting up some antimicrobial stewardship programs within the hospital.

And somewhere in that next year, the programs got transferred to Public Health -- to the new agency, Public Health Ontario as part of a transfer of a lot of provincial programs into the agency.

JOHN CALLAGHAN: And did they get realigned into regional hubs at one point?

DR. GARY GARBER: They did. That happened in 2016, I believe it is. We found --

certainly when I became the medical director and then the chief, we found that there were some difficulty with having very small offices of three people. If you had a three-person office and, frankly, one person was on mat. leave, you would have a two-person office. You then would have someone on holiday.

It wasn't really functioning very well, so the idea was to have -- for partially economy of scale and also to have a critical mass, we elected to combine the office into larger offices still with a regional presence.

So the goal is to really have five hubs: The north, the west, the east, central, and central west, but we retained a number of what we called satellite offices that still retained a presence.

So although there's east, which is based in Ottawa, there's still a satellite office at their provincial lab in Kingston. And north, although it's one, really had people distributed between Sudbury, Thunder Bay, and we had one person working out of Sault Ste. Marie.

And our Toronto hub which had been a series of offices around Toronto got centralized to

head office, but we had a satellite office in Orillia.

JOHN CALLAGHAN: I'd like to sort of speak about Public Health Ontario. We heard there was a bit of realignment, and you mentioned it a moment ago, where the IPAC was restructured. That was in 2019; is that correct?

DR. GARY GARBER: It actually happened in 2020. I first heard of this -- that there was going to be a realignment in 2020.

In fact, my VP at the time flew up to Ottawa and told me that there's going to be a realignment on Christmas Eve, and it was to come into effect on January 22nd, I believe was the date.

JOHN CALLAGHAN: And while we're on it, what did that mean for your role and for the focus of IPAC at Public Health Ontario?

DR. GARY GARBER: Essentially they were amalgamating or consolidating the infection control department with the communicable disease and emergency response team into one department which was going to be called Health Protection.

And there was going to be a -- the second team within Public Health Ontario was going

to be Health Promotion which would include health promotion, some of the other support functions, and I believe it's occupational health.

In doing that, my role as chief was ending -- into discussions because there was going to be a leadership void. I agreed to stay on as a medical director until the end of March in which -- and in those three months, they were going to be recruiting a new medical director for the Health Protection department -- or portfolio I think they called it.

JOHN CALLAGHAN: So IPAC would no longer be a separate subdivision as it were?

DR. GARY GARBER: Separate department, that's correct.

JOHN CALLAGHAN: Prior to this reorganization, what kind of work did your IPAC group do and what kind of numbers of IPAC positions did you have?

DR. GARY GARBER: Okay. Well, initially when I first started, we had about -- we had about 80 FTEs in the department to distribute. In our regional infection control section, originally we had over 40 people distributed across the province.

The rest of the team was divided up predominantly between Toronto and the Ottawa office where I had a small research team.

In that team, especially in the regional offices, two-thirds of that staff were infection control practitioners. The criteria to get that position, you had to have a minimum of five years of active infection control experience along with having your CIC or, you know, Certificate of Infection Control.

And these people were, in many ways, go-to advisors to smaller hospitals, sometimes liaising with larger hospitals when it came to things like Ebola and certainly provided a lot of the education, training, and support for new infection control practitioners in those venues as well as in long-term care.

JOHN CALLAGHAN: And just to be clear, did you have any sort of regulatory oversight function in respect of hospitals in long-term care, or was it really educational?

DR. GARY GARBER: Well, Public Health Ontario, the way the act was created or in the famous napkin that Sheela Basrur wrote on, that policy and enforcement was always within the

Ministry, and guidance and technical support was within Public Health Ontario.

So even the Provincial Infectious Diseases Advisory Committee whose guidelines are used in many ways as the gold standard for infection control in the province are, in fact, guidelines and not policies, although hospitals and organizations may adapt them as policies.

JOHN CALLAGHAN: And what would the Public Health Ontario IPAC division's interaction with long-term care have been in that period?

DR. GARY GARBER: It was quite variable. It was anything from organizing committees of practice to bring local groups together either for meetings or virtually.

It would be for dissemination of documents. So, for example, if there was a new PIDAC guideline, it would be quite a cumbersome guideline. It would be our regional support teams that would provide the interpretation of that guideline to the folks on the ground so they could appropriately implement the guidelines.

We had a whole series of educational videos and pamphlets, et cetera to teach people in different clinical practice how to put on and take

off personal protective equipment, you know, the donning and doffing we talk about.

And so even though the procedures are the same, they were re-targeted whether you were in acute care or long-term care so people felt it was actually appropriate for their particular setting.

And the videos are made at Public Health Ontario. Many of the actors were actually our staff. And, of course, they were often involved with teaching.

The teaching could either be showing the video to a series of staff and going over it. Sometimes it would be -- staff would be watching it during their breaks when the staff would often be called to go into nursing homes to do teaching or long-term care in general, including helping to adapt and adopt hand hygiene protocols, for example.

And more recently or towards the end, we were engaging with some long-term care homes to engage a urinary tract infection program to decrease the number of cultures taken for asymptomatic urinary tract infections.

And our pilot showed that by doing that, we could decrease antibiotic utilization in

these nursing homes by between 30 and 35 percent.

COMMISSIONER JACK KITTS: Gary, can I just ask a question to make it more clear in my mind? So SARS was a hospital disease spread in hospitals, and your proposal to the SARS panel was to ensure that the hospitals that had the IPAC expertise shared it with the community hospitals across the region as the Regional Infection Control Network, and yours was one of them.

So since then, is the relationship between hospitals and long-term care -- was that taken over by IPAC central, and what is the relationship between infection prevention and control and long-term care homes coming into COVID?

DR. GARY GARBER: That's a real complex question, Jack, quite honestly because it's highly variable. If you break it down into segments of health care -- so, for example, in acute care, we have this maldistribution of infectious disease, infection control, and microbiology expertise.

And you will see that the Ottawa Hospital may have 20-odd experts, and next door we have our children's hospital that has another 4 or 5 or 6.

Until recently, hospitals in Ottawa

like the Montfort and Queensway Carleton did not have infectious disease expertise. And if you go across the province of 115 or 120 hospital corporations, probably three-quarters of them do not have that expertise within their walls.

In northwestern Ontario now, you have two infectious disease experts, and no one with microbiology expertise. They're incredibly swamped.

Northeastern Ontario, it's only based in -- I think there's one in Sudbury and one in Sault Ste. Marie. And you go right across the province and see the same thing. In southwest, you have your expertise really in London, but west of London you don't have that expertise.

So the idea really was to make sure that people working in these smaller hospitals -- and some of them aren't all that small. They can be 150-, 200-bed hospitals -- can tap into the expertise to make sure that their patients are similarly protected as the landscape changes.

So that's just acute care. Long-term care, there's no template. Until really the spring, there was no real connection between acute care and long-term care.

A lot of the long-term care support for outbreaks, which usually would tend to be respiratory outbreaks, occasionally gastrointestinal outbreaks, was really under the purview of the health units who would go in and investigate and basically limit visitation and things like that.

The acute care teams really had very little to do with that other than at times supporting the Public Health units when they had questions.

And the Regional Infection Control Networks were kind of a bit of an interface between the acute care Public Health and the long-term care sector either providing guidance, education, support.

In many cases, in some of the regions, we would actually do joint educational sessions with the local RICN and the health department or the health unit.

COMMISSIONER JACK KITTS: Right.

DR. GARY GARBER: I don't know if that answers your question.

COMMISSIONER JACK KITTS: Well, it's -- where is the responsibility or accountability for

ensuring -- like, in the proposal after SARS, there was an agreement that the hospitals that had the expertise were to share it or, like, a hub-and-spoke with the hospitals that didn't, and I think there were created coordinators, infectious disease coordinators.

Wouldn't the natural progress be to go from there to a long-term care home and, you know, where would that leadership come from?

DR. GARY GARBER: Again, great question that I don't have a good answer for, to be honest. I don't think we had one model across the province. I think it was very -- I think it was very regional.

I think just like many other aspects of health care, a lot of it was dependent on kind of who you know, what kind of local relationships you had as opposed to saying that -- you know, there wasn't -- you know, the Regional Infection Control Network had a rule, and you may recall that even that in some jurisdictions, not in our area, not in Toronto but in other areas, there was controversy into how that was funded because the regional networks were actually kind of through the Public Health branch, and there was a sense at one time

where some of the Public Health units said, "Well, why is the money going to this network? Why isn't it going to Public Health?"

So, I mean, even the setup of the RICNs at this time was not without some controversy.

COMMISSIONER JACK KITTS: Okay.

DR. GARY GARBER: Just to elaborate, the RICNs were initially set up in line with the LHINs, the Local Health Integration Networks, even before the LHINs were established.

And initially when the LHINs started, the RICNs were not part of the LHINs and then were put part of the LHINs. So there's a lot of back and -- to'ing and fro'ing and back and forth politically, and that's your...

COMMISSIONER JACK KITTS: Just one more question on that then. So you're aware of the hub-and-spoke model now between hospital and long-term care.

Is that very similar to what you did many years ago after SARS except it's now hospital to long-term care? And if so, is this the model that's going to succeed, in your opinion?

DR. GARY GARBER: In my opinion, I think that model will work really well in Toronto

where you have, you know, 7 or 8 large hospitals with a lot of expertise. And what, the Toronto area has 23 long-term care homes? You can divide that up easily.

If you go into eastern Ontario where you have two academic -- large academic centres in Kingston and Ottawa and, in between, you may have 70 long-term care homes, I think the numbers don't add up.

And you have the same kind of problem if you look at Hamilton and Niagara or the same problem you're going to have in central west or southwestern Ontario.

So, again, it's an issue of how do you divide it up? Do you have some hospitals in downtown Toronto then supporting long-term care in Orillia north? I don't know if that's been really thought through in terms of how you distribute the expertise to 600 long-term care homes. So I do have concerns about that model.

Back in June when we had some discussions about that, you know, there was talk at the time that you'd sort of have three levels. You could have sort of some provincial oversight. You could then have some regional support which could

have been the Regional Infection Control Networks providing such support, and then at the local level, you could have hospitals involved.

So you could -- so the hospitals could do their part, but you'd also have another layer that could fill the gaps where the hospitals couldn't do it with some overall provincial policies.

My understanding early on with some of the proposals that was on the table, I don't believe that has gone forward.

COMMISSIONER JACK KITTS: Thank you.

JOHN CALLAGHAN: Yes, Ms. Coke?

COMMISSIONER ANGELA COKE: You had mentioned before in 2020 they had done the realignment of IPAC function.

I'm just interested from your point of view if that's something that has either strengthened or weakened the robustness of the IPAC function.

DR. GARY GARBER: In my opinion, I would say it has significantly reduced the robustness of infection control within Public Health Ontario, and part of that was how it was rolled out.

Although it was an amalgamation of two departments, the entire leadership of that portfolio was all from the communicable disease side of the house. So all the infection control expertise was much lower down.

So, for example, when they did set up the Incident Management System, the IMS system, and the infection control activity was quite low down having to report through several layers before it would get up to senior leadership.

So there's actually some -- I wouldn't say it was intentional, but it ended up becoming more problematic because some of the IPAC issues out front unless one tried to, shall we say, jump the system somewhat.

And certainly what that did in its implementation was it truncated the ability of the regional teams to do the work that they were doing in the community because there had to be a number of layers of approvals before, for example, they could go into a long-term care home.

COMMISSIONER ANGELA COKE: Okay. Thank you.

JOHN CALLAGHAN: So just take a jumping-off point there, but before we do, I just

want to make it clear that while you had programs that would assist long-term care homes, they weren't required access to your program.

I think the phrase you used with me was selection bias, which I take it means that it was up to them to avail themselves of what was available; is that right?

DR. GARY GARBER: That's correct. So the urinary tract program that I mentioned, we did a pilot in two. We use a municipal home and a private home. We eventually rolled it out on several iterations using a very iterative way of getting people -- well, it's over 100 homes.

But we then wanted to get the next 100 homes in, and then it became difficult to get homes to sign on to participating in the rollout of the program.

And we have no jurisdiction to mandate it. All we had was great data to show how this program would be good for their residents and, frankly, save their staff time, but if they weren't interested, there was really nothing we could do about it.

JOHN CALLAGHAN: So we've heard, frankly, some very horrific stories about the state

of IPAC in some of these homes, and I take it they could self-select as to whether they wanted to get better by taking your educational courses or not; correct?

DR. GARY GARBER: That is correct. And, Mr. Callaghan, as we did discuss previously, one of the biggest difficulties that my former staff had identified was the dramatic turnover of staff within long-term care homes.

So if you had a really good nurse and you were going to put some time into him or her developing skills, infection control, and my team might be acting as mentorship and they're doing that and trying to implement it, if that person was good, probably within a number of months they were given other corporate responsibilities, or they would move to a different facility.

And it was the same thing with training the staff in long-term care homes. You could train the staff in hand hygiene, and three months later, the staff turnover was such that you'd be starting from scratch.

So it was very difficult to be able to maintain the level of basic IPAC expertise within the homes.

COMMISSIONER FRANK MARROCCO (CHAIR): Did it matter, Doctor, whether it was a for-profit or not-for-profit long-term care home?

DR. GARY GARBER: Commissioner, we didn't really look at long-term care homes from the perspective at that time. And I can tell you there -- you know, there was one -- there was one private or, whatever you call it, long-term care home chain that was certainly very interested in infection prevention control, actually asked our expertise because they were trying to develop their own surveillance system.

And yet there are other homes that I'd had some meetings with who seemed interested, but -- and we couldn't get to first base. Yeah, I don't know if one can paint them all with the same brush.

COMMISSIONER FRANK MARROCCO (CHAIR): And the not-for-profits, any noticeable difference in their attitude towards this?

DR. GARY GARBER: We never did -- certainly I didn't and my team, we never did that as an analysis. The first time we really started looking at the analysis was when some of my colleagues -- and you know the data now -- looked

at the COVID rates and identified that data.

And, you know, I'm one of those papers. One of my staff, Kevin Brown -- talked to Kevin Brown who is an epidemiologist, was very involved with those analyses. Prior to that, we had never formally had data to substantiate a difference.

COMMISSIONER FRANK MARROCCO (CHAIR): So from your perspective, it was just a long-term care home?

DR. GARY GARBER: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Could have been in private, public, charitable? It didn't matter from your perspective? You weren't looking at it like that?

DR. GARY GARBER: We were not, no.

JOHN CALLAGHAN: We, on a previous occasion, looked at the senior management structure of Public Health Ontario, and I think between the beginning of 2019 and your departure, 12 of 24 senior managers were gone.

And I was wondering, did you have attrition within the IPAC group over the 2019-2020 period?

DR. GARY GARBER: 2019 we had what I

call sort of our usual turnover of a couple of people retiring or finding better -- you know, better opportunities.

We were limited halfway through the year in terms of replacing people who were leaving because the concerns about the budget.

2020 was very different. As much as I had tried, even with the change in the department, to maintain a message to the staff that even though IPAC was not a separate department, that the work was every bit as important, particularly with the start of a pandemic, and that the focus on the staff should be in terms of good work and a reporting relationship.

Nonetheless -- I'm just trying to think. Probably from March until November and it has continued since, we had at least ten departures of senior, very experienced individuals from the organization prior to my departure. And I know there's been several actually just in the last month.

JOHN CALLAGHAN: When we talk about IPAC -- and Commissioner Coke was going on this point. You have the regional offices, and at the time that COVID hit, say, in March, how many staff

did you have out of the community who were IPAC specialists?

DR. GARY GARBER: I think -- well, the community would include downtown Toronto. I think we had somewhere between 25 and 30 certified infection control practitioners within Public Health Ontario, and on top of that, we had, you know, myself as a full-time physician and my part-time physician colleagues who also have interest in IPAC.

So we had a pretty sizable team in terms of being able to provide support or sometimes what we call the ICRT, the Infection Control Resource Team. It'd be a team we'd send into a hospital or long-term care in an outbreak to do a one-day investigation and provide recommendations.

JOHN CALLAGHAN: So we've heard IPAC was a continual story in all these long-term care homes that went into outbreak, and I was just wondering whether you felt your group was utilized, and if it was, whether it was utilized appropriately, and if not, what observations you have about it.

DR. GARY GARBER: Well, it's hard to -- you know, part of that is, you know, I'm trying to

remember back what was going on and, you know, try and separate sort of, like, you know, my feelings from my thoughts, if you know what I mean, because it was a very -- you folks know.

You can imagine what it's like to be working 7 days a week, you know, 14, 15 hours a day, and it's all bad news. And you have a group of people who really want to do a lot, and you have some ideas, and we were in a situation where we were losing the ability as a department to really get to the senior leaders saying, "Hey, you know, we can do some things."

So, I mean, I think that was sort of -- so you have to sort of frame it a bit that way. And part of that difficulty is that there was -- because of the formation of Ontario Health, there was this real concern within Public Health Ontario that if the organization looked too much like health care, that Public Health Ontario would be subsumed with the other organizations and agencies into Ontario Health.

And so, you know, it was told to me indirectly that one of the reasons to have a lower profile IPAC department is we were the only department within Public Health Ontario that really

had a clinical face. Of course, the other is the lab, but, you know, the lab is the lab.

And so they didn't want the IPAC department to have a big visibility in this. We were involved with committees and things like that when we're called upon, but when we brought up saying, "Hey, you know, we could send in -- if there's a couple of nursing homes in an outbreak, we could send a team in, investigate, and make recommendations."

You know, we were basically told, "No, we don't have the bandwidth for that. No, we can't do that. No, it's up to the health -- it's the health unit's responsibility to do that. They can call us in when we need it."

So one of the frustrations for a lot of my staff at the time -- it was my staff really until the end of March. Then I guess you could call it -- it was my -- I don't even know what the term is. I felt a connection but no official reporting relationship.

There was a real frustration of the fact that these people with expertise were not able to basically help out to scope.

COMMISSIONER FRANK MARROCCO (CHAIR):

This was fundamentally so that it would not give the impression of being a health care service provider because, if it was, it would get absorbed by Ontario Health?

DR. GARY GARBER: Well, that was a concern of the former CEO. My editorializing is his approach to, you know, budgetary structures, things like that was keep your head down so, you know, no one chops it off. And so I think that was why we're sort of being put below the radar.

But realistically, in March, the notion was our role is support Public Health, and Public Health's role is long-term care, so we will support Public Health when they want us to support them.

JOHN CALLAGHAN: So that I understand, you had 25 to 30 people who were quite capable of going into long-term care homes and assessing --

DR. GARY GARBER: Correct.

JOHN CALLAGHAN: -- a situation from an IPAC perspective --

DR. GARY GARBER: Correct.

JOHN CALLAGHAN: -- and they weren't used?

DR. GARY GARBER: That's correct.

COMMISSIONER FRANK MARROCCO (CHAIR):

I'm sorry, Mr. Callaghan. I missed your question. And they weren't used? Is that what you said?

JOHN CALLAGHAN: They weren't utilized. In other words, there were 25, 30 senior IPAC specialists, five years of training, who were available to go in and assist long-term care homes either individually or on a team basis, and they weren't utilized by the Province. Have I got that right, Dr. Garber?

DR. GARY GARBER: That's correct. And I'll expand. Most of the people we're talking about would have been people with ten or more experience.

To give you an idea where some of these people have gone since they left Public Health Ontario, one is doing work for the WHO. Several others are now acting as -- basically managers of IPAC for some long-term care homes including, you know, for hospitals, et cetera, and others are doing consulting work.

So, I mean, they were helping out, but, I mean, a lot of this happened much later on. And I know those who stayed, and a number, you know, before I left expressed a lot -- they've expressed a lot of burnout because of the feeling of

frustration with what they couldn't do.

I think we all have the same sense that we wish we all could have done more back in March and April.

COMMISSIONER FRANK MARROCCO (CHAIR): And this was largely driven, in your view, by a desire to keep a low profile so as not to get absorbed by Ontario Health?

DR. GARY GARBER: Well, I think that's part of the underlying. It was a real shift that even though -- the IPAC department was always considered different from the other departments because we had connections, not only -- our role was to work with Public Health but as well the health care sector.

So we were unique among the other departments in that respect. And the push really was that the focus would be exclusively to the Public Health units.

JOHN CALLAGHAN: I think you'd mentioned to me, like, this was a unique experience. I mean, this is a once-in-a-century pandemic for that type of worker. What did it mean to the workers not -- or the IPAC specialists not to dig in, as it were?

DR. GARY GARBER: Well, you know, at the time, I was explaining it to people that, you know, COVID really was the IPAC Olympics, that, you know, we had people who had been training for years, who had the expertise to support their hospitals. We always had little outbreaks. We knew how to do outbreaks. We knew how to cohort people, et cetera.

And with all that training you've heard, this was the time to get out there and -- you know, I don't want to say "go for the gold." That's pulling that analogy way too far, but, you know, at least participate. And instead, the staff were sitting on the bench.

JOHN CALLAGHAN: Did that remain so until you left in December, as far as you were concerned?

DR. GARY GARBER: Well, it changed somewhat towards the end of April, you know, as the -- I mean, again, I wasn't -- you know, I was peripheral to some of the discussions and because I was involved with some Ontario Health committees, so I had the opportunity to bring some of these issues up to some of the folks there.

But in the end of April, some of the

IPAC folks were now being asked to go into long-term care and review the processes and make recommendations.

I was no longer supervising that, although I did in May join one of the team members in Ottawa to do a site visit because I wanted to see the process myself.

But -- so there was some of this going on, but it was -- you could almost say it was more of a peacetime inspection. Most of these homes were either coming out of outbreak or were considered at risk of future outbreak. It was not going on at the time where things were at their worst.

JOHN CALLAGHAN: Were you called in -- at that time, were they called in to work with inspectors of long-term care or inspectors of labour, or was this an independent review?

DR. GARY GARBER: Jeez, now I can't remember the exact details. Basically our folks would often go in with someone from the health unit, and I know a lot of the focus was on long-term care homes that were either considered in the red or yellow; in other words, they were at risk of outbreaks based on previous problems or

because they had been previously in an outbreak. So that seemed to be the priority to go into those kind of homes.

JOHN CALLAGHAN: In March and April, I take it from what you were saying -- did you raise this issue with others?

DR. GARY GARBER: Most certainly. In March, I was actually joining the Ontario Health's long-term care table. I was then replaced when Dr. Jessica Hopkins joined and became the medical director.

We didn't need four people on those calls, so I was focusing more on the PPE parts with different aspects of the Ministry.

But at that time, I'd had some email and I had a conversation with Catherine Brown. I certainly talked to the people within Public Health Ontario, you know, Shelley Deeks and then Jessica Hopkins, just to remind them that we did have the capability of making a difference and tried to build on the expertise we had when a few of the members of the Ottawa office helped with the repatriation of passengers to the Trenton Air Force base.

And our team had the -- when they went

there, they were actually training in realtime the Red Cross volunteers and helped with the cohorting of the people who came off the plane and where they went into the homes for that period of time.

So it was -- and that was extremely well received by the Federal Government, the military, and the local Public Health unit where, in fact, were subsequent repatriations. We then got formal letters of request to enter from the Federal Government.

So we had that expertise where we knew it made a difference. If you went where people are well-intentioned but didn't have the experience and you had one or two people with experience, you could do the training just in time to make sure people had the PPE, knew what to look for, and not spread disease.

JOHN CALLAGHAN: You mentioned emails. We've had some difficulty with the emails. So there were emails to Ms. Brown, Ms. Deeks, and Ms. Hopkins; is that your recollection?

DR. GARY GARBER: Yes.

JOHN CALLAGHAN: We'll follow up with the government to get those.

Now, the last thing I just wanted to

cover with you is you did sit at a couple of these tables, and perhaps you might tell us what that experience was like. You just mentioned one there, the --

DR. GARY GARBER: A lot of the tables I was at were related to either the use of PPE, the appropriate use of PPE, discussions with unions in terms of some of the controversies related to that, and some of the other -- in fact, I was one of the, I guess, advisors to the PPE allocation committee.

I was also providing expertise to Attorney General's office related to the courts, Solicitor General related to the prisons. We provided advice to Ministry of Education related to some of the rollout of PPE for the schools. So, I mean, there's a lot of work there.

My experience is that -- you know, sometimes when I read the newspapers or the commentaries and I see people always trying to provide their other points of view, I think a lot of people recognized how many people were working incredibly hard to do the right thing in realtime with changing information and changing advice.

It was certainly a unique experience. I would say it could be frustrating, but in most

cases -- you know, in almost all cases, the sense of collegiality of everybody wanting to do the right thing was really impressive.

You know, I say this only because, you know, it's really easy to point fingers at people who work in government in retrospect to say, "Why did you make that decision?"

But, you know, in many cases, what I saw was the best decisions were being made with the information we had at the time. And then you got new information, and you had to make modifications.

And I'm talking about the science part. The politics, you guys can hear that from other people.

JOHN CALLAGHAN: I think those are all my questions. Do the Commissioners have further questions?

COMMISSIONER FRANK MARROCCO (CHAIR): I don't know that we do, but I do have one -- maybe what might end up being the last question, and that is is there a change that you would -- that occurred to you, a different way of approaching the problem?

DR. GARY GARBER: I'll tell you one of my most frustrating moments back in March. It's

when I was on a call on a Friday afternoon with one of the long-term care homes that was in outbreak.

And it was unclear at the time. They had about two cases. There was four or five other patients from clients/residents who were ill, who were being tested.

And the question I asked the home with the health unit was, "Can you cohort? Can you move the sick people? Can you take the ones you know have COVID in one place, the sick people in another and separate them from the rest?" And the answer I was told was no.

And it was the one time -- maybe one of the few times in my career that I just felt helpless because I just knew what was going to happen.

I mean, it's one of those homes that ended up having, like, 90 percent infection rates, and you just knew it was going to happen. It was very clear that on the ground, they didn't know what to do about it, and we weren't in a position to help.

And the reason why I say that is I learned from that because then -- because I learned that I didn't ask the right question. Because the

question I should have -- when they said, "No, we can't cohort," the question I should have asked was, "If everyone is in their room, what are you doing with your dining room, or what are you doing in your rec room? Can you use that space as swing space to cohort sick people?"

How do you think outside the box when you have to control your infection? You know, in a submarine where there's a hole, you close off that section. How do you do that in a long-term care home?

And, yes, two months later, a lot of the long-term care homes started putting in outbreak protocols and figuring this out, but at the time, that was not something that had ever been done.

And I think that was a lost opportunity at that time because the expertise and cohorting was not in the long-term care homes, and frankly, in most cases, wasn't in the health units.

And we had a team, and in retrospect, we -- maybe we should've pushed harder to say, "No, we really need to have a look at this so we can help you make these decisions," but it was all happening too fast.

So I think, to me, that's one of the real lessons learned that I had was we didn't think outside the box in terms of how we could use the equipment, how we could use our staff. A month later, we were in a better position, but a month later, for some people it was too late.

COMMISSIONER JACK KITTS: Gary, this may be in the same line of -- because I know exactly what you're saying about doing the best -- making the best decisions with the available information, both science and experience.

Thinking outside the box for long-term care, did you think about creating capacity outside the home in other facilities like pop-up areas or in hospitals which had now much lower occupancy rates? What was your thought process about using those methods?

DR. GARY GARBER: Yeah, I mean, that's a great question, and, you know, part of that is, you know, it just happened that I was doing a week-on clinical service at the General the week of March break when, you know, we declared emergency.

And think about it. A week before, we didn't feel we had an emergency. So here we are declaring an emergency. I'm covering the

infectious disease service. The hospital is at 100 percent capacity.

Once we went to emergency, then we cleared out capacity, but from March 15th probably to the first week in April, that capacity in acute care didn't exist.

So, you know, when it was being used later on, you know, where hospitals are down to 60 percent occupancy, it made sense, you know, where people were able to, you know, now use hotels that were empty. I mean, again, on March 15 to March 20, none of that existed.

So, again, that's where the retrospectoscope -- could we have thought on March 2nd we should clear out the hospitals? Had we done it, people would have thought we were crazy. So, you know, I think it's all a matter of timing.

JOHN CALLAGHAN: You made a comment. Do the Public Health units have IPAC specialists or --

DR. GARY GARBER: Yes, they do.

JOHN CALLAGHAN: So they would have had some scope --

DR. GARY GARBER: Oh, yeah, they do,

but, you know, again, you can have a health unit where there's one person responsible for infection control for a region. You know, you have a few people doing communicable disease who may not have IPAC experience. They have Public Health inspectors.

But it's not as if you have a -- you know, some of the bigger health units have some capacity, but in the smaller health units, you just don't have that person who is going to be able to run around to six, seven long-term care homes.

JOHN CALLAGHAN: In your years, did you ever get asked to attend a pandemic planning session whereby you would have drilled scenarios?

DR. GARY GARBER: I think we did, as I can recall. I remember we did training in the IMS system. We did some -- we did a tabletop exercise at some time or another. I honestly don't -- at this point, I don't remember the details.

JOHN CALLAGHAN: That's fine.

DR. GARY GARBER: I certainly don't recall it happening much after. We probably did some stuff around Ebola, but I don't remember much after that.

JOHN CALLAGHAN: Okay. Those are my

questions. I don't know if the Commissioners have anything further.

COMMISSIONER FRANK MARROCCO (CHAIR): Doesn't seem like it. So, Doctor, thank you very much for sharing your thoughts with us. It's a perspective we didn't have really before we got a chance to speak to you, and we very much appreciate it. Appreciate your thoughtfulness.

DR. GARY GARBER: Well, thank you. I was just hoping it was helpful.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 4:24 p.m.

REPORTER'S CERTIFICATE

I, CARISSA STABBLER, Registered Professional 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 1st day of February 2021.

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

Page 8, line 3: The line "around '86, '87" should state "around" '06, '07."

Page 14, line 14: For clarity, Dr. Garber was referring to PHO staff at line 14.

WORD INDEX